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ADULT CHILDREN OF ALCOHOLICS AS THERAPISTS: A PHENOMENOLOGICAL STUDY OF LIVED EXPERIENCE

by

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ABSTRACT

This study focuses on therapists who label themselves Adult Children of Alcoholics (ACOAs), and counsel clients who are also ACOAs. The purpose is to describe the experience of counseling through a phenomenological inquiry into the question: "What is the experience of counseling Adult Children of Alcoholics, for the recovering therapist who is also an Adult Child of Alcoholics?"

Since this research issue involves the generation of new data, a qualitative methodology was most appropriate. An unstructured, dialogal interview process was utilized with the aim of extracting the "essence" of this lived experience, as described by the participants. The interviews were audio-taped and transcribed verbatim for the purpose of data analysis. Four participants provided a solid information base for this study.

The procedures of analysis that were employed are outlined by van Manen (1985) and Berg (1989). The main focus was on uncovering common themes and meanings in the data. Five major themes emerged, along with several sub-themes. The first theme was named "Developmental Stages", and was divided into three segments: i) Lack of Awareness, ii) Emerging Awareness, and iii) Striving for Integration. Several sub-themes were included in this theme. Other themes were labelled Control, Responsibility, Boundaries, and Confrontation. The sub-themes that were included with these themes were: Roles, Authenticity, Abandonment, Self-Disclosure, and the Affect on Clients of the self-disclosure.

Implications have potential relevance for clients, in assisting them with their choice of therapists. There are also ramifications for the training of students and therapists in the helping professions.

We gather other people's experience because it allows us, in a vicarious sort of way to become more experienced ourselves.

van Manen, 1985

ACKNOWLEDGEMENT

I would like to extend my heartfelt appreciation to the co-researchers who so willingly shared their experiences with me. This study would not have been possible without their openness and full cooperation.

DEDICATION

To my mentor and friend whose unconditional love nurtured my consciousness to a new view of the world.

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CHAPTER ONE

INTRODUCTION

STATEMENT OF PURPOSE

This study is for the purpose of understanding and describing the experience of counselling Adult Children of Alcoholics, for therapists who are themselves recovering from being raised in alcoholic homes. The inquiry focuses on the generation of new data, grounded in the philosophy of existential-phenomenology, which is built on the foundation that the human condition must be understood free of the presuppositions of our cultural heritage (Valle & King, 1978). The goal is to evoke the essence of this lived experience as revealed through descriptive techniques. With the understanding that there is a mutual dependency between the individual and the world, the aim is to bring to reflective awareness the nature of this personal experience in conjunction with the understanding of others (van Manen, 1985).

BACKGROUND

A 1985 Gallup poll reports that nearly one out of four people state that alcoholism is a problem somewhere in their family (Marlin, 1987). Historically, the identified patient was the substance abuser. More recently, the spouse of the abuser has been recognized as a co-dependent who is preoccupied with the behaviour of the alcoholic (Schaef, 1986). As a result of such marital unions, there are an estimated 28-34 million children and adults who grew up or are being raised in families where the focus is on alcohol, rather than the welfare of the family unit.

Members of such dysfunctional families adopt rigid roles as a method of coping with and surviving a chaotic childhood (Woititz, 1983). Several of these roles condition the child to give service, take care of others and focus on understanding how to deal with relationships (Wegscheider-Cruse, 1987). In adulthood, a disproportionate percentage of these individuals gravitate toward helping professions. Gil (1988) claims that this career choice represents a type of displacement where the adult child is able to recreate her original life situation by relating to a client through a symbolic representation of the self.

There is a consensus in the literature that if a therapist practises counselling ACOAs before they themselves have been treated for the traumas of their own childhood, they not only perform a disservice to clients, but perpetuate their own co-dependency (Schaef, 1986; Cermak, 1986; Wegscheider-Cruse, 1987; Whitfield, 1988). Wegscheider-Cruse (1987) states:

> Co-dependent therapists as counsellors become accomplices——would-be helpers whose actions undermine and thwart the therapeutic process. (p. 5)

The literature suggests it is critical that therapists identify their own pain remaining from childhood and work through a recovery program. This life-long process requires a strong sense of commitment to self.

FRAMING THE RESEARCH QUESTION

During the initial stages of my own recovery as an ACOA, I began to realize that this experience was having a powerful impact on my clinical practice. What my clients and I perceived as my profound sense of compassion was more a reenactment of my childhood role as parental caretaker. The burden of this responsibility evoked the same anxieties I experienced as a child. This traumatic reaction alerted me to the fact that once again I was in the midst of dysfunctional relationships, this time involving clients rather than family members. As my recovery process continues, my guiding philosophy is that while I am *in* a system that often promotes such dysfunctions, I must not be *of* it.

Lofland & Lofland (1984) suggest that social researchers "make problematic in our own research matters that are problematic in our lives" (p. 8). Reflecting upon my experience has served as the basis of the evolution of my research question. The core question of this investigation is: "What is the experience of counselling Adult Children of Alcoholics, for the recovering therapist who is also an Adult Child of Alcoholics?"

CHAPTER TWO

CONCEPTUAL FRAMEWORK OF THIS STUDY

The conceptual framework that guides this study is grounded in a humanistic paradigm which values the essence of the individual. It also encompasses a holistic perspective where the individual reflects his/her world and simultaneously, this world mirrors the individual (Schaef, 1989). This approach assumes the axiom of Systems Theory which stresses that the whole is greater than the sum of its parts (Von Bertalaffy, 1968). The research modes which best exemplify these concepts are embodied in "qualitative" methodologies. They present alternative paradigms to the traditional, positivist perspective, and are often labelled: post-positivistic, ethnographic, case studies, phenomenological, hermeneutic, and naturalistic.

CRITIQUE OF QUANTITATIVE RESEARCH

Quantitative methodology is considered a useful approach to reality if the aim is to numerically measure a social phenomenon (Patton, 1975). Traditionally, it has also received a greater measure of respect, since it is based on the normative paradigms of our society. This paradigm of empiricism and logical positivism views the world from a stereotypically male value system where objectivity, fragmentation, and generalizations are accepted as the only way of

being in the world. It is the hallmark of our high-tech society, in which control of the research process is paramount.

Critics of this world view assert that it approaches and portrays reality through a narrow set of lenses (Schaef, 1987). Lincoln & Guba (1985) state that this leads to a limited, inadequate conceptualization of science. By operationally defining concepts, subjective meanings and intricate implications are lost. Deducing theory from the data suggests that the attained conclusion is the only possibility for consideration. This leads to a determinism that limits human free will and a reductionism that attempts to force humanity to abide by a single set of laws. The assumption is that reality can be broken into segments and studied independently. A hierarchal premise separates the researcher from the subjects under investigation. The axiological assumption of "value freedom", alienates the researcher from self, by implying that one's values and biases can be disassociated during the research process. In my view, this approach to research ignores the humaneness of all individuals involved and the interrelatedness and complexity of social issues.

Schaef (1987) indicates that these concepts operate under the myth of the "White Male System" which claims to know and understand everything. It suggests that this is the *only* perspective and innately superior to any other. I concur with Patton (1980), that a "paradigm of choices" must exist, which recognizes that different methodologies are appropriate for asking different research questions.

The alternative paradigm which I will now present is more appropriate to my research question.

ALTERNATIVE PARADIGMS

GROUNDED THEORY

The discovery of "Grounded Theory", attributed to Glaser & Strauss (1967), is a qualitative methodology in which the theory is "derived from data and then illustrated by characteristic examples of data" (p. 5). This generation of theory involves a process where hypothesis development, data collection, and data analysis are performed simultaneously. The ultimate aim is to explain a societal process through constant, comparative analysis.

Some of the basic tenets of this methodology will be utilized in this study. However, Reason & Rowan (1981) contend that the methods of grounded theory remain within the boundaries of the old paradigm "where the researcher essentially retains an *objectivist* perspective and *uses* his subject matter to his own ends" (p. xx).

NEW PARADIGM RESEARCH

Several concepts are central to the "New Paradigm" that distinguishes it as radically different. Collaboration, participation, experiential knowledge, and heuristic explanation are key principles. Cooperation between researcher and subject is paramount, as both contribute to creative thinking in all stages (Haron, 1981). Hierarchy dissipates as participants are in a peer

relationship, sharing fully in the process of the research experience. Filstead (1970) states that the "gap between the empirical social world and the researcher's interpretation closes" (p. 5), since the life experience of the subject is esteemed as valid, and the researcher's own consciousness become an integral part of the process (Stanley & Wise, 1983). The research cycle involves a new way of being, thinking, communicating, and making sense of the world (Reason & Rowan, 1981). Questions that are asked are relevant to humanity. The method of investigation is congruent with the question and allows for serendipity throughout the whole process. The "self" is included in the data and remains open to the experience as it proceeds. A holistic strategy is maintained as an effort is made to capture the gestalt of the question being asked.

This paradigm stresses that the aim is to understand rather than to predict a phenomenon under study. Focus is on obtaining detailed descriptions of people and their experience. This necessitates the extension of propositional and practical knowledge to also include experiential knowledge (Reason & Rowan, 1981). This subjective, first-person knowing serves as the basis for formulating inner hypotheses which can be checked for validity by being compared to other peoples' subjective knowledge. Rogers (1964) states that the criteria for validity in the new paradigm are two-fold:

> Either my hypothesis about the internal frame of reference of this individual is confirmed by the individual himself, or the inferences made about his internal frame of reference are confirmed by consensual validity (p. 8).

Therefore, validity in this context is concerned with the "meaning and meaningfulness of the data collected and instrumentation employed" (Patton, 1975, p. 18).

This model emphasizes that experiential self-study produces data that are not distorted deliberately or unintentionally, because constant feedback between researcher and subject identifies incongruities (Reason & Rowan, 1981). Strategies utilized to ensure that data are interpreted accurately are: remaining close to the data, having sensitivity to qualitative distinctions, viewing the process from a holistic perspective, and developing empathy with the participants by focusing on their personal meaning of the data (Patton, 1975). The result is an "interpersonal knowing" which requires a safe, trusting atmosphere where the internal frame of reference can be divulged (Rogers, 1964).

Trustworthiness is an essential component of validity and must be established if data are to be applicable to the study, consistent between subjects and free of bias (Lincoln & Guba, 1985). Constant re-checking, peer debriefing, and making explicit the researcher's assumptions are several methods which aid in producing trustworthy and believable data.

Stanley & Wise (1983) state that to generalize such data would cause it to "lose the particularness of reality" (p. 46). This paradigm recognizes that social phenomenon are so variable that the data must be interpreted in context, considering local conditions, and focusing only on the participants of a particular study (Patton, 1980). Generalizations that are made between these subjects can only

be generalized to others as a working hypothesis, to generate another specific study, rather than as a conclusion on the initial inquiry.

EXISTENTIAL-PHENOMENOLOGY

Phenomenological inquiry is a methodological approach, falling under the rubric of New Paradigm Research. This approach was employed in this study. Van Manen (1985) describes this as the study of lived experience, where we seek to disclose and elucidate the essence of phenomena, through an insightful thoughtfulness in an attempt to gain deeper understanding of what it means to be human. Existential-phenomenology is an extension of this philosophical principle:

> which seeks to explicate the essence, structure, or form of both human experience and human behaviour as revealed through essentially descriptive techniques including disciplined reflection.
>
> (Valle & King, 1978, p. 7)

The research question asks what it is like to have a certain experience, with the aim to connect a relationship between the consciousness of the subject and the external world (Van Hesteren, 1986). The focus is on the subjective construct of reality. From this perspective the traditional form of objectivity serves to eliminate and deny the essence of reality. Colaizzi (1978) stresses that:

> objectivity is fidelity to phenomena. It is a refusal to tell the phenomenon what it is, but a respectful listening to what the phenomenon speaks of itself (p. 52).

The assumption is that reality is within the human mind and should be respected and affirmed as valid experience. Through sustained contact and openness to serendipity, the researcher utilizes a "verstehen approach" which stresses that only through empathic understanding of the other's perspective can we make meaning of their reality (Patton, 1980). This necessitates the researcher to be an authentic human being who does not hide behind a role, sharing information with the subject as it emerges. A partnership between the researcher and subject is maintained through the dialogal interview, which serves a reflective function for both parties (Bogdan & Taylor, 1975). This approach extols the use of insight and intuition as important elements in accessing the core meaning of the phenomenon under study (Filstead, 1970).

The ultimate aim is to obtain a "thick description" of the phenomenon through a hermeneutical process of meaning. This process emphasizes "interpretation, explanation, and proper understanding" by extracting the deeper meaning in the raw data (Van Hesteren, 1986, p. 206). This can be accomplished by presenting several descriptions, which will result in data rich with meaning not only to the investigator, but to all participants of the study.

RATIONALE FOR CHOICE OF METHODOLOGY

Existential-phenomenology is rooted in a philosophy which is congruent with my personal frame of reference. Stanley & Wise (1983) indicate that a relationship between theory and practice are necessary

in order to produce pragmatic results in our studies. My practice methods are based on the humanistic, holistic, client-centered paradigm of social work, therefore this research method corresponds perfectly. This model allows me to be consistent and authentic in my personal, professional, and research efforts by being emotionally engaged at every level. Lofland & Lofland (1984) indicate that if such involvement does not exist, then confusion and frustration will make the research process problematic.

This model appeals to me because it transcends the traditional research goals of simplicity and condensation. I believe the only way we can do justice to research is by addressing the complexity of the human situation through the expressive medium of descriptive writing. This method of inquiry also correlates with my commitment to feminist consciousness which eliminates the unilateral power of the researcher, by focusing on the cooperative, participatory, and interrelational aspects of the research process (Stanley and Wise, 1983).

CHAPTER THREE

LITERATURE REVIEW

ADULT CHILDREN OF ALCOHOLICS

Although the focus of this study will be on ACOAs, the literature makes it clear that 90-95% of us were raised in homes with varying dysfunctions (Friel & Friel, 1988). These dysfunctions are the basis and result of a "poisonous pedagogy" which violates the rights of children by exalting unquestioned obedience and the control of emotions and desires (Miller, 1988). Bradshaw (1988) stresses that adults who were shamed in childhood experience a cutting off from their "true self", preventing them from becoming genuine, whole adults. Creighton (1986) states that similar dysfunctions occur in families which practised physical, psychological, sexual, food, and drug abuse. Middleton-Moz & Dwinnel (1986) indicate that trauma victims and veterans of war should also be included. Schaef (1986) states that any family that does not foster autonomy, that rewards learned helplessness, or that displays neurotic behaviour puts its members at high risk for a dependent/co-dependent relationship. Strictly religious families where black and white thinking prevails also fall into this category. The implications is that the symptoms that are displayed by ACOAs can be generalized to these other populations as well.

Well-Functioning Versus Dysfunctional Families

Many ACOAs have no idea what a healthy family is. As children they accepted their situation as "normal", but as they are exposed to a broader perspective, they begin to question their original perceptions (Woititz, 1983).

A smoothly working family is characterized by consistency. Rules are verbalized, fair, and flexible, giving the child a sense of security and direction. Communication is open, and the expression of emotions is encouraged. As emotions emerge, they are accepted and understood. Roles are clearly defined, however, members are able to adapt and shift roles as the circumstances vary. The child learns flexibility and spontaneity, gaining a sense of autonomy. Constructive alliances may be formed to aid in the positive operations of the unit (Black, 1982). Boundaries between individuals exist and the uniqueness of family members is cherished. Members are encouraged to differentiate by establishing their own set of values, however are guided by caring, nurturing parents. Although stresses are a part of life, positive experiences generally dominate.

In a dysfunctional family, chaos reigns. Unpredictability and inconsistency oscillate its members between a state of despair and the desire to restabilize family homeostasis. The focus is on a dysfunctional behaviour, rather than establishing healthy relationships between family members. There are unspoken rules based on shame, guilt, and fear. Most rules are arbitrary, however, the most common one is "don't talk or feel". This forces members to

suppress or repress emotions. If one chooses to express a feeling, the response is usually judgmental and blaming. Consequently, individuals lock themselves into roles based on the perception of what they need to do to survive the chaos and bring stability into the home. Often, destructive triangulated alliances are formed, usually with one parent and child opposing the other parent. The result is an enmeshed system where children obtain a pseudo-self personality, remain fused to the family of origin, and continue to live lives dominated by stress and fear.

Roles ACOAs Adopt

Ackerman (1983) states that approximately 10% of children from troubled homes escape virtually unscathed in spite of the traumatic circumstances of their childhoods. The remainder adopt roles as defenses, not only to withstand the trauma, but also in an attempt to make the family more safe and loving. Their efforts are frustrated in childhood, as they do not realize their precarious position in the complete scheme of the family. As they adhere to these roles in adulthood, they create and surround themselves with a reality that results in the same disappointments. Although a person can clearly fall into one category, often a combination of roles may be accepted. These roles are also interchangeable as the family situation changes. The following roles are described in the literature (Black, 1982; Deutsch, 1982).

1. THE HERO

The family hero is often the oldest child who displays competence and maturity beyond his/her years. The parents make this child the repository of their dreams and (s)he responds by providing pride, hope and respect to an ailing family. Excellence in every performance serves as a distraction from the family's problems, and is rewarded at home, school, and work. Where parents fail to provide structure and consistency, the family hero succeeds. This person becomes very adept at planning, setting goals, and manipulating to achieve them. The female hero is expected to manage family responsibilities, sometimes substituting for an alcoholic mother, or a co-dependent spouse who is despondent and seemingly helpless. The male hero is sometimes excused from home responsibilities in order to devote all of his energy to excel in the outside world.

These children are often triangulated, taking the side of the enabling co-dependent, since they have the shared problem of eliminating the abuser's negative behaviour. The hero's role is to make up for the family's weakness and correct its imbalance. This perceived responsibility is so firmly internalized that when the inevitable failure occurs, it is attributed to the hero's own inadequacies. Such a responsible role leads this person to feel a need to be in control, independent, and without personal needs. Therefore, criticism or being wrong cannot be tolerated. To ensure such persons that failure will not occur in any aspect of their lives, they will drive themselves at a grueling pace, becoming very

competitive and constantly striving for perfection. Achievement is the measure of their self-worth, gaining them praise and respect in their field of work. However, work also becomes their escape from intimacy and emotional expression.

The price for accepting the role of hero is indeed high. Physically heros pay with coronary disease, stomach disorders, allergies, migraines, and strokes. Emotionally they feel inadequate, angry, and guilty. The social price is loneliness, due to a lack of trust and the inability to accept from others. From a spiritual perspective the hero appears to be a saint. In reality this spirituality is based on the compulsion to placate the Dependent (alcoholic) and lighten the load of the Enabler (co-dependent spouse). In marriage, heros create an imbalance by giving without taking. Professionally they are drawn to helping careers, where they are prime candidates for burnout. Such "generosity" depletes the hero of inner strength, leaving him/her with the internalized fear that he/she will never be adequate, let alone saintly.

2. THE SCAPEGOAT

The reverse image of the family hero is often called the Scapegoat (Deutsch, 1982) or Acting Out Child (Black, 1982). This person fits the stereotypic view of a child from a dysfunctional home by drawing attention to the self through negative behaviours. In fact, scapegoats are making their contribution to the family by embracing and expressing the family's rage and chaos. By acting

irresponsibly, the scapegoat often is placed in dangerous and compromising situations, bringing humiliation to self and perceived disgrace to the family. As youngsters they drop out of school, are sexually active (seeking intimacy), and become substance abusers. They can not possibly compete with the Hero, although they do serve the family well by providing it with a distraction and a blame for the real issues.

The price for acting this role is usually paid in an institution. Ironically, this could be the beginning of recovery for the individual. If the professionals are systems oriented in their approach to treatment, they may uncover the underlying cause of such maladjustment. However, chances are the scapegoat will be labelled deviant and efforts will be made, in a linear fashion, to repair the poor behaviour.

As the scapegoat gravitates towards peers with similarly low self-esteem, his/her self-destructive behaviour escalates. Such persons become more uncooperative and rebellious. Their anger freezes into a chronic attitude of hostility, which masks their painful rejection and loneliness. They have learned early in life to expect little affection, understanding, peace, or positive reinforcement from the family. It is not surprising that they do not expect it from other members of society. The effects of such deprivation are serious and often the first to be visible. Social skills are shallow, the person is self-centered, lacking in genuine concern for others. Unable to establish healthy relationships, there is little motivation to achieve in other areas as well. If creativity is used, it is in

the context of anti-social acts which eventually may lead to court. Spirituality is blocked because the prescribed training usually involves a God who rewards good and punishes evil. In treatment, the most difficult task may be to bring the scapegoat to the realization he/she is a worthwhile being and life has some positive meaning.

3. THE LOST CHILD

This child seems to have no role to make his/her presence felt in the family. It is the loner who adapts to the situation by striving to avoid family conflict. Because this "Adjuster" (Black, 1982) does not make demands, a sense of relief is felt amidst everyday chaotic conditions. However, the Lost Child is enacting the family's shared sense of insecurity and helplessness, by withdrawing emotionally and physically. His/her loneliness, fear, and seeming unimportance is countered by a vivid fantasy life. Intense shyness, passive resistance, and gender identity conflicts contribute to their avoidance of interpersonal relationships. Repressed negative feelings are released in a variety of somatic and psychological symptoms, ie. stuttering, learning disabilities, compulsive eating disorders, asthma, and sometimes schizophrenia.

In spite of these difficulties, the Lost Child is not as easily detected as the scapegoat, because of his/her low profile and solitude. If they are referred for therapy as children, professionals have a difficult time breaking through their passive barriers. As adults they usually do not seek counselling as a result of their

learned powerlessness, and low expectations of themselves and others. If a helping professional does reach this adult, therapy must be done in gradually increasing doses (Gravitz & Bowen, 1985) capitalizing on the positive tendencies associated with this role, ie. independence, creativity, and flexibility. Eventually the person may accept a sense of entitlement and a new perspective on anger and conflict, thereby gaining confidence to shape his/her own life.

4. THE MASCOT

By the time the mascot arrives on the scene, there is usually great deterioration within the family. The cute mascot is viewed as an immature, fragile object of protection, since it's usually the youngest member of the family. The Hero has someone else to care for; the Scapegoat has someone to like and be liked by; the Lost Child, although resentful, now finds it even easier to withdraw. To the parents, who may be feeling guilty and wishing they could redo their childrearing practices, the mascot pacifies their fears with joviality. His/her central goal is to dispel tension through comic relief. The clowning becomes compulsive as a result of the hidden fears and dangers the mascot can not express in a healthy way. Since the home is frequently anxiety provoking, the mascot becomes hypervigilant to all signs of tension, always ready to douse flare-ups.

Consequently, this nervous, hyperactive child grows into a high-strung, immature adult, prone to chemical dependency to quiet his

chronic fears. Like the other siblings, the mascot suffers from a sense of inadequacy, unimportance, guilt and loneliness. Mascots' spouses are often the strong, silent Hero who can act as protector. In therapy, the compulsive humour becomes a constant distraction and obstacle to sustained intervention. To overcome this nervous, compulsive activity, the mascot must understand the origins of his behaviour, and redirect those energies into finding healthier ways to relax.

5. THE PLACATER

Black (1982) also notes the role of a Placater. Being called to settle family disputes, this pacifist takes the responsibility seriously by becoming extremely emotionally involved in everyday chaos. The placater spends a lifetime diminishing the fears of others, becoming very skilled at listening and demonstrating empathy. To fill this role adequately, placaters are never allowed to disagree, squelching their own disappointments by diverting the attention to others. They carry an apologetic attitude into adulthood, where they become susceptible to spouse abuse.

ADULT CHILDREN OF ALCOHOLICS AS THERAPISTS

"Co-dependency" is another dysfunctional pattern of coping that is born of the rules in unhealthy family systems. Wegscheider-Cruse (1987) defines it as:

> a specific condition that is characterized by preoccupation and extreme dependence (emotionally, socially, and sometimes physically), on a person or object. Eventually, this dependence on another person becomes a pathological condition that affects the co-dependent in all other relationships. (p. 2)

As ACOAs learn early in life to counsel their troubled families, they are comfortable in providing service to others in their professional lives. Schaef (1986) indicated that any professional (physician, lawyer, social worker, etc.) who works with addictive persons is at extremely high risk for a co-dependent relationship. They are in constant contact with individuals who exhibit symptoms of denial, projection, and rationalization, which were typical dysfunctions in the homes they grew up in. Consequently, it is critical that these professionals be aware of their own vulnerability, in order to prevent enmeshment with their clients.

Cermak (1986) states that therapists who have not addressed their co-dependency often display the same symptoms as their unrecovered clients. As they often overidentify with the role of therapist, they vacillate between a grandiose sense of power in the therapeutic process and an overwhelming shame for the inability to control the client's growth. They lose sight of the distinction between their personal identity and their role of therapist. They forget that the therapeutic relationship involves a triad including the client, the person who is acting as therapist, and the role of the therapist.

Woititz (1989) claims that these are instinctive responses which are activated by learned survival skills from childhood. In her

research, she has identified several commonalities that are displayed by therapists who are ACOAs. (pp. 96-101):

*They have a need for clients to like them.

*They seek approval not only from supervisors and peers, but also from clients.

*They avoid conflict in the therapeutic process.

*They have difficulty making referrals (in the fear that their perceived incompetence be discovered).

*They have impatience with stuck clients.

*They look for a "treatment road map" (structure, order, and black/white directions for therapy).

*They are poor stress managers (don't give themselves permission to relax).

*They deny their own counter-transference (have difficulty dealing with their imperfection).

*They tend not to limit their caseloads.

Wegscheider-Cruse (1987) adds that the professional who is co-dependent lacks knowledge about the dynamics of co-dependency and is often resistant or unwilling to learn anything about it. These therapists are prime candidates for becoming "professional enablers" who minimize the concept of co-dependency (Wegscheider, 1981). They act out a similar role to the family enabler, who uses denial, avoidance, covering up, protecting, and taking responsibility for others as a method of personal interaction.

The professional enabler views the client's issues in a linear fashion, by not addressing the complex dynamics of the dysfunctional system. While family therapy is recommended as the most effective method of dealing with addictive issues (Creighton, 1988; Steinglass,

1979; Wegscheider-Cruse, 1987), the untreated professional often unknowingly becomes part of the dysfunctional family system. She reacts to the individuals in the family in response to their respective roles, rather than identifying the rigidity of those roles. Counseling becomes ineffective as the therapist:

> *identifies with the enabler
> *is afraid of the dependent (alcohol abuser)
> *seeks attention from the lost child
> *is angry with the scapegoat
> *enjoys the relief provided by the mascot
> *and discusses solutions with the family hero
> (Wegscheider-Cruse, 1981, p. 224)

The effective therapist avoids these pitfalls because she is aware of her own feelings, has a healthy self-worth and recognizes her own weaknesses and defensive behaviours. She addresses her reactions to each family member directly by stating how their behaviour effects her personally and the effect it is having on the therapeutic process.

Rather than using the role of therapist as a vicarious method of helping self, the ACOA therapist is encouraged to seek outside help to address his/her own pain. Friel & Friel (1988) recommend a comprehensive recovery program that includes participation in ACOA groups, individual psychotherapy and family therapy. The therapists who are in the process of their recovery, are not only healing themselves, but dramatically improve their relationships with their clients (Wegscheider-Cruse, 1987). Recovered therapists are able to empathize and more likely to believe a client's traumatic history, because of their personal familiarity with these difficulties. Since they can identify with the client, they are able to more clearly

mirror the client's feelings. However, there is the danger that personal opinions and biases are so strong, that they may be imposed upon the client.

Gil (1988) indicates that there is an ongoing debate in the counselling profession regarding the disclosure of the therapist's background. It is evident that if a counsellor discloses that she is an ACOA, it will alter the therapeutic relationship in various ways. For some ACOA clients, this increases the counsellor's credibility. The client feels validated, better understood, and safer. Because the client feels respected by the therapist, she finds it easier to open up her most intimate feelings.

Other clients react negatively to such a disclosure. Sometimes they lose respect for the therapist and withdraw in a cautious self-protection. When personal boundaries are weak, clients may inappropriately request details of the therapist's family experience. The therapist may then feel obligated to disclose unnecessary information, violating the boundaries even further. Some clients compare themselves to the therapist and criticize themselves for not being as healthy.

Gil suggests that transference should occur against a blank slate, therefore does not recommend that a therapist disclose their background as an ACOA.

The ultimate message of the literature stresses that if we are not aware of our family history, we run the risk of transferring the dysfunctions we learned into our professional lives. Consequently, if a professional remains untreated, she will perpetuate her own

dysfunctional behaviour and enable her clients to remain in unhealthy patterns of interaction.

* * *

Much of the literature concerning ACOAs supports the philosophical stance of Alcoholics Anonymous (Woititz, 1983; Wegsheider, 1981; Kritsberg, 1985; Ackerman, 1983). This movement is based on the Medical Model, advocating the *disease concept* of alcoholism. Consequently, the terminology utilized is reflective of medical terms.

My personal philosophy espouses the axiom that alcoholism is a negative reaction to a dysfunctional family system (Creighton, 1988). Although I have chosen to retain the common and familiar language of the Medical Model, certain words will represent significantly different meanings from my perspective. For example, the word "recovery" refers to a psychological learning process which enables one to change previously learned beliefs and behaviours which adversely effect the individual.

I would also like to point out that the literature which I reviewed focused on the indentifying characteristics of ACOAs, understanding their significance, and methods of coping with them (Ackerman, 1987; Woititz, 1983; Black, 1982). The purpose of this study was to supplement this valuable information with a systematic study of the *lived experience* of being an ACOA therapist.

CHAPTER FOUR

METHODOLOGY

DESIGN OF THE STUDY

The methodology of this study was structured on the four key procedural activities as outlined by van Manen (1985):

1. turning to a phenomenon which seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualize it;
3. reflecting on the essential themes which characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting. (p. 2)

The importance of turning to the nature of the lived experience cannot be overstated. Van Manen stresses that the origins of research must commence with a deep questioning of an experience which impacted us profoundly. This initial procedure will prevent us from addressing the research in a disembodied fashion, allowing us to expand knowledgeably to other complementary descriptions of similar experiences.

ORIENTATION TO THE PHENOMENON

My interest in this phenomenon began when I discovered that commonalities existed among Adult Children of Alcoholics (Woititz, 1983). Although I have always realized that I grew up in an alcoholic

family, "naming" myself ACOA had a significant impact on me. Schaef (1987) states: "that which goes unnamed may exert considerable influence over us, but because we have no words for it we cannot address it directly or deal with it" (p. 9). At this point, I was able to begin a recovery program which addressed unresolved childhood issues as a direct result from being raised in such an atmosphere. During this ongoing process of recovery, I am more cognizant of transference and counter-transference issues in my clinical practice. Boundaries between myself and clients are more appropriate and feelings are defined and addressed more adequately. The experience of practising counselling is evolving to be a more productive force in the lives of my clients and myself.

It is through this lived experience that I was able to formulate my research question. My aim was to explore what the experience of counselling may entail for therapists who have identified themselves as ACOAs, and to extrapolate the meanings of their personal experiences. In extracting these subjective meanings, van Manen (1985) suggests that "it is better to make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories" (p. 9), in order to expose the fact that they exist and may persistently reflect into our consciousness. Lincoln & Guba (1985) stress that "inquiry is not and cannot be value free" (p. 9). Therefore, the way to be true to the phenomenon is to accentuate the fact that there is not only one reality, and that to assume so, I would be proposing an artificial concept of reality (Filstead, 1970).

The call to this phenomenon was kindled by my personal experiences in the counselling field. Through existential investigation my aim was to develop a deeper understanding of this experience. As van Manen (1985) expressed: "All understanding is ultimately self-understanding" (p. 12).

GENERATION OF DATA

The researching of a phenomenological question requires a protocol that goes beyond the objectivistic quality of traditional inquiry. It involves an exploratory component where the researcher must remain sensitive and open to all interpretive possibilities. A separate stage of "data collection" does not really exist, since the process is interwoven throughout all contacts with the interviewees. This requires not only the establishment of a trusting atmosphere, but also a mutual collaboration between researcher and interviewees. Because I strived to establish peer relationships with the participants in this study, I will refer to them as "co-researchers" rather than subjects.

CO-RESEARCHERS

In choosing co-researchers it was critical that they be selected by specific criteria rather than randomization methods. Bogdan & Taylor (1975) state:

> An obvious criterion that you may apply in choosing research subjects is whether or not they are the "kind" of people in whom you are interested (p. 102).

Purposeful sampling provided me with the "kind" of people I was interested in. They had to be counsellors who have been raised in homes where at least one parent was alcoholic. Part, or all, of their caseload included clients who are also ACOAs. Educational backgrounds were in the fields of clinical psychology, social work, and addictions counselling. In order to be considered "recovering" these therapists had to be familiar with ACOA literature and have addressed some of these issues in their personal lives through individual therapy, attendance at ACOA group meetings, or through discussion of this literature with significant others. In order to contribute to this study, they had to be capable of reflecting upon and articulating their experiences fluently. Colaizzi (1978) states that "experience with the investigated topic and articulateness suffice as criteria for selecting subjects" (p. 58).

In cooperative inquiry, language is the primary tool used to mediate a shared vision, therefore, it was critical that there be a mutuality of understanding between the co-researchers (Reason & Rowan, 1981). This understanding was obtained not only through verbal communication, but also through the use of a non-verbal interconnectedness where the co-researchers needed to be present for each other on an intuitive plane.

> The original and archetypal paradigm of human inquiry is two people who agree through face-to-face meaningful encounter about how to symbolize their experience in words.
>
> (Reason & Rowan, 1981, p. 26)

My role in this process was not merely to extract words from the participants, but to reflect on the etymological origins of these words,to ensure that personal meaning is congruent with collective understanding. The implication is that my commitment included the necessity of remaining close to the lived experience throughout the process by keeping in mind the original question and focusing on the nature of this phenomenon. The participants' commitment included the willingness to reexamine the data by providing continuous feedback.

The number of participants in a phenomenological study "depends on various factors that must be tried out in each research project" (Colaizzi, 1978, p. 58). I selected the four individuals through the anthropological method of "snowballing", which is a process of referring potential candidates (Grinnell, 1985). These participants provided me with rich, descriptive data, used as the basis of the analytic process.

CONTRACTING WITH CO-RESEARCHERS

The initial contact with potential participants provided an orientation to this project. A written statement outlining the aims and methods of the study was presented (Appendix I), along with the opportunity to read the research proposal.

The second informal meeting was for the purpose of building rapport, which is essential for the establishment of a trusting relationship. We further discussed the arrangements concerning the

core interview. Confidentiality, anonymity, freedom to withdraw from the study, and potential risks to the participant were discussed thoroughly before the consent form was signed (Appendix II).

THE PHENOMENAL INTERVIEW PROCESS

The core interview was an intensive, in-depth, non-structured process. The intent was to keep the time frames of the interviews fluid, however, they were all completed within the range of 1 1/2 hours. My ultimate aim was to conduct a phenomenal interview which was characterized by:

> maximal mutuality of trust, attaining a genuine and deeply experienced caring between interviewer and interviewee, and a commitment to joint search for shared understanding. Interviewer and interviewee respond to one another as total persons, ready to actively examine and disclose both remote and accessible aspects of their lives, including experiences, present responses, and imageries.
>
> (Reason & Rowan, 1981, p. 203)

Such fundamental equality and mutual commitment necessitated free access to each other for the purpose of further exploring and re-examining ideas. The aim was to eliminate the distinction between interviewer and interviewee as we strived to enter each others' existential worlds through reciprocal empathy. I believe this approach resulted in an expanded protocol which reflects the depth of both the process and content of the interview.

Although these interviews were open ended, I heeded van Manen's, (1985) caution to remain ever mindful of the central question being explored, in order to maintain a clear orientation to the lived

experience. Interviewees were often reminded of the core question: "What is the experience of counselling ACOAs for the recovering therapist?" Supplementary questions focused on the "essence" of this experience by encouraging further reflection in an attempt to expand consciousness. This was achieved through appropriate silences, "probes", requests for clarification, and the use of spontaneity to elicit further investigation of the topic (Dudley, 1987).

By tape recording the interviews, the accuracy of data collection was increased, and the possibility of distortion was minimized. This also enabled me to be more attentive to the co-researchers. I assured the interviewees that their privacy would be safeguarded, as no other person would have access to these tapes. I personally transcribed them verbatim, and erased them or returned them to the co-researchers after the transcripts were completed. Participants chose a pseudonym in order to ensure anonymity. Information which may have identified the therapists or their clients was altered in order to protect their identity without effecting the outcome of the study.

In a follow-up session, each individual had the opportunity to verify the accuracy of the transcript, reflect upon it, and add pertinent data, or delete data that would be identifying of them. Participants were also given an opportunity to discuss any personal feelings that arose from this dialogal process. At the conclusion of each interview, I followed Bogdan & Taylor's (1975) suggestion to make a note of my impressions and observations of non-verbal expressions. This information provided me with a clearer frame of reference when I was interpreting the data.

CONTENT ANALYSIS: UNCOVERING THEMES

After the protocols were transcribed, I re-read them to obtain a gestalt impression of these descriptions. By immersing myself into this data, I began making notes of patterns that arose. I was initially concerned that no themes would emerge, however, I maintained faith in Van Manen's (1985) assurance that when we attempt to isolate thematic statements from descriptive experiences that a person has shared with us, "there will always be something there for us to gather" (p. 21). In the early stages of data analysis, it became evident that themes were present.

Van Manen (1985) recommended "highlighting" relevant phrases or statements which seem particularly revealing about the experience described. At this point each phrase had to be given equal value, in order not to make premature decisions about its importance. The next step was to transform these themes into more phenomenologically sensitive language. This involved the process of formulating meanings that are hidden in the context of the data. Colaizzi (1978) indicates that this is a precarious leap since we are moving beyond the protocol's descriptions. These meanings are given with the protocol, but are not necessarily explicit. It is the phenomenological researcher's responsibility to carefully extract meanings which are connected to the original data, write them as descriptive statements and verify them with the co-researchers for their truth-value.

"Clusters of themes" were then assembled that were common throughout all the descriptions. This is part of the synthesizing

process of reconstructing the data into meaningful wholes (Lincoln & Guba, 1985). This part of content analysis included a process of coding each theme on separate index cards which formed the basis of a filing system. Categorizing themes continued and relationships between categories were examined until there was an exhaustion of sources, and a saturation of categories occurred. At this point, the search for new information was no longer productive. Continuous member checks with the co-researchers created an interpretation of the data that produced the intersubjective knowledge which is the basis of phenomenological knowing.

Berg (1989, p. 43) suggests an excellent outline of how to establish a systematic filing system, where one annotates codable themes by systematically searching for similarities and dissimilarities in the raw data. Each index card identifies the general theme, the page number in which it is located and a brief verbatim excerpt. Subthemes are also noted and cross-referenced for easier access. I agreed with Lofland & Lofland (1984) who state that although the analysis of qualitative data is a complex procedure and the researcher is faced with the agony of omitting some information, it is nonetheless an exciting part of the process of research.

WRITING A PHENOMENOLOGICAL STUDY

Structuring phenomenological writing is considered to be more of a careful cultivation of thought rather than a methodological technique (van Manen, 1985). Lofland & Lofland (1984) indicate that a

continual process of thinking and reorganizing of data may necessitate several rewrites before the text is completed. However, several suggestions are given to present the data in an organized manner. I chose to structure my description of the data thematically, organizing my writing around the themes that have emerged during the stage of content analysis. Verbatim examples from the raw data were extracted to help make visible the essential nature of this phenomenon. The intent was to indicate that a relationship and congruency exist between the original statements and their interpretations. Since phenomenological writing "involves the totality of our physical and mental being" (van Manen, 1985, p. 28), I also included my personal impressions and biases that were affecting this process. Finally, a connection of the themes revealed in my study was made to relevant ACOA literature to provide a broader context to these findings.

TIME-LINE OF THE STUDY

Selecting co-researchers, interviewing and transcribing the audio-tapes took place between mid-May and mid-July, 1989. Data analysis and the writing of the thesis was completed by mid-September, 1989. This was in preparation for oral presentation by the end of September, with the aim of convocating in November, 1989.

CHAPTER FIVE

THE ABRIDGED INTERVIEWS

In order to present a coherent description of the data that was collected, in this chapter I am including abridged versions of the taped interviews. Most of this information is quoted directly from the original text of the interviews, however, it has been edited and summarized in the interest of brevity. Although these "stories" have been condensed, they were verified by the participants for accuracy. While they are representative of the original transcripts, identifying information has been changed to protect the identity of the co-researchers and their clients.

One purpose of including these stories is to bring this experiential phenomenon to life. Another aim is to give the reader a general overview of the original data collected, and a sense of continuity and clarity while studying the findings in the next chapter. This also serves the purpose of increasing the validity of the study, by including the co-researchers' accounts of their experiences, in their own words.

ANN'S STORY

Ann came to Alberta after completing her Bachelor of Social Work elsewhere. She has been working as a counsellor for the past three years. Most of her clients are abused women who are ACOA, and are married to (or living with) alcoholics. "I see many of them alone, but I really try to get their spouses and children involved also."

Concerning her personal recovery she says, "I've had a lot of personal counselling before the ACOA literature came out. None of my therapists mentioned the possibility that my father's drinking could have had an effect on our family. The focus in counselling was always on living a more righteous life, because these therapists belonged to the same church I was attending...I became familiar with the ACOA movement about the same time I started working...I was overwhelmed when I read Adult Children of Alcoholics by Woititz. For the first time in my life I could put things in perspective. It was like a light bulb went on, and I said: now I know why I'm so screwed up."

Ann has been an avid reader of the ACOA literature for the past three or four years. "I began to realize that there was a connection between what happened to me personally and what was happening with my clients. Initially, I felt really overwhelmed with my ACOA clients. Rather than empathize with them, I seemed to get hooked into their problems. I didn't seem to have any personal boundaries...I over-identified with them. It's like I had no boundaries, and would let them invade my space totally."

"I remember one particular client...I totally identified with everything she was saying, and I would then have to take care of my own feelings that were emerging, rather than being there for her. I was so overwhelmed...I could hardly function through that session. This was one of my first ACOA clients. This happened a lot in the very beginning. None of the people I worked with were very familiar with ACOA literature, so no one could make any connections for me." She states that, "I haven't been aware of my issues for very long, but I feel like things are coming together now. It's all falling into place."

"Now I still have to protect myself with certain clients...young women who were abused, older angry men, or the passive older woman who is very manipulative...Most of the time, when I feel centered, I do just fine. But sometimes, I meditate before a session, and put a protective boundary around myself. So during the session I can be more objective, and keep myself separate from the client, instead of being overwhelmed by feelings they trigger in me. So it's as if I contain my feelings temporarily, and after the session, if I need to, I go away and process my feelings. I either write down what's going on for me and discuss it with my therapist, or I talk about it in staff meetings...depends on what it's about."

Ann's way of protecting herself previously was to "split off into space", and sometimes not be attentive to her clients. "It's an awful thing to say as a therapist, but quite often I was out of the room mentally...I know this was my way of protecting my sanity. I did that a lot as a kid, and I guess this defense mechanism carried over to my

counselling practice". After about a year of functioning this way, "I ended up burning out, because I wasn't taking care of mine or my clients' emotional needs". With the help of a therapist who was familiar with ACOA issues, Ann was able to get in touch with her core issues, and was able to function in a more healthy way both personally and professionally. "I feel I'm being much more useful to my clients. Even though they sometimes trigger things for me, I can put my own issues aside for the time being, and be there for the client...then deal with my stuff later. It's like a mutual growth process...my clients are helping me heal at the same time I help them sort out their own stuff."

Besides meditating before a session and putting a protective boundary around herself, she also takes a few minutes for herself between sessions. "I tend to overbook, and then I really get into trouble...so I'm learning not to take on more than I can handle comfortably. Sometimes during the day, I plan for a walk by myself, or to have coffee with a friend". She finds that maintaining a nutritious diet is also important. "I noticed that my work suffers when I don't eat properly...I tend to do that when I get too wrapped up with my work."

Ann's father was a violent alcoholic, and her mother the passive, manipulative enabler. Being the oldest child in the family, she readily adopted the role of Family Hero, taking over responsibility each time her mother would have a nervous breakdown. "Not only did I take over my Mom's responsibilities, I felt like I needed to protect and rescue her from my father. I also tried to placate my father

while he was being a jerk, and keep the smaller kids quiet while he was at home". The role of Hero carried over to the rest of her life, as she became very perfectionistic in everything she did. "I expected only the best from myself. Even when I dropped out of High School, I was determined to be the best Drop-Out ever! I got very involved in volunteer work, and everyone praised me for that. I worked my way up in the office where I was employed, because I worked harder than anyone could imagine."

In the field of social work she had a hard time moving out of that role. "I found it very hard to not play the role of Hero with my clients, not to take responsibility for them. Now I realize that when I'm not in that role, it doesn't allow the client to be in their role. They can try being in their role, but there aren't two players to the game...so they find different ways of dealing with their problems if I don't rescue them. In other words if I can be my authentic self, then that forces the client to be an authentic person also.....The ACOA literature has really helped me to get in touch with myself. To get in touch with the authentic self, rather than reacting to my clients in my phony role of Hero. When I relate to the client as an authentic person too, then I don't see her as the "Victim" (and respond by rescuing), I see her as a person going through an experience. I see the Total Person, not the Victim role."

Some client issues still trigger reactions from Ann. "Sometimes I still have a hard time dealing with conflict. Having been a "pacifist" all my life, I try to placate them, settle them down. I have a fear of anger. With some clients, particularly men, I'm still

afraid they might lose control and may hurt me...Initially, I would be really afraid, and do my best to get them under control...that's getting a little easier now, but there are still some clients that trigger that fear." When that fear is triggered, it makes it difficult for Ann to confront a client. "I still can't confront a client when they're angry. If a client is trying to con me (or herself), I have no difficulty confronting them with that, in a gentle sort of way...but when they're mad, I avoid confrontation altogether."

Control is an issue for Ann in several ways. "My real fear was that because a client was losing control, I would also lose it...it's a real transference thing, because when I was a kid and saw my Dad out of control, I felt really powerless. My stomach would tighten up, and I would withdraw, feeling like the whole world would cave in on me". Today, by putting a boundary around herself, she can remain in the session with an angry client, aware of her own feelings, where they originated, and not feel overwhelmed by them.

She's also seeing a difference in her style of counselling as she lets go of the need for control in every aspect of therapy. "Even though I prefer to use the Rogerian style, I still find I have to maintain a measure of control in the sessions. I tend to split off in the Rogerian style...it's like I lose control of myself when I lose control of the session. I feel much more in charge when I do Strategic Family Therapy, or a structured type of counselling. I'm learning to deal with this better. I don't feel so anxious...real butterflies in my stomach...when a client gets out of control, but I compensate by trying to stay in charge of my schedule. I try hard to

start and finish on time...still feel uncomfortable when I have a cancellation, or an unexpected twist of events. Serendipity makes me feel like things are happening out of sequence. So it's like a pattern is broken, and that's scary. It's fearful because it's not controlled. You're not in control when serendipity happens (laugh). Change is hard to accept when you're so used to doing things one way...even though that way was not very healthy."

"I was very hypervigilant as a kid...you know, always on guard to see what would happen next, and how I was going to take care of it. As a therapist, I've had to really let go of being super-responsible for my clients. I used to hang on to every word they would say, so I wouldn't miss anything...and try to interpret the deeper meaning of everything. I would loan them books, and never get them back...I worked so hard at trying to figure out their solutions. Now I may make suggestions, but I let the client come to me, and we clearly contract what their role will be in the therapeutic process. Not only is it easier on me, it's much healthier for the client to take responsibility for herself. Somehow I had this idea that it was all up to me."

"I had to work very hard to learn how to say "no" to clients. Not only would I do inappropriate things for them, I would take on much more than I could handle"... In retrospect, it was a powerful feeling to think you had so much influence in your family, being such a good kid. I felt like everyone depended on me...and that's what it felt like as a therapist at first. Clients would get so dependent on me, but I started to get resentful of that. When I started to grow

and develop on a personal level, I began to realize that I was keeping my clients stuck developmentally."

"Termination has been a terrible struggle for me as well. It triggers abandonment issues for me. Either I couldn't terminate, hang on to a client longer than necessary, or I would break off the connection too quickly. It was a protection, so that I wouldn't have to think about saying good-bye for too long. Sometimes I would feel like I was abandoning them, but usually it felt like they were abandoning me. Of course, now I recognize where that came from. I was emotionally abandoned by both parents, yet they wouldn't allow me to separate from them". Today, Ann has no difficulty preparing herself and her clients for termination, but "sometimes a client will trigger old issues if she stops seeing me without letting me know why...I may either feel abandoned somewhat, or like I've failed her in some way...when in fact, it usually has nothing to do with me. It's a trust issue, too. Sometimes I don't trust that a client will be able to manage on their own. In some cases that's a legitimate concern, but sometimes it's my need to hold on to the role of Hero. What grandiosity, huh?"

In preparing for this interview, Ann found that she didn't trust herself. "Part of it is my need for perfection...you know, give the best interview ever...but partly it's not trusting the process. I wanted to write down questions and issues so that I wouldn't forget them. I have a hard time trusting that this process would just flow...I guess it's still that need for control."

The ACOA literature was helpful in uncovering the connection between her present struggles and her family of origin issues. "It really relieved me of a lot of responsibility to know that these were not just *my* problems, but *our* problems. I did a genogram with my therapist and the inter-generational patterns were so clear. It was great to have the literature validate this for me. I had an especially difficult time with loyalty...feeling like I was betraying my family of origin...by dealing with these issues. Later I felt guilty that I didn't get a handle on all this crap sooner, because now I can already see the symptoms in my children. So I kept slipping back into that responsible role."

As a therapist "I find it so helpful to have this ACOA framework to work with. I now have a good support group of therapist who are familiar with the ACOA movement." Feedback from clients is also positive. "I have clients referred to me because they know that I'm an ACOA. They say that they feel like I will understand them better. I know that I don't doubt their story, no matter how horrendous it may sound to others. I know they're not making it up, in most cases they minimize it quite a bit. I'm pretty good at picking up on their minimization of their trauma. I used to do that myself. So I challenge them, have them look at their issue more realistically. For example, one client thought it wasn't all that bad to be beaten as long as there weren't any broken bones. I help them recognize the true pain they went through and let them grieve it. I feel like I can really empathize with them...especially when I keep strong boundaries around myself...I can really be there for them, and comfort them. It

takes time to build up trust, but most clients have said they feel more trusting of me, knowing I have gone through similar experiences myself. For many clients it's the first time that their experience has been validated as *real*. Those are really moving times for both of us."

Ann tries to be selective in her self-disclosure if clients are not aware of her ACOA background. "I only self-disclose if I think it's going to be helpful to the client. Some clients are in such bad shape that they don't need to know my shaky background. I think it would make them feel insecure. But after we build a strong rapport, and I think it's appropriate to the situation, my self-disclosure can be very normalizing for them. It makes them feel less isolated, and can build a stronger bond between us."

In the early stages of being a therapist, Ann would feel incompetent, but would "overcompensate by being exceptionally good at solving their instrumental problems. That's how I gained my reward, from the clients and from my employer. I was very task oriented, didn't get into feelings too much...at least not consciously. But subconsciously I was really hurting and not knowing why." Now that she's moving into more awareness and authenticity she feels she has more choices. "I can see myself moving toward having more flexible boundaries with clients...I can be with the client without abandoning myself. I can allow the client to come into my space without feeling violated. It's a matter of choice...I have the ability to interact with someone and give as much as I feel I need to, or want to, to them...and still not lose myself in the process. Before it was

either—or. I had this protective strategy that was a polarization...either protect my client (or mother/father), or protect myself. Now I can balance that out. I can choose to do what's healthy for both of us."

However, she feels that balance is difficult to reach. "Where I was overly responsible before, I fear that I will become too laxidazical...too distant from the client...too objective...not caring enough. It stems from this fear that now that I can look after myself, I'm deserting the client. But I know that's not rational. I look at it as a developmental process. I don't have to be afraid of all these negative things taking over. I know I can choose to move in a positive direction. This is my way of controlling things today...by my making choices...rather than being involuntarily controlled by others."

The area that Ann would like to develop in herself in the future is her spiritual self. "A lot of alcoholics and ACOAs go through a stage where they hate the God they grew up with. I don't accept that "God" any more...but at the same time, I haven't found a "God" that I can be comfortable with. The spiritual part of my life is lacking because of this uncertainty. Often clients will bring up their spiritual struggles in sessions, and I feel that I could be more helpful if that part of my life was more settled. It's something that I'm working on right now."

If Ann were to give any advice to ACOA therapists it would be: "to get in touch with your own issues. Try to break through the denial. Even if there wasn't alcoholism in your family, it's very

likely there was some other type of dysfunction. None of our families were perfect, so it's pretty likely that there are issues you have to resolve in your own life. The other thing that I found very important is to build a support system for yourself. I now attend Adult Children Anonymous meeting and I have a group of people at work whom I can talk with about personal issues. Balance your life so that you have a lot of interests and a variety of people to interact with. I enjoy my friends who aren't social workers, because they give me a different perspective on life."

Ann feels that she will not be completely satisfied with her career until she does her graduate work. "I feel much more confident today as a counsellor...but I would like to move into a better paying position, and I know that won't happen until I get my Master's degree...so that's one of my goals for the future."

BOB'S STORY

Bob has counselled in various capacities for over twenty years. In the Armed Forces he served as a medical assistant, who is "a cross between a doctor, a padre, and a social worker. The focus was always on medicine, but if something went wrong psychologically, they automatically went to the medic. I worked in medicine psychiatry in de-tox, with alcoholics". After retirement from the Armed Forces, he trained to become a Certified Addictions Counsellor. Presently, he has a thriving private practice where many of his clients are Adult Children of Alcoholics.

Concerning these clients, Bob states, "I don't see ACOAs as any different than alcoholics, or drug addicts, or anything else....They all manifest their problems in the same manner, which is this self-defeating coping mechanism that develops. In some of us it's really pronounced, and in others it's rather subtle. A lot of people seem to have the idea that an Adult Child is some kind of whimp....in fact, they function extremely well, but in a dysfunctional way. It's a paradox." He indicates that although the ACOA may appear functional externally, internally there is a lot of chaos. They try to maintain a semblance of order by controlling, "this allows them to know where they're at, at all times...always prepared, but never relaxed."

Bob believes that co-dependency is the disease which is at the core of the ACOA issue. "Co-dependency is a single disease entity by itself, and it manifests itself in a number of different ways: alcoholism, compulsive gambling, relationship addictions, stress

disorders....It's like John Friel says, co-dependency is just a word that we can use to describe a series of symptoms. So we have to stop identifying Adult Children, and we're going to have to start using Co-Dependent, to describe the whole sphere."

"Co-dependency is a disease of feelings....which affects me at the very root of the soul." He indicates that "it's a complicated process" which is environmental and hereditary. "I can trace the co-dependency in our family a long way back...but it goes deeper than that. There's some sort of genetic link. We're making genetic links with alcoholism, maybe there's a genetic link with co-dependency in that there's something unique about me that makes me co-dependent. There are some points about prone people. We used to talk about the proneness to alcoholism, but you can convert that to the proneness to co-dependency:

1. Low self-esteem.
2. Dependency conflicts, like we avoid pain, can't delay gratification, so we seek out booze, or sex, or people, or excitement.
3. Inability to see the natural consequences of our actions.
4. Poor empathy toward others."

Bob sees that there are "two types of co-dependency, the really helpless co-dependent and the really aggressive co-dependent. The helpless sort seem to be really feeling and caring, but in essence, they don't care about shit, but themselves. They're full of sympathy, not empathy." While he feels that we all have these characteristics, they are magnified to the extreme with people who are prone to co-dependency. He feels that his co-dependency led him to a path of alcoholism. "I was co-dependent first and then I became an

alcoholic....I was an aggressive drunk with my family....but I never came home until I was finished drinking." However, for many years, he didn't see the similarity between his type of drinking and that of his alcoholic/co-dependent clients. Consequently, he doesn't feel one has to be a recovered alcoholic in order to work with alcoholic clients...."Just reach into your co-dependency bag" and you'll be able to identify with these clients, because that's our commonality."

Before Bob was aware of his co-dependency issues, he was in a state of denial which he expressed by attempting to look like he was constantly in control. He indicates that not only "didn't I make a link between their type of drinking and mine"...."I in fact, tried to make a difference between myself and my clients. That was how I always kept myself safe." In counselling sessions power struggles arose around "the whole issue of who is in charge....In the first couple of years of counselling, my clients had to know their place. That's a typical co-dependency thing, because co-dependents know their place." So his way of getting control of a session would be to let the client know that "I'm the boss here!"

This is still an issue for him at times. "I think the hardest time is when I'm dealing with a co-dependent couple...and one of them is very aggressive and reluctant to be there. I have difficulty in that area, because I want to control". Initially he would control by

trying to "pacify them, kiss their ass...don't upset them. But now I address what I'm seeing."

Often he was intimidated by clients who hold high positions in the business world. "But now I'm seeing these guys are just like me, he puts his pants on the same way....I try to look at their vulnerabilities, their co-dependency, their alcoholism. He realizes "this guy is coming here for help——help him." Although this fear is "still sometimes triggered in the early stages," he is now "careful not to go the other way, where you become insensitive, and start attacking them because of their role, their job."

Anger in clients "would trigger a response in me: fear. And then my anger takes over, because I know I'm powerful. And co-dependent clients know that, too. So I used to use that power. Originally, I used to get into power struggles, and be unable to work with the client." Impatience would set in and "I'd throw my hands up in dismay, and walk in and see my boss, and my boss would say, "find something good about him Bob, and work with him". Then I would say, "that's the kind of support you get around here", and I'd storm out. Now what I do when I see that anger, I try to elicit the focus of that anger..." by establishing the source of it.

This impatience with clients was pronounced in the early stages where his expectations of himself to "be strong, don't be a whimp, got translated to the clients, especially to the female patients in the service. I was very unsympathetic sometimes to a lot of problems that would manifest themselves in and around the time of their period."

Eventually, the time came that Bob became aware of his own issues of co-dependency and being raised in an alcoholic home. He states that Adult Children "wake up one morning and see themselves being able to understand and relate to what someone is saying about these behaviours. And they say, Oh, my God, that's why I'm the way I am. And they go through a period of immense joy: that I know why I'm all screwed up, followed by a period of: oh, oh, now what? Because all of the stuff that I have inside, that I've been keeping a lid on is starting to spill out. They're afraid they're going to be overwhelmed by those feelings inside."

That's exactly what happened to Bob. He identified his own issues while he was training for his certification. When one of his professors began to talk, "I started getting this overwhelming fear coming over me, and then the sadness came, and then the tears. I cried for two days." In a guided imagery that day, he "got in touch with the pain from that morning, and it just overwhelmed me. Then the next day, I started getting this phenomenal sense of *I know why I'm so fucked up!* A young woman, who was working on her own Adult Child issues, helped him through that period of recognition.

The intergenerational pattern of dysfunction is evident in his family. His paternal grandmother "was a vicious woman, who had eight children, my father being the eldest. She used to get people's attention by knocking them over the head with a piece of kindling wood, or maybe stabbing their hand with a knife at the table." His mother was a middle child of ten children, who married at 18. Her father was a rum-runner, and there was "no sense of family on neither

my mother's or father's side." Bob's father was an alcoholic and "died nine years ago at a very young age from heart disease". His mother remarried, and is now also drinking. In spite of all the turmoil at home, Bob feels that there were "a lot of positives that my family gave me, especially my Dad. They did the best the could."

Bob was an only child until he was seven. "From the age of seven to fourteen I have a memory gap which is really bad." At age fourteen he began acting out in various ways and "I was always the brunt of my mom and dad's wrath." That's why he always saw himself as the family Scapegoat, "but my bother says I'm the family Hero, because Dad always talked about me in high terms. But I didn't see it that way." He also felt like a Lost Child, since he left home at the age of seventeen, and didn't have very much contact with his family. "But I guess when I look at it I was the family Hero. I was going to be a priest...they were grooming me for that." But he seemed to rebel against the role that was ascribed to him by breaking the strict family and societal rules that he was expected to follow.

In spite of his rebellion, he "always had a hero, my choice wasn't always good, but it's the power I attributed to that hero. That goes back to the love of my father, and never feeling that I pleased him....So anyone who ever is in a position of authority like my father.... (like my platoon corporal), I was always so careful that I always did the right thing. I was very good, and I was recognized

early. But I could never grasp that, I thought I needed to manipulate them...what a con!"

His father's passing was very hard on him, and he finds it important to maintain a spiritual connection with him. "I still talk to my dad on a regular basis" partly to try to make up for that "sense of loss of what we never had...that is so tragic for co-dependents...not only what we lost, but never had to begin with...the sense that others have this, but I don't." Two songs describe the feelings he has about his father: "A Cat In the Cradle" by Harry Chapin and "The Living Years" by Mike Rutherford. They're "sad songs about sons and fathers, and about growing old, and one day realizing you have no bond with your kids, and visa versa."

For a long time Bob felt like an impostor in his role as counsellor. "I was feeling as a fraud as the physician's assistant as well. That's when my co-dependency became really bad...and that's when my drinking got bad." To maintain a feeling of competence, he would "stick specifically to alcoholism, but if we got out of that realm, such as sexual issues, there would be a little shakiness around that." Even though he was certified by two boards, he felt that he was somehow inadequate because he did not have a university degree. "I was working with social workers, psychologists, and psychiatrists who were always applauding me and my work, but it was never good enough for me....I'm at the point now where I'm good at what I do and I know it, and I don't need to be degreed....But it was that internal credibility that I struggled with."

There was also a struggle with authenticity. "In the military I was a paratrooper....everyone knew I was an elite commando, so I didn't have to defend myself physically or anything like that....So I attached a lot of importance to the things I do, rather than what I was. Later, when I sobered up, I got in touch with: it's OK to just be who you are". Professionally, he "had this idea that counsellors had to be strong, all together", and while he was in that role, clients would trigger personal issues for him and he "had that sense that I was shaky/flaky". Now that he's striving for authenticity and genuineness in his personal life, he hopes that this allows clients to be genuine with him. He teaches that there are some "counsellor characteristics that we need to promote in ourselves: concreteness, confrontation, genuineness, respect, immediacy, potency, empathy, and self-disclosure. The two most important are respect and empathy...because if you don't have those...all of our transactions are going to be phony."

"There are two types of therapists: "Scanners" and "Modelers"...the "Scanners"...are rather aloof, head moving like a scanning camera...very little emotion...you know, very Fritz Perlish. The "Modelers" use some of their emotions to elicit responses in their clients and show a more empathetic side." That is what Bob is aiming for as a counsellor.

He sees the role of therapist as "being able to unwind that stuff, not to get caught up in it....to be a living, sober, role model....to be congruent...not elitist....honest." Although he values his training, he states, "your most valuable asset as a therapist is

yourself, and the feelings you have inside". But because "our reality was twisted a long, long time ago", it took a lot of affirmation from colleagues to help him realize that he is doing good work. A developmental process is taking place, "I can show you on a calendar who I was with and what took place from early 1983 when I got sober. I can tell you where I was at each particular place, and what growth took place. It was normally from being positively affirmed by loving, caring people, who have worked through their own shit."

Recognition of his own issues has given him "more clarity" about client issues, and more empathy toward them. Previously he "used to acknowledge them, but not really lend any credence to it". He uses self-disclosure selectively, and finds that with "a lot of alcoholic clients it's a major breakthrough....one of the things that helps them get well, is when they stop placing people on pedestals". When clients know he's human, with his own daily struggles, "there seems to be that sense of: well, maybe he understands me". Trust between therapist and client grows. Then he is able to confront a client in a caring way by "pointing out the incongruities in their lives". "Confrontation is a painful word for co-dependents...but if you care for your clients, you're going to confront them. If you don't, you're not doing it because you're afraid, and you're caring for yourself not your client."

Although he tries to be more spontaneous in his recovery, he realizes that "we have to have our boundaries....we can't have lowered boundaries." He's now more conscious about invading people's personal boundaries and feels especially vulnerable around victimized women.

He prepares himself by talking to himself about professional ethics. His boundaries have become more flexible as he chooses selectively what he discloses to clients.

He has found that his personal "co-dependent experiences have provided (him) with so much insight that (he) has to use it". He's recognizing that the therapeutic process is a mutual growth experience for client and therapist. "There's got to be two computers working...one that says what's going on with the client, and one that says what's going on with me". "When I saw my own characteristics mirrored in my clients or visa versa, I started to make a major breakthrough as a person and as a therapist."

However, "we all need a therapist...a good support network". Bob has such a group of people who let him know when he's relapsing and needs to get in touch with himself. If "you have no one to debrief with, you're heading for trouble...burn out."

At this stage of his recovery, Bob is "losing the sense that (he's) a phony". He's striving for a balance in his life, "I was foolishly impulsive" at one point in life, "today the challenge is not creating things, but going with whatever is being presented to me...I've got to play the cards that He sends me". Professionally, "I don't need special acclaim. I just turned down a trip to lecture in the (United States)...I lost a lot of money"...but he chose not to go because of the stress it would put on his time and the sense of commitment he has to his clients. He is striving to strike a balance between being irresponsible and overly responsible. "Co-dependence is a constant balance in extremes".

"When you work on your issues with your clients, and see your own stuff, you start to realize you have a whole lot of choices". His ultimate choice was going into private practice. Here he is learning to nurture himself emotionally by interacting with supportive people. He is looking after his spiritual needs by searching for a church that is more suitable for him. He tries to watch his diet and to run daily to maintain physical fitness.

He advises counsellors who are Adult Children of Alcoholics "that when you recognize things about yourself, don't try to hide them, but try to work on them....I have a fear about this thing called "quality wellness"...like there's this focus...that I can't look like I'm fucked up. So where do I go to hurt?" Recovery is an ongoing process where you should be "willing to address your issues and be able to reflect it on yourself, then you'll be able to experience your own personal growth." That growth will increase the level of work you do.

MIKE'S STORY

Mike has participated in the field of social work, in various capacities, for about 15 years. He has a Master's degree and is currently a family therapist.

In his family of origin, his father was alcoholic and Mike was the Lost Child. The denial was very strong in his family. "There are six kids, and only two of us acknowledge that there was an alcohol problem...it was all very fuzzy...and still is...I knew my Dad drank, but nobody put the label on it. It wasn't framed in a way that you could make sense of it...The only thing that I was aware of is that I was the different one in the family, somehow the problem to everybody else..." Because everyone around him appeared to be happy he wondered "why am I so depressed?...I couldn't play the game, but I didn't even know there was a game going on. I didn't know what the rules were. It's a very bizarre experience. It's crazy-making...but you just carry on". When there is "no labeling, no framing the experience, you have to do it yourself."

"I think it's useful to look at the theory of Post Traumatic Stress (Disorder). I think a lot of ACOAs are suffering from PTSD, in a sense that they walk around sort of half-stunned, in shock...I used to label it as being dumb...but I really think I was sort of stunned...in shock". He feels it was a self-protective mechanism he used at the time. But it did not occur to him for a long time that his childhood traumas might be the reason for personal issues in his

adult life. He finds the ACOA movement a very useful tool for his personal and professional life.

Mike's control issues and insecurity emerged as a result of doing this interview. "I don't know what I'm going to say...part of me felt like I should have some sort of script prepared. I think that's probably part of my ACOA background, to be ready for anything (laugh)...When I prepare for a lecture...I like things 1, 2, 3...It's probably a control issue, because once I have the 1, 2, 3 outline, then I can be spontaneous...it's my security blanket."

With those comments, he proceeded to list the characteristics of ACOA therapists that were outlined in my proposal, which he read previously. "All together there were nine characteristics and I checked off five...that fit for me:

1. Have a need for clients to like them.
2. Seek approval.
3. Avoid conflict in therapy.
4. Have difficulty making referrals.
5. Tend to not limit their caseloads."

"I don't feel I get impatient with stuck clients, look for road maps, poor stress manager, and I think I can recognize counter-transference." After he read my thesis proposal, "little light bulbs went on. I haven't really connected all that necessarily with being ACOA."

Although he has been reading the literature for a while, it wasn't until he had an experience "last year...for the first time that I really pulled it all together in a comprehensive way. That was really useful because then I could put the patterns together". In counselling alcoholics or ACOAs, he "initially started...with whatever

(he) learned in graduate school...without really connecting that with (his) own experience." Today he finds that "working with ACOAs especially, I learn more about my own ACOA issues...they trigger things for me. It's sort of a mutual process... I can help them sort out their issues, but at the same time...I'm doing a little bit of running through my head what that means to me...it's synchronistic."

It seems that once he became aware of ACOA issues "all of a sudden I have all these ACOA clients (laugh)". For example, when he was dealing with the issue of hypervigilance in his life "the cosmos sends me clients who are dealing with hypervigilance...the more you look the more you see...and you can see the patterns there, and then help them reframe their own experience."

He dislikes the word "recovery" because "it almost implies that recovery is some process you go through and come out the other end...to me it's just a process. I suppose it starts at a cognitive understanding of my experience, being aware of the emotional reaction I have." Making sense of his personal experiences has been a "very gradual process...to become aware of it. I can't really tell you definitely when it sort of clicked in for me..." With that personal awareness, his development as a therapist has also evolved.

"I think I had boundary issues when I first started, around how much of myself I'm going to pour into this (practice). I quickly learned, because I was over-pouring, without being aware why...I was a real rescuer, the good guy, the nice person...getting your clients to like you. What happened, I started to burn out almost right away...so

I had to start setting up some boundaries in terms of how much time and energy I was going to give it."

For the first couple of years "I felt inept, incompetent...I was trying to take out of my graduate school work the theory and superimpose it on anyone I was seeing...make that Freudian analysis fit for whatever was happening. Once I figured out that wasn't working, I started to explore...other theories...and could integrate what I was learning (and that included all that was coming from the cosmos), and it all kind of came together in a pot pourri of stuff that works."

At the beginning he felt he "was getting in (his) own way"..."and I'm sure it's really hard on the client, when you're trying to sort out your own issues and their issues. Probably very interfering." One of the key things he had to work on is taking responsibility for his clients. "There's this theory I picked up somewhere about the difference between being responsive and responsible...I want to respond to the client, but I'm not going to take personal responsibility for their life. That probably was my salvation to be able to stay in this field for 15 years". At this time, he also recognized his own limitations about what he could and could not do for a client.

"While I don't want to take any responsibility for their life, I also don't want them to take any responsibility for my issues". It became very important to set up personal boundaries, particularly with self-disclosure. "I'm pretty selective about what I share about myself. If I feel that inappropriate questions are being asked, I

just turn it right over to them." Sometimes he discloses that he is an ACOA. "I think it's an intuitive thing...I only do it when intuitively I know it may be helpful to them, but it's not often". If a client triggers personal issues for him, "I might share my own struggle (with that issue) or I might not. But whether I disclose to them or not, I'm making mental notes of my own stuff". Clients' reaction to his self-disclosure "basically (has) been positive, or I wouldn't have done it."

He has firm boundaries when sharing with his colleagues, as well..."if I share, I would do it individually, with specific people". Family of origin issues influence him in this area. "...there were certain ground rules in the family, that you don't tell a problem...not supposed to have a problem". So, "I suppose my own privacy issues come up". However, when he needs to debrief with someone, he has a friend who is in the counselling profession, whom he trusts to "bounce it off."

He usually does not have any issue with trusting clients. "I like to start with the basic premise that they're giving me the straight stuff, but I try to make allowances if they have to sort of feel fairly safe with me before they're going to do that". However, "I have a real reaction with alcoholics (and I assume it comes from my own ACOA history)...when they tell me stories about how they've cleaned up their act...all that stuff. I don't trust that. And I think when I first started I probably did. I think I got pulled into that alcoholic con."

He also reacts strongly to certain phrases that clients sometimes use. One example is "that children should be seen and not heard. That really hit me, because I spent so much time being invisible in my family". Being the Lost Child he would "fade into the woodwork...be anonymous, invisible." He recognizes that "the small child within is still vibrating to some of it...and so angry to think that a parent should tell you to be invisible."

At times, abandonment issues come up. "I suppose abandonment issues get in there" because if he makes referrals, "...I guess I get concerned that...the client would experience abandonment." During termination he may also feel abandonment himself "...not always, it depends on the level of commitment and the relationship we established...It is sort of hard for me to terminate..."

In regard to control issues: "I don't think I have a need to control what goes on with my clients. I have a real need to control what goes on with me. My control issues have more to do with feeling in control of my own life...feeling in control of what happens with me, or to me". The only exception is when a client displays anger. "I may feel the need to want to settle them down". He does that by "helping them to reframe their anger in some way, because anger is really usually covering up something else anyhow. Usually it's a lot of hurt...I share that with them."

Anger "affects me a lot...I tend to get...rattled. My father was a very angry man, had a lot of hostility...and it was very frightening. One of his supervisors "had the same kind of incredible rage...I just became paralyzed. I was like a little kid again. I

still react to anger, especially if it's directed at me. I tend to be very defended, rattled, thrown off course." When he goes back into his role, "I get defensive and withdrawn...I blend into the wall and try to pull it together, try to get myself back together again." It's part of his personality to "want harmony. I suppose there are times when I try to make the anger go away in a session in order to meet my own needs. I think that still may happen sometimes". It is very easy to revert to your role "I think I go into that really easily with anger."

Mike also reacts to the "Puer Aeternus" (The Eternal Boy). "As a counsellor, that's one of the personalities I really react negatively to...the male who doesn't want to grow up...they're commitment phobic...who seek out women who seek out that role of Mother/co-dependent, who will be responsible for them, and let them be boys...my father was like that. There's a very unconscious coming together of (these men) and co-dependent women." When I mentioned that this was an issue for myself as well, he commented, "I think that happens a lot with female counsellors."

In regard to confrontation, he confronts clients "in a way that's not hostile or angry. I try to do it in a way that's really supportive and not get them too defensive, not to back them up against the wall...I will try to feed back to people my own impression of (what's going on)...very gentle confronting as opposed to backhanding them". Even with alcoholic clients who are trying to con him, he feels that "if people want to tell me that, that's fine, I don't generally hit them over the head with it". However, often "they may

not acknowledge it, but they may go away and think about it," and the results of the confrontation may never be known to the therapist.

He finds interaction with a client emotionally nurturing. If an issue is triggered, "just to be able to verbalize this experience in a back and forth exchange...I suppose that was nurturing to myself in that particular moment"..."I think that's one of the beautiful things about counselling, is that there is a back and forth, and you get as much (out of it) as they are...what's nurturing about it, is to be able to talk about it."

He finds the work itself very enjoyable. "I really enjoy coming to work...it's not stressful. There are certain people I would rather not see, but overall, I enjoy every day. Something exciting usually happens, or you learn something new every day...there's always some gem that comes out of that particular interview that may be useful to myself, or useful theoretically". He does not relate to therapists who do not enjoy their work. "...maybe they're taking on too much responsibility and allowing their psychic energy to be drained...maybe there's a boundary issue there, I don't know, but I don't experience that. I can't imagine ever retiring... for me it's very energizing. As opposed to putting energy out, I'm putting energy back... I'm willing to give people all kinds of energy, but I hang on to enough, I'm doing that certainly, but I'm getting back also. So it's sort of a mutual exchange of energy."

Although he considers himself "probably a bit of a workaholic", he has a balance in his daily life. "...there's a lot of hiking and cross-country skiing, and I try to jog and work out with weights."

There is also a spiritual element that he looks after. "I don't belong to any church...but I certainly believe in an existence beyond this reality." He has a great "interest in the dream world and psyche, and the flow of the unconscious." "I often feel in an interview that it's not me talking...something comes from somewhere...I try to plug in to the client and the cosmos at the same time, so that I'm open to whatever will flow from the cosmos to the client, and I'm really the facilitator, the conductor."

He sees his discovery of the ACOA movement as "the unfolding of the cosmos...I think it's very synchronistic. As I've become aware of certain counselling issues, then there's a certain something that happens that you start seeing more of them. And then there's a certain coming together of the inner and the outer world. So when I become more aware of a certain issue, then it appears more in the light...It's certainly been a positive thing to be able to work with this particular clientele, and help them make better sense of their own experience, and at the same time make sense of my own experience. That's why I hate to lose my clients, because it's a mutual learning kind of thing."

Therapy with ACOAs is no different than with his other clients. "I think for every client I see, my approach is generally historical, in the sense to help them make sense out of their life...reframe their early experiences". The difference with ACOAs is "that at least in ACOA there is a growing framework which you can work with...you know, help them work with their own childhood...It helps to expand their

awareness of what that experience would be like. It can help you and the client make sense out of it."

Mike's advice to other therapists who are ACOA is to "make sense out of their own history...and how it affects their adulthood and their work with clients...to see it as a process and learn from that." "That's why I feel it's been so important for me to figure out my own ACOA history, and what that meant, and what my role is in the family, so that that doesn't have to get triggered as much, and I can be more aware of when it happens. It gives me more choices." It also allows him to be more authentic, "I think we're always in search of the authentic self. I think I still am... and it helps the clients in their search for their authentic self, too...it gives them permission" to step out of the role they were previously playing.

He is able to "pick up (client issues around ACOA) sooner, then I would have probably ten years ago." However, feeling competent as a therapist is still sometimes a struggle. "Sometimes I still don't...it's hard to feel competent. But I think at some point I could let go of graduate school and theory, and pay attention to the process of the interview. You know, that trust that whatever I needed to say would come. I'm not quite sure when that happened, it sort of evolved."

He hopes to continue this course in the future. "I suppose I just want to continue making sense of my own life experience, try not to get pulled into the drama of what's going on...you know, being responsive without feeling responsible...I felt responsible for so long...but for the future, I have to keep learning, keep doing this

kind of work, and be helpful to people in pain". It is not easy. "I'm struggling every day with my own background...there are still issues...so much tragedy." When observing the intergenerational patterns developed in his extended family members, "there's so much tragedy going on...insanity...it feels really hopeless...I could get really depressed about it...I feel like I carry that sadness around a lot...you know, that chronic kind of thing that gets triggered sometimes with clients."

He made reference to Healing and Wholeness by John Sanford, who talks about "wounded healers". "I could think of all these ACOA counsellors...probably wounded healers...I don't think they ever heal...After they become aware of their own woundedness, they go on a path of healing, but I don't think you ever heal." He believes "we all go into this (profession) unconsciously, for our own reasons...I think I felt the need to be needed...to work out my own childhood issues, to understand them." However, that does not mean they cannot be good therapists. While healing their own wounds, they could be "using that woundedness in a way that can be helpful to clients."

Although Mike had opportunities to move into high profile positions, he consciously chose to remain a family therapist. "There were times when I felt financially pressured, but I chose between the money and my emotional health."

LIZ'S STORY

Liz is a psychologist who has been practising counselling about eight years. She began her recovery process during her professional training, which she feels has been a critical part of the training process. "I feel I'm only as effective as I am healthy, in terms of mental, emotional, and I would even include my physical health...I'm talking about exercise and being overweight...this is a sign of not caring for yourself." "It started for me a long time age, before I knew anything about ACOAs, or even recognized that I had come from an alcoholic family...but knowing that there was dysfunction in my family, and that there was pain for me to deal with...So I have been doing my family or origin work for over 10 years, although it was only a couple of years ago that I started hearing about ACOAs and their characteristics...did I put it in another context...put it all together."

When she heard lectures on co-dependency and Adult Children she realized "a lot of the things that my clients were saying to me were things that I had also experienced...but I hadn't put it in that "Aha, so this is it...I'm an Adult Child"...but that really fit, that really explained a lot of things that were happening."

After this awareness, "I feel much closer to my clients, and I think they feel closer to me, because I'm more on topic and more open...it's not always said in words. I think that when you're in denial (before we do our own work), we distance ourselves from our clients...you know...a little judgemental, hierarchal. Being aware of

your own issues, you can be more empathic, closer, open. I think you then can take people further emotionally than you could before." Therapists who have not done their own work tend to be more cognitive, but "cognitive work is only a small portion of it, it gives them some important beginning steps."

Liz recognizes that "labels can be very restrictive", so she found it difficult to initially label herself an Adult Child. However, "I really believe that when you do your healing work, you do move. I don't feel like an Adult Child anymore...I don't have an unhealed child." Of course she realizes that "I still have parts that I need to look at...that still come up", but she prefers to refer to herself as an "Adult Adult" as Sharon Wegsheider-Cruse put it.

She has no difficulty disclosing to her clients that she comes from a dysfunctional background. However, "I am a little cautious about how much I disclose. I will disclose a lot more in a workshop that I lead...but when I start with an individual...I think they really need to know somebody is in charge." Most clients react favorably, "they really like that I'm human, but some people still have a hard time with it." They expect the therapist to be the expert who can look after them.

Most of the time she does not feel that she is controlling with her clients. "I'm quite patient...give them a lot of rope...so they don't have to fight against me". However, "with addicted people, you need to be really confrontational, not in a nasty way, but be really straight...I can get fooled by games sometimes." Before she was aware of these issues, she did not pick up on some of these things. "I think

you put up with a lot more, you don't call people on what they're doing. For many of us, you want to be, sort of, the be-all and end-all to your clients, so you're really empathic, always understanding, let them do anything they want."

Sometimes "I still get hooked by needy, whiney women, who want to be told what to do all the time." However, she has learned how to protect herself by setting boundaries. She stated that when we do that we're "teaching our clients how to set their own boundaries...so it's important role modeling." "I have some pretty strict boundaries...make every effort to stay within the contracted time for appointments...rarely give my home phone number...don't work in the evenings anymore...use my secretary more for screening...protect myself with a waiting list...take holidays and breaks." She has also "set up a therapeutic community, or environment" with other colleagues where "I can go to them and say I need to talk. And we're very confrontational to one another, in a very caring way...we process everything we do."

"I work a lot with anger...I don't think I get hooked by that stuff very often." However, "that's probably when I put a shield around me...and set up a protective environment...where there are rules...that you don't hurt yourself or me, or the furniture, and you stop when I ask you to stop." She "teaches people that they can think and feel at the same time." Initially, anger work "really, really frightened me...I would freeze up and I don't do that any more." If she feels a client is dangerous, she does not hesitate to refer him/her to a residential program dealing with anger.

"I don't think sometimes we realize how much we take on. I've heard a Jungian therapist say that she covers her throat chakra...she talks about it being toxic", dealing with some of the issues therapists deal with. "This stuff sneaks up on you, even more than we recognize, and it really does lead to burn-out." She does not always remember to protect herself consciously, "but I'm seriously thinking of doing it more...some cleansing after I do work."

Before she was aware of ACOA issues, she didn't feel overwhelmed with her clients, "and I wonder if it wasn't because I didn't know all that I was dealing with...I feel more overwhelmed more often now." However, she deals with any emerging issues right away, before they get out of hand. "Sometimes we see so much...even more than the client sees...that can be overwhelming sometimes. I find I need to put that into perspective. I go to my peer group, or my supervisor, or to a treatment program."

She tries to maintain a balance in her life by having a variety of friends. "Most of my girlfriends are therapists...but as a couple, our friends are not helping professionals...My family life and life outside needs to be as important as my work". However, even in her professional life she aims to balance the type of work she does. "I don't want to work only in this area...it's really hard work...exhausting. I would burn out too quickly...So I try to balance" by working in other areas, besides strictly clinical counselling.

She feels a major transition is taking place in her life. "I grew up the Hero...and I have quite a convincing aura of confidence."

But that was merely a role she was playing. "There were times I would feel just awful inside...shaking and scared...As I've dropped the Hero role, it's far more difficult for me." In being more authentic she has discovered she is "far quieter than I used to be...this is the other side of me that I haven't allowed myself to really experience. It feels much more integrative to me, and I'm very reluctant to take on this Hero stuff anymore." "Dropping that role has been really hard, because people see you that way, and there are a lot of strokes" that the Hero receives. As a therapist you respond by "trying to take responsibility for the client, trying to please them, needing to be successful, always finding solutions...and if you can't, then you take a real crash". This is all an attempt "to cover up feelings of inadequacy...but when you've had to be a Hero all your life...look so good on the outside, then things on the inside haven't been paid attention to". "We still see this in academia, that's it's really not appropriate to deal with your own stuff...so that's reinforced again...of course, that leads to burn-out."

There are still issues that are difficult to deal with in sessions. "I would still get hooked, I think, by somebody who is close to my age and dealing with their own addiction...I don't know if I could stay objective." Those are times when she slips back into the rescuer role. There was a time when she would "try to do it all myself, wouldn't ask for help, and usually get into trouble." Now, "I would know I was in trouble if I didn't know what to do, and would give it to one of my co-workers. She recognizes that ACOA therapists have difficulty referring clients elsewhere, but it's good to "know

that we don't have to do it all by ourselves." She has learned to let go of her over-responsible role. "I felt like I was carrying it all by myself...so I did some therapy around my own responsibility" in order to be more objective in certain situations. That is "one of the things I still struggle with...being over-responsible and super-caretaker...it has to do with pleasing my clients." If a personal issue is triggered for her in a session, she is "pretty good at pushing it away, and then dealing with it later."

Generally, she has no difficulty with trust issues concerning clients because her "radar is quite in tune with that." She recognizes that some clients may be distrusting of her, but that "would seem appropriate given the circumstances." If a client does not trust her "a few years ago that would have been a problem for me...", but now "I really see myself as one person on someone's journey...I keep that in perspective." Eight years ago "I don't think I knew that...but that's one of the issues I dealt with long ago, my own issues of abandonment. So when clients would leave me, it was difficult." At those times her perfectionism would get in the way, "I would have had to have done the best, most perfect job, and then they could go." Today, she does not have difficulty letting go of a client. "I think that was the help of my training process as a therapist."

In her attempt to be more authentic she is "trusting of (her) own process...I am more trusting of myself. I am much more confident of my skill...knowing that my work is good. That doesn't mean I'm perfect, but knowing that I can work."

She feels that more options are available to her as she moved out her role. She is tired of serving in high profile capacities and is directing her energies elsewhere. "It feels like a phase of moving in and doing some more sorting and growth...making a connection spiritually. It's interesting, because I feel much closer to my husband...more in touch with my kids...closer to myself, and to people who are important to me. I'm just going to be where I am."

There is considerable pressure to expand her practice. "I think there's a real kind of seduction to being successful...the money is a seduction, but also being seen as being very successful." It is a "very subtle" way of slipping back into the role. "My gut tells me that's not the right way to do it...but it's scary too, because the train might pass you by...I keep remembering the cream rises to the top."

Although she is very content with her present situation, she plans on moving into other areas of interest in the next few years. "Now I'm doing thing that I only dreamed about, so there's a big charge in that for me...I accomplished the things I said I would." In the future, "I don't ever want to stop using my skills, but I may use them in a different way." She would also like to expand her training to include "more work in the spiritual area. I would like to do more non-traditional things like body-work, different types of meditation, or learning more about the medicine wheel." However, in the meantime she is enjoying the present.

Liz does not treat ACOAs any differently than any other clients. "We always talk about Adult Children of Dysfunctional Families."

However, when she does a three generational history, "I have found a lot of alcoholism in their history, but it's not always their parents. Often their parents are the children of alcoholics. That just illustrates how these things get passed on from generation to generation."

In speaking to other therapists who are ACOA she says, "Do your own therapy. Heal yourself first...and I don't think that means that...if you're a beginning therapist you can't do therapy. It just means you need to know your limits." People who run into trouble are those who are doing things they don't feel confident about. "If anger still triggers fear in you, don't even start anger work. Ask someone else to do it, or get your own therapy done."

CHAPTER SIX

RESULTS OF THE STUDY

In this chapter I will discuss the themes that were uncovered from the data collected during the interviews. The following themes will be presented: developmental stages, control, responsibility, boundaries, and confrontation. Direct quotations from the original interviews will be included to substantiate the findings with the co-researchers' own words, thereby, increasing the validity and reliability of this information.

THEME ONE: DEVELOPMENTAL STAGES

After careful analysis of the data, it appears that the experience of counselling for these therapists could be described as a developmental process. I have categorized this process into three stages, which I will refer to as:

i. Lack of Awareness
ii. Emerging Awareness
iii. Striving for Integration

Three sub-themes will be discussed which occur within each stage:

a) specific function of each stage
b) different strategies utilized
c) different results obtained

STAGE ONE: LACK OF AWARENESS

Before the term Adult Children of Alcoholics was coined, these counsellors were unaware of the impact of their chaotic environments. They did not suspect that they might have been "developing predictable problematic patterns of behaviour in which they get stuck over and over again" (Gravitz & Bowden, 1985, p. 4). Hiding under a facade of strength, they often experienced spontaneous age regression, not understanding the causes behind their arrested emotional development.

It is clearly evident that it is possible to heal some of these childhood traumas. This healing occurs in stages, and is a continual process, not a one-time event. For some, this process begins with the suspicion that a problem exists. At times, this may occur long before they are aware of the role that alcoholism played in their lives. However, "central to the treatment and the recovery process for ACOAs is the knowledge that the source of the problem was being raised in an alcoholic family" (Kritsberg, 1985, p. 75). As Liz indicated:

> (my recovery) started for me a long time ago, before I knew anything about ACOAs...although it was only a couple of years ago that I started hearing about ACOAs...did I put it in another context...put it all together.

The lack of awareness that I am referring to in this study concerns the fact that the therapists were not aware of their ACOA background, and did not make a connection between their personal background and the influence it may have been having on their clinical practices. The following section includes statements that are key indicators of this lack of awareness.

STATEMENTS AS KEY INDICATORS OF LACK OF AWARENESS

Ann: "It was not until I became familiar with the ACOA literature...I began to realize that there was a connection between what happened to me personally and what was happening with my clients."

Bob: "I didn't make a link between (my clients') type of drinking and mine..."

Mike: "...in counselling...ACOAs, I initially started...with whatever I learned in graduate school and reading, without really connecting that with my own experience...It wasn't until last year...I really pulled it all together."

Liz: "...a lot of things that my clients were saying to me were things that I had also experienced...but I hadn't put it in that "Aha, so this is it...I'm an Adult Child"...but that really fit, that really explained a lot of things that were happening".

The following statements indicate that becoming aware has been a gradual, developmental process for these therapists.

STATEMENTS AS KEY INDICATORS OF A DEVELOPMENTAL PROCESS

Ann: "I look at it as a developmental process. I don't have to be afraid of all these negative things taking over. I know I can choose to move in a positive direction."

Bob: "I can show you on a calendar...where I was at each particular place and what growth took place..."

Mike: "I dislike the word "recovery"...it almost implies that (it) is some process you go through and come out the other end... to me it's just a process...a very gradual process...to become aware of it...I'm not sure when it happened, it sort of evolved."

Liz: "I really believe that when you do your healing work, you do move. I don't feel like an Adult Child anymore...I still have parts that I need to look at...but I don't have an unhealed child."

a) FUNCTION OF STAGE ONE

Lack of awareness served a protective function for these therapists. Gravitz & Bowden (1985, p.17) indicate that ACOAs have survived by learning to deny, block out, repress, isolate, and/or disassociate themselves from reality, in order not to be overwhelmed by it. These are similar symptoms that are described in Post Traumatic Stress Disorder (PTSD). Although PTSD was initially identified in war veterans, it is more recently being noticed in ACOAs and other individuals who experienced severe trauma on a prolonged basis (Cermak, 1988; Kritsberg, 1985; Gil, 1988; Whitfield, 1987). The four major symptoms of PTSD include:

1. Reexperiencing the trauma long after it has passed: often expressed through nightmares, recurring thoughts, or sudden reemergence of survival behaviours.
2. A psychic numbing: where emotions are constricted and anesthetized.
3. Hypervigilance: characterized by the inability to relax chronic anxiety, and panic attacks.
4. Survivor guilt: where chronic depression and a sense of guilt prevail.

(Cermak, 1988, p.86)

It appears that my co-researchers displayed some of these symptoms, and protected themselves in the early stages of their careers, by not being fully self aware in the process of counselling.

STATEMENTS AS KEY INDICATORS OF PROTECTIVE FUNCTION

Ann: "splitting off into space...I know this was my way of protecting my sanity."

Bob: "I tried to make a difference between me and my clients. That was how I always kept myself safe."

Mike: "I think it's useful to look at the theory of PTSD...I really think I was sort of stunned, in shock...I think that was (our way of protecting ourselves)."

Liz: "I didn't feel overwhelmed with my clients, and I wonder if it wasn't because I didn't know all that I was dealing with..."

b) STRATEGIES UTILIZED and

c) RESULTS OBTAINED

The protective strategies that these therapists used in Stage One were often unconscious responses to a stressful situation. Not being aware of the traumatic effects of their childhoods, they continued using the same strategies that were effective in helping them survive their traumas. These strategies were temporarily effective. Ultimately, however, they resulted in a feeling of incompetence and led to burn out. Woititz (1987) indicates that ACOA therapists are natural candidates for burnout, since they have difficulty saying "no", and tend to give more of themselves than they have to give. The following statements indicate the various strategies that were employed during this stage, and the results that followed.

STATEMENTS AS KEY INDICATORS OF STRATEGIES UTILIZED

AND RESULTS OBTAINED

Ann: "...in the beginning...I was so overwhelmed...I'd be splitting off into space...and would then have to take care of my own feelings that were emerging...".

Result:
"I felt so incompetent...but would over-compensate by being very task oriented...I ended up burning out."

Bob: "...in the early stages, I mirrored those social workers and psychologists that I worked with...to buy myself some credibility.
...maybe I'm not certified well enough...maybe they'd take me up in front of the Board of Ethics...so (with clients) we stuck specifically to alcoholism...I would try to pacify them, kiss their ass...".

Result:
"Something that we all have to acknowledge is that we're all going to burn out."

Mike: "I tried being the good guy...getting the client to like you...

Result:
"...what happened, I started to burn out almost right away..."
"I felt inept, incompetent."

Liz: "...wanting to be the be-all and end-all to your clients ...always understanding...and they can do anything they want..."
"...distance (the) client"
"I tried to do it all myself...and usually get into trouble."

Result:
"...feelings of inadequacy (emerged)..this could lead to burn out."

STAGE TWO: EMERGING AWARENESS

This stage correlates with the stage of "Emergent Awareness" that is outlined by Gravitz and Bowden (1985). They indicate that:

> Emergent awareness refers to the stage in the recovery process when adult children of alcoholics begin to become aware of the psychological, physiological, and genetic vulnerabilities that they acquired as a result of being reared in a home where there is an alcoholic. In emergent awareness children of alcoholics recognize that there was something wrong in their childhood, and they no longer need to deny it. They become free to acknowledge their experience and its effects on them. (p. 29)

After making this discovery, the ACOAs are able to proceed with their recovery, making major changes in their lives. Although it is certain that each individual works at his/her own speed, Kritsberg (1985, p. 76) states that there are three primary components which must interact for progress to proceed in a balanced way. These components include:

1. Emotional Discharge - where the ACOA is able to release repressed feelings in a cathartic way.

2. Cognitive Reconstruction - which involves a process of acquiring an information base concerning fundamental life skills, and restructuring cognition as a basis for developing healthier behavioural patterns.

3. Behavioural Action - when the individual proceeds to make changes in behavioural patterns that previously were considered problematic.

a) FUNCTION OF STAGE TWO

The function of Stage Two is to bring to conscious awareness the interrelatedness of the therapist's personal issues from childhood, and the effects they were having on their clinical practices. As they developed new coping strategies for dealing with personal issues, this insight concurrently enabled them to develop different strategies for interacting with their clients. The ACOA literature, personal counsellors, and fellow colleagues played critical roles in facilitating this insight during this stage. The following statements indicate the emerging awareness in my co-researchers.

STATEMENTS AS KEY INDICATOR OF EMERGING AWARENESS

Ann: "I was overwhelmed when I read "Adult Children of Alcoholics" by Woititz. For the first time in my life I could put things in perspective...I said, Now I know why I'm so screwed up."

Bob: "...when I saw my own characteristics mirrored in my clients, or visa versa, I started to make a major breakthrough as a person and as a therapist."
"I used to think (my) sensitivities were liabilities, and then I started to realize what an asset they were."

Mike: "(before) there was no labeling, no framing the experience ...(now) there is a growing framework which you can work with...(which) helps to expand awareness...it can help you and the client make sense out of it."

Liz: "I was really aware that a lot of the things that my clients were saying to me, were things that I had also experienced ...but I hadn't put it in that: Aha, so this is it, I'm an Adult Child...that really explained a lot of things that were happening."

b) STRATEGIES UTILIZED and

c) RESULTS OBTAINED

The protective strategies that were developed during this stage, were made on a more *conscious* level, rather than being a *subconscious* reaction to a stressful client/worker relationship. As a result of using different strategies for coping, the therapists' self-confidence grew, and they felt they played a more useful function in the therapeutic process. In Ann's case, a new problem emerged as she consciously took care of her feelings during sessions. She found it difficult to interact with a client, without abandoning herself in the process. Cermak (1986) states that this is a common occurrence for ACOAs and co-dependents.

> The rules of co-dependency seem to dictate that relating to another person is incompatible with relating to one's own needs and feelings. As a result, co-dependents tend to choose one extreme or another: denial of themselves to keep someone else happy, or compulsive avoidance of others to keep themselves safe. (p. 18)

The quotes which follow demonstrate the new strategies that were being developed and the different results that were obtained.

STATEMENTS AS KEY INDICATORS OF NEW STRATEGIES

AND RESULTS OBTAINED

Ann: "...rather than splitting off...I would take care of my own feelings that were emerging (during the session)...rather than being there for the client...I could hardly function in the session."

"My therapist helps me unravel what's going on..."

"I find it so helpful to have this ACOA framework (literature) to work with."
"I now have a good support group of therapists who are familiar with the ACOA movement."

Result:
"I feel that now I'm being much more useful to my clients ...it's like a mutual growth process...my clients are helping me heal, at the same time I help them sort out their own stuff."

Bob: "...when someone questions my ability...my initial response (would be), oh, God, I screwed up...then I'd play my tape and say: this has nothing to do with you."
"I know (when) things are not well with me, and I need to be taking care of myself...I pick somebody...and share it with them...we all need a place to go to hurt...we all need a therapist...or a good support network that we can process this stuff with."

Result:
"...give more empathetic responses, rather than react to the behaviour (I) see...be more objective...able to unwind that stuff, not get caught up in it."

Mike: "(by reading the literature) I became aware of the roles and the games they play...I don't get hooked as much...I can see the patterns there, and then help them reframe their own experience.."

Result:
"...it's a mutual process...I found, working with ACOAs especially,...that I learn more about my own ACOA issues."

Liz: "I'm a real straight shooter...don't get hooked by my clients...more objective..."
"I would know I was in trouble if I didn't know what to do...so I would give it to one of my co-workers...(before) I was reluctant to ask for help."
"I have set up a therapeutic community, environment...(where) we process everything we do."
"...(sometimes) I go to a treatment program..."

Result:
"...there's not that separation between us."
"being aware of your own issues, you can be closer and more empathic, more open (with clients)...I think you can take people further emotionally than you could before."

STAGE THREE: STRIVING FOR INTEGRATION

Gravitz and Bowden (1985) indicate that Adult Children experience a stage of integration where they "rediscover and reclaim the wisdom of their inner experience" (p.85). At this time, there is a unification of the individual, where one feels a sense of completeness, eliminating the internal chaos which is often felt by ACOAs. Following this integration, the focus evolves to a stage of "Genesis", which "is the expansion of the body, mind, and spirit, and the developing awareness of a *higher self*" (p.103).

Marlin (1987) suggests that ACOAs strive "...to find a balance between doing too little and doing too much" (p. 170). My co-researchers found the struggle for integration a continual endeavor to maintain balance in their personal and professional lives. The integrative function of this stage enabled them to develop strategies where the focus is on nurturing one's emotional, physical, and spiritual needs. As they continue to evolve in this process, they are discovering they have more options then they previously considered.

Several sub-themes emerged, which will be included in this stage. They are as follows:

1. Striving for *balance*.
2. The recovery process is a *continual struggle*.
3. Strategies are *holistic* in nature.
4. *Choices* are recognized.
5. There is a *seduction toward success.*

a) FUNCTION OF STAGE THREE

The function of Stage Three plays an integrative role in the lives of these therapists. There is a continual struggle to balance their personal and professional lives in a holistic manner.

STATEMENTS AS KEY INDICATORS OF INTEGRATIVE FUNCTION

AND THE ROLE OF BALANCE

Ann: "I haven't been aware of my issues for very long, but I feel like things are coming together now - it's all falling into place."

Balance:
"Where I was overly responsible before, I fear that I will become too laxidazical, too distant from the client, too objective, not caring enough."

Bob: "The biggest role (as therapist) is to be a living, sober role model...to be congruent."

Balance:
"Something you have to remember as a counselor with clients, is always striking a balance...the biggest factor that you're going to struggle with is balance in your life...and co-dependency is a constant balance in extremes."
"...you have to be careful you don't go the other way, where you become insensitive."

Mike: "I think it's the unfolding of the cosmos...it's all very synchronistic...there's a certain coming together of the inner and the outer world." "...it's a mutual learning kind of thing."

Balance:
"I'm probably a bit of a workaholic...but...there is a balance..."

Liz: "It's like there's sort of a transition...it feels much more integrative to me."

Balance:
"I feel that I have sort of two parts, the challenge for me is to keep them in balance."
"My family life and my life outside needs to be as important as my work."
"this type of work is exhausting...I don't want to do just that...so I try to balance."

STATEMENTS AS KEY INDICATORS OF CONTINUAL STRUGGLE

Ann: "I keep slipping back into that responsible role...change is hard to accept."

Bob: "I struggle with my co-dependency issues daily."

Mike: "I'm still struggling every day with my background."
"I don't think (wounded healers) ever heal. After they become aware of their own woundedness, they go on a path of healing, but I don't think you ever heal." "I have been...healing my childhood experiences, and you carry that into adulthood...the small child within is still vibrating."

Liz: "there are still parts that need to be looked at...and come up."

b) STRATEGIES UTILIZED

In this stage a theme was revealed which indicated that a holistic approach was utilized in developing coping strategies. Three categories were exposed, in which the co-researchers nurtured themselves on an emotional, physical and spiritual level. This may be as a result of their aim to balance their lives, and their awareness of the importance of these three aspects of personal development. The following quotations will demonstrate the types of strategies the therapists utilized to obtain the nurturing they required in these three areas of life.

STATEMENTS AS KEY INDICATORS OF STRATEGIES UTILIZED

EMOTIONAL NURTURING

Ann: "I meditate before a session and put a protective boundary around myself."
"I tend to overbook...so I'm learning not to take on more than I can handle comfortably...sometimes, during the day, I plan for a walk by myself, or to have coffee with a friend."

Bob: "I'm losing the sense that I'm a phony...I can't play that game anymore. I have this need for honesty...genuineness."
"I have a lot of people in my life...I need to be nurtured by them."

Mike: "I give people all kinds of energy, but hang on to enough..."
"What's nurturing about it (during interviews) is to be able to talk about it...just to be able to verbalize this experience in a back and forth exchange...that's nurturing."

Liz: "I take holidays and breaks..."
"I've also had to protect myself with a waiting list...and by setting up a protective environment..."
"(doing anger work with clients)...that's probably when I put a shield around me."
"I've been thinking of doing some cleansing after I do work."
"I use my secretary more for screening."

PHYSICAL NURTURING

Ann: "I do a lot of walking in the evenings...and I have noticed that my work suffers when I don't eat properly."

Bob: "I try to keep my weight down...I try to jog daily."

Mike: "On weekends there's a lot of hiking and cross-country skiing, and I try to jog and work out with weights."

Liz: "I feel I'm only as effective as I am healthy, in terms of my own mental, emotional, and I would even include physical health...I'm talking about exercise and being overweight ...this is a sign of not caring for yourself."

SPIRITUAL NURTURING

Ann: "The spiritual part of my life is lacking...It's something I'm working on right now."

Bob: "I'm in the process of finding a church that will serve my needs a little better."

Mike: "I think there is a spiritual element. I don't belong to any church...but given my interest in the dream world and psyche, and flow of the unconscious, I certainly believe in an existence beyond this reality."

Liz: "I see myself doing more work in the spiritual area. I would like to do some more non-traditional things, like, body-work or different types of meditation, or learning more about the medicine wheel..."

c) RESULTS OBTAINED

Although each therapist obtained unique results from utilizing their personal strategies, two common sub-themes emerged. At some point in their professions, each person had been "seduced" by the desire to succeed professionally. This seduction involved the pursuit of financial gain and peer recognition, at the possible risk of threatening emotional health or personal relationships. Three of the therapists are making a conscious effort not to be overcome by this seduction. Ann is presently struggling with her desire to gain more financial security and professional recognition.

The other sub-theme that will be included in this section, is the element of "choice". This theme indicates that these therapists are breaking out of the self-defeating patterns that are so commonly attributed to ACOAs. Having choices provides more hopeful alternatives to a life style which was previously dominated by unconscious reactions which were developed in childhood. Wegsheider-Cruse (1987) stresses that learning to make choices is an essential stage of the recovery process. It seems to be particularly difficult for ACOAs to take such a risk, due to their fear of

uncertainty. However, in overcoming this fear they gain a sense of freedom, which leads to a transformation of Self and the recognition of a Higher Power.

The statements which follow will indicate the results that were obtained by nurturing themselves on three levels. Key statements will be included to indicate their struggle with the "seduction of success", and the fact that they recognize that choices are available to them.

STATEMENTS AS KEY INDICATORS OF RESULTS OBTAINED

Ann: "Now I can be more objective and keep myself separate from the client, instead of being overwhelmed..."

Seduction of Success

"I feel much more confident today as a counselor...but I would like to move into a better paying position..."

Choices

"I can choose to move in a positive direction."

Bob: "I'm losing that sense that I'm a phony...I can't play that game any more...it's like I'm realizing that I do good things."
"My challenge in life today is...going with whatever is being presented to me. I've got to play the cards He sends me."

Seduction of Success

"I just turned down a trip...to lecture to social workers in the (United States)...I lost a lot of money...but I chose not to go because of the stress it would put on my time...I have a sense of commitment to my clients..."

Choices

"When you work on your issues with your clients, and see your own stuff, you start to realize you have a whole lot of choices...my choices are expanding daily, and it comes as a result of acknowledging my co-dependency."

Mike: "It's hard to feel competent, but I think...(I) trust that whatever I need to say (will) come."

Seduction of Success

"There were times when I felt financially pressured (to move into higher paying positions), but I chose between the money and my emotional health."

Choices

"(having knowledge about ACOA issues) gives me more freedom...more choices."

Liz: "I feel much closer to my husband...kids...I'm more trusting of my own process...I'm much more confident of my skills..."

Seduction of Success

"I think there's a real kind of seduction to being successful ...the money is a seduction, but also being seen as being very successful...there's a temptation...to develop our program faster..my gut tells me that's not the right way to do it."

Choices

"I spent most of my life being in a hurry, wanting to get somewhere...wanting to be better, more successful, noticed more...I have accomplished the things I said I would...(but) I'm tired...When I choose to do it again, I will do it differently."

***

Because Theme One is complex and includes various sub-themes, it is demonstrated in summary form on the following page in Table One.

Table 1

Theme One: Developmental Stages

	i) Lack of Awareness	ii) Emerging Awareness	iii) Striving for Integration
1. Function of this Stage	-protective function -utilizing unconscious strategies	-conscious awareness of issues -conscious development of strategies	-integrative function -aim for balance
2. Strategies Utilized	-separating from client -splitting off -placating -remaining cognitive -relying on self -mirroring others	-unraveling own problems in sessions -more aware of cons -seeking support -reading ACOA literature -making referrals -group treatment -personal therapy	-recognition of continual struggle -nurturing self: emotionally physically spiritually
3. Results Obtained	-feeling incompetent -burning out	-don't get "hooked" -feeling more competent -more useful to clients -mutual learning process	-recognizing choices -seduced by success -more objective -not overwhelmed -more trusting -more confident

THEME TWO: CONTROL

All of the therapists interviewed stated that control was a significant issue in their practices. This is congruent with the literature which indicates that "control is perhaps the most dominant issue" in the lives of Adult Children (Whitfield, 1987, p. 68). "The fear of being *out of control* is almost universal", and various strategies are utilized by ACOAs to regain a sense of control (Gravitz and Bowden, 1985, p.46). Hypervigilance, anger and fear are prevalent indicators of the existence of a control issue. This often leads to self-defeating patterns of behaviour that are governed by all-or-nothing functioning and perfectionism. According to Marlin (1987), "controlling behaviour and perfectionism often go hand in hand...(it) drives us to try to control everything about ourselves and our lives"(p.15). My co-researchers disclosed a need to control either themselves or their clients. Woititz (1983) indicates:

> Adult Children of Alcoholics over-react to changes over which they have no control...The child of the alcohólic was not in control...as a result, (they) are often accused of being controlling, rigid, and lacking in spontaneity...it comes from the fear that if you are not in charge, if a change is made abruptly...you will lose control of your life." (p. 44)

STATEMENTS AS KEY INDICATORS OF CONTROL ISSUES

AND COPING STRATEGIES UTILIZED

Ann: "I have a fear of anger...and do my best to get (the client) under control...my fear was that because a client was losing control, I also would lose it..."
"Serendipity makes me feel like things are happening out of sequence...it's fearful because it's not controlled. You're not in control when serendipity happens."

Strategies

"I put a boundary around myself."
"I try to stay in charge of my schedule...I start and finish on time."
"I feel much more in charge when I do Strategic Family Therapy..."

Bob: "The biggest thing is around anger, and the whole control issue of who is in charge."
"(ACOAs, alcoholics, co-dependents), they all manifest their problems in the same manner, which is this self-defeating coping mechanism that (they) develop...they control. This allows them to know where they're at, at all times. Always prepared, but never relaxed."

Strategies

"Originally, I used to get into power struggles (with clients)..."
"(Now), I try to elicit the focus of (their) anger..."

Mike: "I don't think I have a need to control what goes on with my clients...I have a real need to control what goes on with me...feeling in control of my own life...of what happens with me, or to me."
"I don't think I have a need to control what goes on with my clients, except...when the anger starts. I may feel the need to want to settle them down."

Strategies

"I'm always prepared so that the unexpected won't happen..."
"It's like when I try to prepare for a lecture...I like things 1, 2, 3...it's probably a control issue...because then I can be spontaneous...it's my security blanket...to be prepared for anything."

Liz: "My control issues come out more at home than in therapy...I'm not suggesting for a minute that I haven't had those kind of issues."
"(one exception) I can get hooked by needy, whiney women, who want to be told what to do all the time...I can move into sort of being controlling and telling them what to do...the invitation is there..."

Strategies

"...if you tell them (what to do), then you're feeding into what everyone else has done to them." (She does not allow herself to do that).

THEME THREE: RESPONSIBILITY

Woititz (1983), Whitfield (1987), and Cermak (1986) state that Adult Children of Alcoholics are either super responsible or super irresponsible. Usually, a person tends to stay in one category or the other, however, there are times when they vacillate between the two. Bob is a perfect example of this vacillation as he has "gone from this totally irresponsible individual to a super-responsible individual."

Woititz (1983) indicates that ACOAs "don't have a good sense of (their) own limitations. Saying no is extraordinarily difficult...and (they) do more and more" (p. 47). Ann found it "very hard to learn how to say *no* to clients", and Liz stated that there were times when she found herself "working harder than the client." Before Mike could let go of his over-responsibility, he had to "recognize (his) own limitations."

In relationships, these individuals "assume responsibility for meeting others' needs to the exclusion of acknowledging (their own needs)" (Cermak, 1986, p. 17). This stems from the fact that "as children, we shouldered many of the responsibilities in our homes. We continue to be responsible in aspects of our adult lives" (Marlin, 1987, p. 170).

I will first present the statements which indicate that all of my co-researchers struggled with a sense of over-responsibility. Following that, several sub-themes which are related to the theme of responsibility will be discussed. They are:

1. Roles
2. Authenticity
3. Abandonment

STATEMENTS AS KEY INDICATORS OF RESPONSIBILITY ISSUES

Ann: "I found it very hard not to take responsibility for (my clients)...somehow I had this idea that it was all up to me."

Bob: "I had this idea that counsellors had to be strong, all together...I started caretaking...when we caretake, and feel like we're No. 1 and responsible for (the client's) recovery, we're in trouble."

Mike: "There's this theory I picked up somewhere about the difference between...responding and feeling responsible...I want to respond to the client, but I'm not going to take personal responsibilityfor their life. That probably was my salvation..."

Liz: "I still struggle with...being over-responsible, and super caretaker."
"I was trying to take responsibility for the client...always finding solutions...always being able to figure it out."

ROLES

As stated in the literature review, the family Hero is usually assigned the responsible role in the dysfunctional family. Ann, Bob and Liz consider themselves "Heros", so it would appear congruent with the literature that they adopt the over-responsible stance. Since Mike identifies primarily with the characteristics of the "Lost Child", his sense of responsibility contradicts the literature. Deutsch (1982) states that "responsibility terrifies (the Lost Child)" (p. 68). I feel one of the limitations of categorizing individuals, is that sometimes we do not address all interrelated factors that may be impacting the situation. In Mike's case it would be important to consider individual differences, personal maturity, professional training, and life experiences. Although he may relate to most of the characteristics of the "Lost Child", it is certain that he parts with the norm when it comes to being irresponsible.

It is evident that these roles persist throughout the years, and are transferred to all relationships. Ann stated that she "found it very hard to *not* play the role of Hero with (her) clients." Liz acknowledges that "there are a lot of strokes" for being responsible. However, dropping that role has presented other challenge for her. "...It's far more difficult for me...because I'm not playing the role anymore...(in the role) I looked pretty good on the outside, but freaking out on the inside". Now that she is more in touch with herself, she finds it difficult to perform some of the feats she attempted as a Hero.

AUTHENTICITY

Bradshaw (1988) indicates that the primary task for the Adult Child is to discover the "true self" (p. 227). Whitfield (1987), Miller (1981, 1988), Rosenberg, et al (1989) concur that the "authentic self" was stifled by parents and other authority figures in our society. This is accomplished through an acceptance of the "poisonous pedagogy" which espouses the following principles:

1. Adults are the masters of the dependent child.
2. They determine in a godlike fashion what is right and wrong.
3. The child is held responsible for their anger.
4. Parents must always be shielded.
5. The child's life-affirming feelings pose a threat to the autocratic adult.
6. The child's will must be "broken" as soon as possible.
7. All this must happen at a very early age so the child "won't notice" and will not be able to expose the adults.

(Miller, 1988, p. 59)

Therapists who are on their path of healing, often recognize their need to strive for authenticity. Cermak (1986, p. 95) cautions that sometimes a therapist may lose sight "of the distinction between his/her personal identity and the role as a professional." He stresses that the individual who is acting as therapist and the *role of therapist* must remain distinct in order for the therapist to be truly authentic. "Therapeutic authenticity exists when therapists can allow the role to possess its required autonomy, without doing any violence to who they are personally" (Cermak, 1986, p. 96). This

required clear boundaries which allow the therapist to take care of personal needs without neglecting the needs of the client, and visa versa.

The therapists in this study indicated their pursuit for authenticity. The following statements are indicators of this quest.

STATEMENTS AS KEY INDICATORS OF PURSUIT OF AUTHENTICITY

Ann: "I realize that when I'm not in that role (of rescuer), it doesn't allow the client to be in their role...in other words, if I can be my authentic self, then that forces the client to be an authentic person also...it's hard, I keep slipping back into that responsible role."

Bob: "...in the early stages, I mirrored those social workers...I worked with, and that wasn't me...(authenticity/genuineness with clients) that's something I'm striving for, because that's something I'm striving for in my personal life."

Mike: "I think we're always in search of the authentic self. I think I still am...and it helps the clients in their search for their authentic self, too..."

Liz: "...now I'm not playing the role anymore...Trying to be (authentic)...that's not perfect yet, but I'm much more cognizant of it..."

ABANDONMENT

A fear of abandonment persists into adulthood for individuals who have been abandoned emotionally or physically by their parents (Bradshaw, 1988; Gravitz & Bowden, 1985; Marlin, 1987). Cermak (1986) indicates that this fear is triggered for many clients during the termination phase of therapy. A therapist who is aware of this possibility, recognizes that termination is an evolutionary process,

interwoven throughout the treatment. Clients are continually encouraged to become autonomous, therefore, when it is time to terminate, mixed feelings are a natural part of the process for both client and therapist, since the interaction should have been beneficial for both of them. Mike expressed this point when he stated, "That's why I hate to lose my clients, because it's a mutual learning kind of thing."

If termination is difficult for ACOAs, it is not surprising that it may affect ACOA therapists in a negative way also. Those co-researchers who stated that they were concerned for their clients during termination, indicated that their sense of over-responsibility may be a contributing factor. It appears that when they let go of that over-responsibility, they were able to cope with endings in a more healthy manner.

The following statements indicate the therapists' feelings about abandonment.

STATEMENTS AS KEY INDICATORS OF ABANDONMENT ISSUES

Ann: "Termination has been a terrible struggle for me...sometimes I would feel like I was abandoning them (clients), but usually it felt like they were abandoning me...I recognize where that came from, I was emotionally abandoned by both my parents."

Bob: "Once I was able to let go of responsibility, (feelings of abandonment are not triggered for me)."

Mike: "I guess I get concerned that...the client would experience abandonment...it's sort of hard for me to terminate..."

Liz: "I think I actually worked through the abandonment issues in a couple of relationships...(so with clients those feelings don't usually emerge)."

THEME FOUR: BOUNDARIES

"The issue of boundaries is central to the therapeutic process because a boundary defines the "Self" (Rosenberg, et al, 1989, p. 175). Although boundaries are labelled differently by various authors, Friel & Friel (1988) identify three boundary states that are exemplary:

1. Rigid boundaries (too strong)
2. Diffuse boundaries (too weak)
3. Flexible boundaries (healthy)

(p. 57)

In dysfunctional families, boundaries vacillate between diffusion and rigidity. Members do not learn what constitutes healthy limits in relationships. Cermak (1986) states:

> Anxiety and boundary distortions are experienced most intensely in the absence of an external structure that defines interpersonal relationships. ...Without this structure the members of any relationship must continually participate in a mutual negotiation of the interpersonal distance between themselves...The anxiety created by changing interpersonal distance can spiral into fear of abandonment or of being overwhelmed by intimacy.
>
> (p.19)

It is evident that "boundary problems often persist long after we've left the alcoholic household" (Marlin, 1987, p.39). In the workplace, relationships with peers and supervisors are affected.

Therapists may transfer their interactions with parents to the interactions of supervisors. Peer relationships may be strained or confused, since often there is a fear of closeness or distance. Self-disclosure becomes an issue, as "too much or too little ends up being said" (Woititz, 1987).

The theme of boundaries emerged in this study as the therapists identified the need to have healthy psychological and social boundaries with their clients. The sub-theme of self-disclosure will be included in this section, since it is an integral part of this discussion. As stated in Chapter III, there is no clear consensus about the issue of disclosing a therapist's background to their clients. These therapists had to find a balance in the amount of self-disclosure they were willing to share with clients. Mike also mentioned that he defined for himself a clear boundary around how much he would share with colleagues.

The following statements are indicative of the struggle these therapists have had with boundary issues. The quotations that follow are their views on self-disclosure, and the effect that it has on clients when they do self-disclose.

STATEMENTS AS KEY INDICATORS OF BOUNDARY ISSUES

Ann: "I didn't seem to have any personal boundaries...and would let them (clients) invade my space."
"Now, I put a protective boundary around myself...so I can contain my feelings temporarily."

Bob: "We have to have our boundaries...now I'm more sensitive to getting into people's zones...I'm more aware of it..."

Mike: "I had to start setting up some boundaries as to how much time and energy I was going to pour into this..."

Liz: "I have some pretty strict boundaries...rarely give (a client) my home phone number..."
"(working with anger) that's probably when I put a shield around myself."
"...I need to protect myself...but what we're doing is teaching our clients to set their own boundaries...it's really important role modeling."

STATEMENTS AS KEY INDICATORS OF SELF-DISCLOSURE

AND THE EFFECT ON CLIENTS

Ann: "I only self-disclose (about my ACOA background) if I think it's going to be helpful to the client. Some clients are in such bad shape that they don't need to know my shaky background. I thinkit would make them feel insecure.

Effect on Clients:

"...after we build a strong rapport...my self-disclosure can be very normalizing for them. It makes them feel less isolated, and can build a stronger bond between us."

Bob: "I try to limit my self-disclosure these days...I ask myself, why am I doing it...is it because I want to build myself up, or make myself look better?"

Effect on Clients:

"(with alcoholics) I find it (self-disclosure) is a major breakthrough...helps them get well...when they stop placing people on pedestals."
"self-disclosure...can be therapeutic...as long as it doesn't take the focus away from the client."
"...there seems to be that sense of: well, maybe he understands me."

Mike: "I'm pretty selective about what I share about myself...I only do it when intuitively I know it may be helpful to (the client)...sometimes they are so caught up in their own issues, so why shouldI burden them with my issues...other times it feels right."

Liz: "I'm pretty careful about how much I disclose (about myself)...if I jump in there and tell them my life story...there are two of us floating..."

Effect on Clients:

"(Clients) really like that I'm human...there isn't that separation between us...I feel much closer to (them), and I think they feel closer to me, because I'm more on topic and I'm more open."

THEME FIVE: CONFRONTATION

Being raised in homes where anger was expressed inappropriately, ACOAs tend to avoid conflict, since they do not know how to resolve it effectively (Marlin, 1987). This leads to a fear of confrontation in personal and professional relationships. Wegsheider-Cruse (1987) indicates that therapists who have not resolved their childhood traumas, want to be the "Professional Hero" who tend to be the "good guy" or "good gal", instead of a therapist who confronts his/her clients appropriately (p.30).

The following quotes indicate that the therapists in this study are learning healthy ways of confronting their clients.

STATEMENTS AS KEY INDICATORS OF CONFRONTATION ISSUES

Ann: "I still can't confront a client when they're angry. If a client is trying to con me (or herself), I have no difficulty confronting them with that...in a gentle sort of way...but when they're mad, I avoid confrontation all together."

Bob: "Confrontation is a really painful word for co-dependents, it sounds so strong."
"In the early stages of my recovery I never confronted my clients hard enough. I did them a real injustice."
"confrontation is a big part of being a therapist...pointing out the incongruities...if you care for your client, you're going to confront them."

Mike: "I think I (confront), but I do it in my own way, in a way that's not hostile or angry. I try to be really supportive and not get them too defensive...but I try to feed back to people my own impression of (what's going on)...I think that's more useful, very gentle confronting, as opposed to backhanding them."

Liz: "I don't think you need to be confrontational in a nasty way..."
"...with addicted people you need to be really confrontational...really straight...and I'm a straight shooter."

***

The themes and sub-themes that were presented in this chapter are the major findings of this study. Some of these issues are confirmed by the literature as important factors for many Adult Children of Alcoholics. The focus was to relate these issues to the therapeutic relationship and the affect they may be having on the therapists and their clients. Verbatim statements from the interviews were included to clarify the points that were made.

CHAPTER SEVEN

CONCLUSION

This chapter consists of a summary of the methodology utilized, the findings of the study, and the author's personal reflections of this process. The limitations of the study will be discussed, as well as the implications for education and research.

SUMMARY OF METHODOLOGY

This study is an inquiry into a question which addresses the experience of counseling for therapists who are Adult Children of Alcoholics and also counsel ACOA clients. Four therapists were interviewed, in non-structured, dialogual interviews, for the purpose of describing their experiences of the process of counseling. An existential-phenomenological methodology was considered the most practical for this type of study, due to its stance which respects the validity of the subjective experience. This method is also congruent with the researcher's feminist frame of reference, eliminating the need for hierarchy, focusing on the holistic, cooperative and participatory functions of the research process. The participants of this study were considered "co-researchers" who collaborated with the author at various stages of the process.

The generation of data was a continual process that extended beyond the core interviews. Co-researchers had the opportunity to proof read the original transcripts and the abridged versions of their stories. At this point, some information was added in order to present a more complete scenario. Three participants deleted or altered some facts which may have threatened their identity or the identity of their clients.

Content analysis consisted of a process of extracting relevant phrases from the original data, categorizing them into "themes" and organizing these themes into a phenomenological description of the findings. Verbatim excerpts were included with the presentation of each theme, for the purpose of increasing the validity of this study.

One of the major criticisms of qualitative research is that it focuses on the research topic in depth and detail, rather than looking at an issue from a broad, generalist perspective (Patton, 1980). From the quantitative view, this may be considered a limitation of this study, however, I regard it as a necessary trade-off to obtain the detailed, and individualistic perspectives of the co-researchers.

SUMMARY OF THE FINDINGS

Five primary themes, and several sub-themes were uncovered in the raw data. The first theme, "developmental stages", was sub-divided into three stages: i) Lack of Awareness, ii) Emerging Awareness, and iii) Striving for Integration. These stages correlated with literature which indicated that the recovery process

for ACOAs is a gradual, developmental procedure. There were three sub-themes that were included within each of these stages. They signified that a) each stage served a specific function, b) different coping strategies were utilized at each stage, and, c) that different results were obtained during each stage. A summary of this theme was presented in Table One.

Theme Two revealed that "control" was a significant issue for the therapists interviewed, in specific situations. It is also evident that as they become more aware of this issue, they develop more healthy strategies to cope with it. Theme three addressed "responsibility", and how it is connected to the sub-themes of roles, authenticity, and abandonment. Boundaries were discussed in theme four, adding the sub-themes of self-disclosure by the therapists, and the effect that this had on the clients. Theme five raised the difficulty the therapists had with the issue of "confrontation".

RESEARCHER'S PERSONAL REFLECTIONS

As stated earlier, phenomenological inquiry necessitates that the researcher include her whole being in the research process. It is therefore considered undesirable (and impossible) to be totally objective, since the author's personal feelings, impressions, and observations become part of the project. I made every attempt to be open to the participants during the interviews, and I made notes of my personal impressions after each session. When I began to realize that we shared common experiences, I had an immense need to share my

excitement about this commonality. This also served the purpose of assuring the participants that they were on the right track. Since the interviews were so unstructured, the co-researchers were uncertain about the information they were to present to me.

As the literature indicated, through selective sharing of my personal experiences, an empathic understanding evolved with the co-researchers. This resulted in the "interpersonal knowing" that Rogers (1964) refered to, which served as a validity check to verify whether our perceptions and meanings were similar. This minimized the possibility of incongruities and distortions, as they were identified by the co-researchers. A "thick discription" was obtained in this manner, and this collaborative effort contributed to creative thinking for both parties involved.

I made several key discoveries about myself which had significant impact on me. Feeling somewhat unsure of myself as a researcher and therapist, it was very validating and normalizing for me to realize that these respected therapists had experienced some of the same issues that I am still grappling with. My initial reaction would have been to take a one-down position to them, creating an unrealistic expectation for them to live up to. It was very encouraging that they trusted me enough to share some of their most intimate insecurities concerning their professional life. This openness was an indication of their commitment to this research project. Their disclosures also reaffirmed that we are all at various levels of learning, and that this process continues throughout life. This affirmation helped me to accept myself as I am presently; however

it encouraged me to continue progressing personally and professionally.

Being a Hero myself, I identified very strongly with the Heros in this study. While this identification enabled us to have a mutual understanding of each other, it also made me realize that there is a danger of stereotyping any time that we use labels. I found myself *expecting* certain types of responses. When unique issues and comments arose, I was jarred into recognizing how easy it is to fall into the trap of making stereotypic judgements. I also struggled with trying not to play the role of Hero during the interview sessions. At times, I found myself wanting to take responsibility for the whole session, including the feelings of my co-researchers. When deep emotions were expressed, my instinctive urge was to nurture, rescue, and protect. Liz also struck a chord for me when she revealed that it was more difficult for her to deal with some issues now that she has dropped the role. That comment helped me understand that this has also been the case for me, and that sometimes I still have a need to revert back into that role when stressful situations arise. This is an indication to me that it will take some more time and effort to become trusting of the authentic self.

Perhaps the most taxing struggle during this research process was with my need to be in control. Colaizzi (1978) stated that phenomenological researchers must tolerate a certain amount of ambiguity during their research process. Conducting an *unstructured* interview was the ultimate test for me to let go of the need to control. Not having a written script to follow, forced me into a

position where I needed to trust myself and my co-researchers. Mike's remarks about needing an outline rang so true to me. I also had to remind myself constantly to trust that this process would be completed on time, despite the fact that certain steps were completely out of my ability to control them. I concur with Mike's belief that the cosmos provides us with the opportunities we need to overcome specific issues. This study brought me another step closer to learning that the universe will continue to operate, without my attempts to control every aspect of its functioning.

I am presently in the process of setting new career goals for myself. The theme "Seduction of Success" has helped me to review these goals from a new perspective, keeping in mind that balance is a safeguard against burnout. It is evident that these therapists have made significant strides in their personal and professional growth. The information that they shared with me is an important part of my learning process.

LIMITATIONS OF THE STUDY

Dudley (1987) indicates that in doing phenomenological research, there is the probability that the researcher will not be aware of certain information, which will consequently be excluded from the inquiry. Although I used probes to elicit as much information as possible, it it very likely that some important details have been omitted.

In retrospect, I should have clarified more fully the definition of specific words. Mike stated that he did not understand the meaning of "buzz words" such as "growth, recovery, and intervention". In the final stages of writing this thesis, it occurred to me that I neglected one of my most important tasks as a phenomenological researcher by not obtaining distinct definitions from each participant. Consequently, words such as "boundary" may have completely different meanings to each therapist. This fact places a limitation on this study.

The issues of labeling and stereotyping have been discussed, however, they need to be reiterated as a possible limitation. Ackerman (1987) stresses that Adult Children of Alcoholics are not all the same. In his study he has found that several variables affect the impact that parental alcoholism has on children. Consequently, the uniqueness of the individual must be considered in any study. No single explanation is adequate. I cannot overstate that these findings cannot be generalized to all therapists who are ACOAs. Personal differences, professional training, and other related factors must be taken into consideration.

IMPLICATIONS

The findings of this study have potential relevance for both clients and therapists who are ACOAs. Since similar dysfunctions exist in other addictive behaviours (i.e. eating disorders,

co-dependency), the results may possibly be extended to generate new ideas for further studies in these fields.

Clients who are seeking a therapist may gain new insight on the type of counsellor they would like to share their personal stories with. This study further confirms that there seems to be a stronger bond between individuals who have shared a common experience. There is also an indication that therapists who are in their own recovery program are more aware of their own personal issues and consequently more attuned to client issues. This has implications for the client/worker relationship in terms of the roles each individual plays.

Since there is a consensus that therapists should be on a path of personal healing, the implication is that they must first become aware of their past. Training programs for helping professionals could be a first step in gaining knowledge and breaking through that sense of denial. As previously stated, a large percentage of individuals from dysfunctional families enter helping professions. It would seem critical that some form of assessment and treatment program be set up for anyone wishing to enter these fields of study. Effort should be made to present in-service programs to therapists already practising. Because this healing process is an ongoing procedure, it would seem appropriate to monitor the progress that is being made, to ensure that therapists are not harming their clients in any way.

The inductive approach to data collection used in this study could serve as an initial source of information which could "lead to the imaginative development of clearly operational steps and

operational tools for the measurement of the behaviours which represent these inner variables" that may be impacting both ACOA clients and therapists (Rogers, 1964, p. 23). Just as tools have been developed to measure virtually every type of human disorder, this information could be the basis for a tool to identify and measure issues for therapists who are ACOAs. While such tools can be used in a broader sense with larger populations, my personal position remains that generalized measurement tools must be recognized for their limitations. As indicated earlier, it is important to acknowledge that both qualitative and quantitative research have their strengths and weaknesses.

* * *

In conclusion I am including statements by my co-researchers that are indicative of the importance of dealing with one's past. These *recommendations* coincide with the literature which emphasizes that as professionals we must "examine what baggage we bring from our lives into our vocations, into our workplaces" (Wegsheider-Cruse, 1987, p.32).

RECOMMENDATIONS FROM THE CO-RESEARCHERS

Ann: "Get in touch with your own issues. Try to break through the denial. Even if there wasn't alcoholism in the family, it's likely thesre was some other type of dysfunction."

"Build a support system for yourself...balance your life so that you have a lot of interests and a variety of people to interact with."

Bob: "...when you recognize things about yourself, don't try to hide them, and try to work on them."

"Recognize your own problems, your own debilitating co-dependency...because anyone who is working in this field is co-dependent."

Mike: "I would make assumption that if (therapists) are in ACOA (groups) they could make sense of their own history. And I think that's critical, to look at their history, and how it effects their adulthood and their work with clients."

Liz: "Do your own therapy. Heal yourself first, and I don't think that means that...if you're a beginning therapist, you can't do therapy, it just means you need to know your limits... (don't) start doing things (you're) not confident about...or things (you) don't know about."

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APPENDIX I

STATEMENT OF RESEARCH PURPOSE

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For my Master's thesis in Social Work, I am proposing to conduct a study concerning therapists who are Adult Children of Alcoholics. This will be done under the supervision of Dr. Pam Colorado, Department of Social Welfare, University of Calgary.

The purpose of this study is to describe what the experience of counseling ACOAs is like, for therapists who themselves are recovering ACOAs. Since this will be a qualitative inquiry, the focus will be on generating new data from the descriptions provided by participants.

I plan to use an Existential-Phenomenological approach, which stresses that personal experience is always valid and best understood through mutual, empathic understanding. This eliminates the traditional hierarchy between researcher and subjects, consequently, participants are considered "co-researchers". These individuals must be familiar with ACOA issues, and should have addressed some of these issues in their personal lives. Part, or all of their caseloads must include clients who are ACOAs.

The co-researchers will be willing to reflect on their experience of counseling and share it in an audio-taped interview which may last approximately 1 1/2 hours. This will be an in-depth, unstructured interview, however, the focus will be on the core question:

> "What is the experience of counselling Adult Children of Alcoholics, for the recovering therapist who is also an Adult Child of Alcoholics?"

After I transcribe the tapes, the interviewees will be requested to read the transcripts to verify for accuracy. Changes, deletions, or omissions will be made as necessary. Additional information and continuous feedback will be welcome throughout the study. The interpretation of data will concentrate on the uncovering of themes that may arise between descriptions.

In addition to conducting and writing this study, the researcher's responsibility will include debriefing any feelings which may arise for co-researchers, as a result of this process.

Thank you for considering participating in this study.

ROSE SALNIKOWSKI, BSW, RSW

APPENDIX II

STATEMENT OF CONSENT

STATEMENT OF CONSENT

This is to assertain that I have had a general orientation to the proposed research study concerning ACOA therapists and have read the attached information. I understand the aims and methods of this investigation and voluntarily agree to participate. I recognize my right to withdraw at any time and the researcher's corresponding right to terminate my involvement.

I will have the option of choosing a pseudonym to ensure my anonymity. Other identifying information will also be altered to protect my identity. Strict confidentiality will be observed, as no one will have access to the raw data except the researcher. The audio tape of the core interview will be erased or returned to me after it has been transcribed by the researcher. I will do my best to describe my experience of counselling ACOAs, and I will be at liberty to add or delete any information that I choose to. I will also have the opportunity to debrief with the researcher any feelings that may arise as a result of this process.

I fully comprehend the requirements and responsibilities of this contract and hereby voluntarily consent to participate in this research.

_____
Participant

_____
Researcher

_____
Date