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Commentary
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**Generational Patterns of Resistance and Recovery
Among Families with Histories of Alcohol and Other Drug Problems:**

What We Need to Know

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The authors have spent decades observing individuals with severe alcohol and other drug (AOD) problems achieve stable recovery and enhanced quality of life. The ability of individuals and families to enjoy the fruits of such recoveries is all too often interrupted by encounters with these same problems in the lives of extended family members, parents, siblings, or one's own children. This common dilemma within the life course of recovery is the subject of this short essay.

Clinical interventions with alcohol and other drug problems in America have been grounded historically in studies of the pathology of alcohol and drug problems (e.g., extensive studies of the history, epidemiology, psychopharmacology, and personal and social consequences of prolonged and excessive AOD use). We, as a country and as a professionalized addictions field, know a lot about psychoactive drugs, drug consumption trends, the multiple pathways through which people develop AOD problems, and the neurobiological adaptations that contribute to alcohol and other drug dependence. We have also learned a great deal from studies of various approaches to the diagnosis and treatment of substance use disorders. But what do we know from the standpoint of science as a culture and as a profession about the prevalence, neurobiology, pathways, styles and stages of long-term recovery from AOD problems? There are emerging calls to extend the field's pathology and intervention paradigms to a recovery paradigm (Erickson & White, submitted for publication; Laudet, 2008; White, 2005; White, 2007b). This shift would create a more substantive body of empirical evidence capable of answering questions that

are critical to people attempting to initiate recovery, maintain recovery, and enhance the quality and meaningfulness of their lives in recovery.

A growing number of American addiction scientists and recovery advocates are calling upon the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism to co-develop, co-fund, and co-disseminate the findings of a comprehensive recovery-focused research agenda (Laudet, 2008; Laudet & White, 2008; White, 2000). A recent (May, 2008) conference in Philadelphia (*Aligning Concepts, Practices and Contexts to Promote Long-Term Recovery: An Action Plan*) sought to articulate the beginnings of just such an agenda. Similar discussions occurred among key stakeholders (systems administrators, treatment providers, researchers/evaluators, recovery support services providers, representatives from recovery mutual aid groups and recovery advocates) at the Center for Substance Abuse Treatment's 2005 Recovery Summit. A solutions-focused knowledge base is crucial for developing family and community environments that can support long-term recovery and prevent the continued development of AOD problems within our most vulnerable populations.

In this paper, we will focus on one issue—the mechanisms through which individuals with intergenerational histories of severe alcohol and other drug problems resist developing or recover from such problems. We will use this discussion to illustrate just how much we do not know about some of the most critical issues facing recovering people and their families.

Unanswered Questions

Scientific studies confirm that alcohol and drug problems can be and often are transmitted across generations via complex biological, psychological, and social processes. We are beginning to learn more about the risk factors that contribute to this problem transmission across and within generations of family members, e.g., genetic vulnerability, prenatal alcohol/drug exposure, early age of onset of AOD use, parental/sibling modeling of excessive AOD use, drug culture socialization, defective parenting, physical/emotional deprivation/trauma/abandonment, exposure to domestic violence, and isolation from support outside the family (Capone & Wood, in press; Grant & Dawson, 1997; Merickangas, Stolar, Stevens, et al, 1998; Miles, Stallings, Young, et., al, 1998; Nature Neuroscience, 2005). But unanswered as of now are perhaps the most important two questions: 1) How do individuals with a family history of AOD problems and related risk factors resist the development of AOD problems over the course of their

lives? 2) How do family histories of AOD problems and the outcomes of those problems affect individual recovery prospects and processes of other affected family members?

We know that AOD use of individuals within one's immediate living environment exerts an influence on treatment/recovery outcomes (Godley, Kahn, Dennis, Godley, & Funk, 2005; Laudet, Morgen, & White, 2006; McCrady, 2004). In situations where intimate partners are both addicted, the post-treatment recovery or re-addiction of one partner is predictive of the recovery or addiction of the other partner (Hser, 2007; McAweeney, Zucker, Fitzgerald, Puttler, & Wong, 2005). But the role of recovery status of one family member in influencing intergenerational and intragenerational patterns of resistance and recovery for other family members remains a frontier of primarily unanswered questions.

Consider the more detailed questions below that are of concern to anyone imbedded within a family history of alcohol and other drug problems. The terms *resist* and *resistance* as used here refer to the process through which individuals who are high risk for the development of AOD problems successfully avoid developing such problems. The term *recovery* refers to the process through which individuals with severe AOD problems resolve these problems, improve their global health and enhance their participation in and contributions to the life of their communities (White, 2007a).

1. How is the course of a substance use disorder (SUD) and the prospects of successful long-term recovery affected by the presence or absence of SUDs in one's family history? Does recovery of family members from earlier generations or one's own generation constitute a special form of family recovery capital that increases one's odds of successful recovery?¹ Is there any evidence of intragenerational or intergenerational learning or family adaptation to SUD risks? (The intent here is the development of a knowledge base that allows us to move beyond just treatment of individuals to strategies aimed at stemming the processes through which AOD problems are intergenerationally transmitted.)

¹ Recovery capital is the quantity and quality of internal and external resources that can be mobilized to initiate and sustain recovery from severe AOD problems (Granfield & Cloud, 1999). There are different types of recovery capital, including personal recovery capital, family/social recovery capital and community/cultural recovery capital (White & Cloud, in press).

2. What influence, if any, does an AOD-related adverse experience (e.g., hospitalization, job loss, divorce, arrest, incarceration) of one family member have on SUD resistance and recovery initiation or maintenance of other family members?
3. What influence, if any, does an AOD-related death of one family member have on the resistance, recovery initiation or recovery maintenance of other family members? Does the type of death (e.g., overdose, accident, medical complications, suicide, or victim of violence) mediate such influence? What effect does infliction of death upon another by an addicted family member (e.g., an act of violence, death of another resulting from drinking and driving) have on the resistance or recovery prospects of other family members?
4. Do identical twins born within family trees with histories of AOD problems share the same patterns of resistance and recovery? If not, what factors are related to differences in their resistance and recovery experiences?
5. If a son or daughter is at increased risk of developing a SUD because they and one or both parents share a family history of such disorders, do the children have less risk of developing a SUD if the parent is in stable recovery? If one or more children were to develop an SUD, are their prospects of recovery better because of the parent's recovery?
6. Does the degree of density of recovery among family network members with SUDs influence the resistance and recovery odds of coming generations within this family? (Density could be measured by the number or percentage of all family and extended family members with SUDs who achieved stable recovery.) Is there a recovery "tipping point" within families when intergenerational transmission slows or ceases?
7. Are intergenerational resistance and recovery gender-linked, e.g., are sons of recovering fathers less likely to develop or more likely to recover from a SUD than daughters of recovering fathers? What other factors influence resistance and recovery, e.g., role of the family member in recovery (grandparent, aunt/uncle, cousin, parent, sibling); birth order of the person in recovery (e.g., older sibling versus

younger sibling), family member status (blood, adopted, foster), parental status (blood versus step-parent), degree of physical contact (e.g., recovering person residing within or outside the home), and degree of emotional attachment with the family member in recovery?

8. How do the following factors influence the resistance and recovery odds of children whose parents are in recovery: AOD problem severity of the parent, primary drug choices of the parent and the child, developmental age of child at onset of parental recovery, degree of emotional attachment in the parent-child relationship, presence and degree/duration of adverse childhood experiences, and presence of surrogate parental figures?

9. What strategies of prevention and early intervention can specifically lower the SUD risks of children of recovering parents or stop the development of AOD problems at an early stage? Are different strategies more successful with different at-risk populations or at different developmental ages?

10. Does participation of a family member in specialty sector addiction treatment and/or recovery mutual aid groups affect the resistance and recovery prospects of other family members? If so, are there particular types of treatment (e.g., family therapy) that have a greater effect on resistance and recovery of other family members? How does child participation in parental or sibling treatment affect the child's future resistance and recovery prospects? Would that outcome be influenced by the post-treatment recovery status of the family member who was treated? How does participation in child-focused peer support groups (e.g., Alatot, Alateen) or a developmentally appropriate, educational support group for children and adolescents affect subsequent resistance or recovery?

11. How do preferred recovery pathways differ for individuals with and without family addiction/recovery histories? Is the preferred recovery pathway of the parent or other family members predictive of the best recovery pathway for the child in this family who develops a SUD?

12. In what would be an interesting reversal of intergenerational transmission, does the addiction and recovery of a child influence that

child's parents' prospects of addiction, resistance or recovery? Are there effects on sibling resistance and recovery under such circumstances?

13: How are resistance and recovery of persons in AOD-enmeshed family trees influenced by community recovery capital (i.e., the quantity and accessibility of local resources that assist people in resisting and recovering from AOD-related problems)?

14. Within families with histories of AOD problems, do patterns of intergenerational and intragenerational resistance and recovery differ across ethnic, cultural and religious groups? If so, how?

15. What general resiliency factors² within families and extended family networks enhance the odds of resistance and recovery?

16. What manner of presenting one's recovery status/story has the greatest influence on the resistance and recovery of other family members? What effect does degree of exposure of family members to communities of recovery exert on resistance and recovery?

17. Are there specific family activities, events or developmental issues that pose significant challenges to resistance and recovery? If so, what works to support resistance and recovery?

18. What effect does degree of exposure of family members to communities of recovery have on resistance and recovery? Are there other community supports such as faith-based organizations or opportunities for community activities/advocacy that strengthen resistance and recovery?

19. What are the sources of resistance among individuals with family histories of AOD problems who do not go on to develop AOD problems?

² Family protective, resiliency and recovery factors include rituals for family gathering, family communication skills, collective problem solving, personality compatibility, collective health and hardiness, mutual affection and support, shared values, connection to community resources, optimism and hope (McCubbin, McCubbin, Thompson, et al, 1997).

20. For parents with extensive intergenerational histories of AOD problems, are there any indicators or early warning signs suggesting which of their children might be at highest risk for AOD problem development? Are there any research-grounded responses that could lower the vulnerability, increase the resistance or enhance the future recovery prospects of these children?

21. Does personal or family recovery ameliorate the effects of historical trauma?³ Is there a tipping point of healing through which individual/family recovery breaks the cycle of passing on the effects of historical trauma to new generations, e.g., Are the resistance and recovery rates of children in Native American communities elevated within communities whose adults and elders have achieved high rates of recovery?

The Search for Answers

With addiction treatment consciously moving towards a “recovery-oriented system of care” that places emphasis on the role of the family and community in long-term recovery processes, the need to answer the above questions will become more urgent. These questions are intensely personal and important to millions of individuals in long-term recovery. Why, after decades of addiction research, do we not have answers to these questions? Why, after decades of addiction research, have we not even had studies that asked these questions? We will know a recovery research agenda is a reality when such questions are asked and answered within the country’s leading research centers. We will know that achievement is real when the fruits of that knowledge are accessible to all individuals and families in recovery. That day is long overdue.

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³ Historical trauma is the collective distress emanating from immense losses and traumatic events experienced by a whole people and passed intergenerationally through parent-child interactions and interactions with extended family and community members (Coyhis, 2008).

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