NOTICING THE HIDDEN HARM

Cinzia Altobelli *and* ***Cat Payne*** *remind us of the hidden harm of parental drug and alcohol misuse to children and young people, and introduce a family intervention – M-PACT*

This article aims to raise awareness around the impact that substance misuse has on children in particular but also on the whole family. It explores some of the dynamics and challenges practitioners are presented with when working with children and families living with addiction, and key issues for navigating through this sea of complexities.

The second part of the article shares the work that Action on Addiction's Families Plus programme has been carrying out since 2006 through M-PACT (Moving Parents and Children Together), a therapeutic family intervention designed to give children a voice to acknowledge, reduce and reframe some of the effects of parental substance misuse.

Hidden harm

The Advisory Council on the Misuse of Drugs first drew attention to the effects of parental substance misuse by publishing the *Hidden Harm*[1] report in 2003. The report states that 'parental problem drug use can and does cause serious harm to children of every age from conception to adulthood' and that 'reducing the harm to children from parental problem drug use should become a main objective of policy and practice'[1]. It also stated that 'effective treatment of the parent can have major benefits for the child' and 'by working together, services can take many practical steps to protect and improve the health and wellbeing of affected children'[1].

Key findings from serious case reviews of 2009-2011[2] leave little doubt that far more needs to be done to identify problems at an early stage to provide the necessary support to families.

The extent of the problem

It is difficult to get accurate figures about how many children live with, and are affected by, parental substance misuse. It is thought that as many as five million people in the UK are dependent upon drug or alcohol use, with potentially eight million people and an estimated two million children being affected[3,4] – resembling something of epidemic proportions.

It is further alarming to learn that 62 per cent of parents say their use of drugs or alcohol has no effect on the family, with older parents (72 per cent of those aged 45+) and women (66 per cent compared to 56 per cent of men) being most likely to recognise no effects[5].

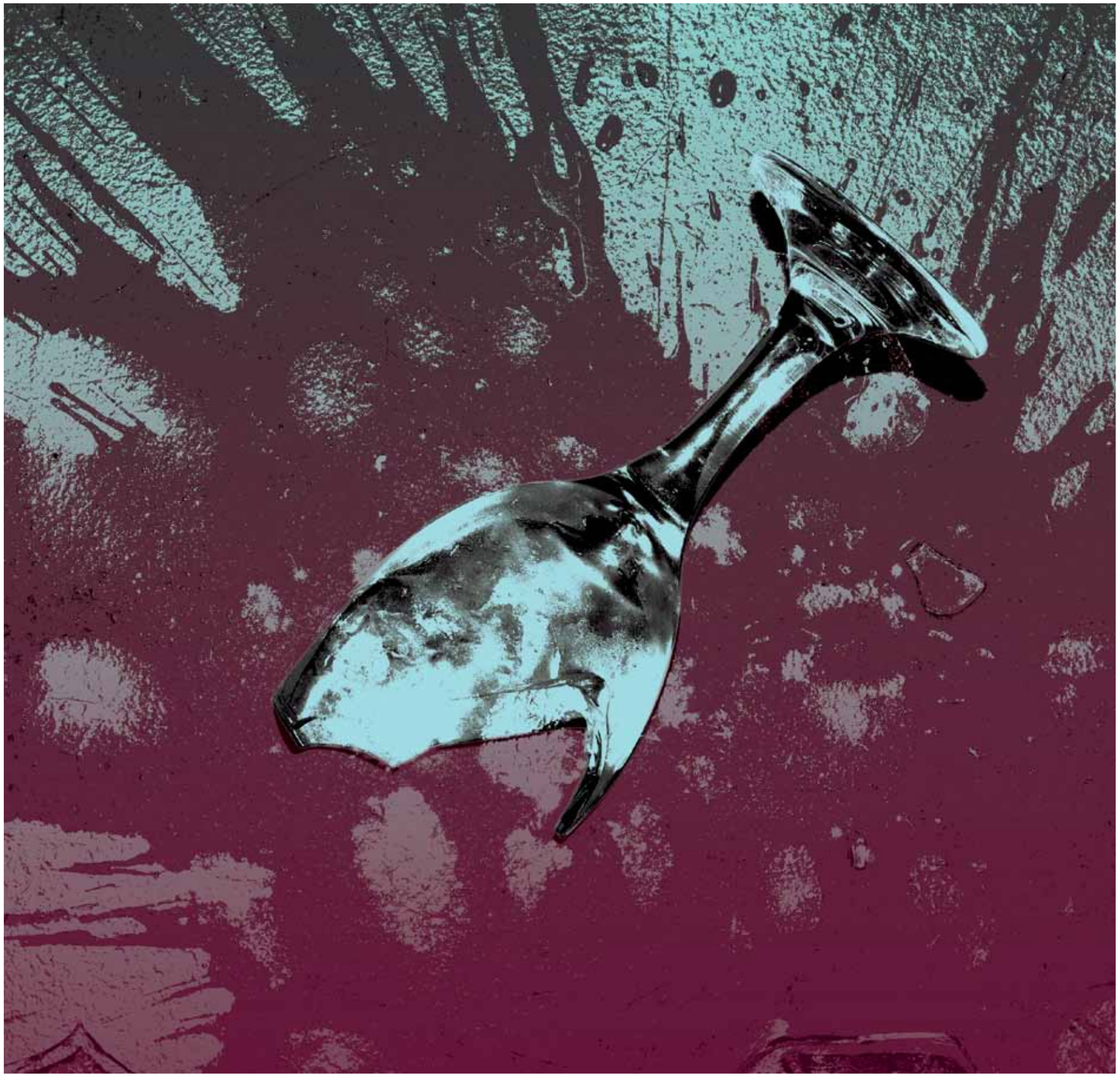
Only nine per cent of parents recognise the negative impact of their drinking or drug use on their family, yet 62 per cent of children who were subject to care proceedings were from families with parental alcohol misuse[5].

Research also shows that children living with parental *alcohol* misuse are identified much later than children living with parental *drug* misuse, and that gender is relevant here, as boys tend not to ask for help, compared to girls[6].

The effects of living with parental substance misuse

Parental substance misuse affects children in many areas of their development and it is often linked to neglect and emotional abuse[7,8,9]. Neglect was also an underlying feature in 60 per cent of all serious case reviews in 2009-2011[2].

Much interest has been shown in the role that resilience can play in ameliorating some of this detrimental impact, and the ways in which resilience could be promoted. However, Kroll[10] eloquently describes how, for children living with parental substance misuse, the experience of denial, distortion and secrecy can become the norm. In our work with families, we often witness a 'role reversal' whereby children become the only 'responsible adults', with parents unable to meet their needs or those of their siblings. The 'loss of childhood' may also go hand in hand with a preoccupation about their parents' health and the internalisation of blame about their parents' misuse, in order to make sense of the situation. Worryingly, their role as 'caregivers' may also have far-reaching implications in how they see and define themselves and enter future adult relationships.



Children who live in a neglectful or abusive home environment may stand out at school, increasing their vulnerability to bullying, and may also display emotional and behavioural problems and poor educational performance.

These are some of the experiences relayed by children when asked about their experience of living with addiction during M-PACT programmes:

'addiction means hearing grown ups fighting'
'it means being blamed and thinking it is all my fault'
'looking after the adults and being worried and frightened'
'being asked to keep secrets that burn and poison you inside'
(M-PACT programmes 2006-2013)

Effects and dynamics of addiction on the system

Supporting the child alone, without thinking about and working with the context he/she lives in, will not help in changing the environment. But a systemic view and understanding of how addiction affects the family provides important clues for identifying potential risks and providing appropriate interventions.

When a family is affected by addiction, the 'substance' becomes the system's organising principle. We need to acknowledge how the attachment to the substance comes at the expense of *any other significant relationships* in the family. The family pulls out all the stops in order to cope and adjust, often becoming hypervigilant, fearful and as if walking on eggshells. The more the system feels out of control due the unmanageability of the situation, the more the family members become controlling in an attempt to create some order and manage fear. Denial, blame, shame and secrecy bind the system and become part of its fabric – it's a matter of self-preservation.

Coping strategies such as colluding with the problem, minimising or denying its effects, and isolation, can lead the system to become 'frozen' or 'trapped' in time. But the problem is that parental concealment of substance misuse can be 'crazy making' with everyone's perceptions being negated. We can often observe compartmentalisation of feelings, behaviour and thinking, as well as compliance with unspoken family 'rules'.

Yet fear of change, even for the better, can be just as threatening as addiction itself because it will endanger the tenuous equilibrium the system has achieved at such a high cost. Isabel Menzies[11], building on the earlier work of Elliott Jaques, describes 'social defence systems' that are activated to ward off anxiety. Indeed, we recognise that the system is programmed to go back to its default position when the status quo is challenged, and that it will take time to make changes. A way in is provided by understanding and validating the system's defences and appreciating what lies behind.

Potential traps for practitioners

However, working systemically presents its own challenges. It is hard to retain one's subjectivity and separation and not to collude with the system's unspoken rules and quest for self-preservation. Often, practitioners can end up mirroring the system's shadow and disavowed feelings. The practitioner, therefore, is required to tolerate what is intolerable for the system.

The key challenge for us as practitioners is to identify both strengths and vulnerabilities within the family, and measure parental capacity to meet the child's needs in the context where it is happening

Some of the traps practitioners may fall into are cited in the findings from the serious case reviews[2] mentioned earlier: 'lack of curiosity', 'questioning and accepting unrealistic explanations' and a disconnection from the children's experience. I wonder if the practitioner's 'ability to see and reflect' can become impaired as they become part of the system's dynamics? This is where reflective supervision can be valuable in exploring parallel processes, and transferential and countertransferential responses.

A multi-agency approach can also help to view the situation from different perspectives and provide more information.

Some final considerations

Gaining insight into the system's dynamic provides contextual understanding of what governs the environment the child lives in and whether it meets his/her needs. It also provides an initial map for assessing potential risks and for timely interventions.

Effective assessment and targeted support rely on an appreciation of the level of denial and resistance that is encountered. And it is important not to underestimate the impact of 'attachment' to the substance and its effect on parent/child relationships. It is crucial, too, to use the impact the work has on ourselves, because this can provide invaluable information about the system we are working with. What's needed, therefore, is to exercise curious and empathic questioning, share information and take a collaborative inter-agency approach. It goes almost without saying that we must acknowledge gaps in our knowledge and keep up to date with safeguarding training.

The key challenge for us as practitioners is to identify both *strengths* and *vulnerabilities* within the family, and measure parental capacity to meet the child's needs in the context where it is happening. This is a fundamental aspect of the M-PACT programme.

M-PACT – Moving Parents and Children Together

M-PACT was started in March 2006, when a small team from Action on Addiction's Families Plus service began the first of a two-phase pilot programme to address the issue of the hidden harm that many children experience when living with parental substance misuse. The programme offers *a whole family approach*, working, where possible, with parents and/or adults who are *in loco parentis* and their children, aged between eight and 17. The programme is made up of 10 sessions and is followed up with a reunion 12 weeks after the review session. An individual family assessment is followed by eight core sessions and an individual family meeting to review the programme and to make future plans.

M-PACT is best described as a psychosocial and educational brief intervention and the programme is for any family where one or both parents are, or have been, substance misusers.

Assessment is the cornerstone of good practice and the M-PACT programme is no exception to this. Two facilitators gather detailed information and carry out a careful assessment of each family member. Assessment is seen as a process that in many respects is part of the programme and may need to be continued and reviewed during the eight weeks.

How it works

One M-PACT family came to the programme through Children's Services: Beccy was 13 and had self-referred during a domestic incident between her parents at their home. Beccy's father, Josh, was an alcoholic in denial of the scale of his problem. At assessment it was clear that her mother, Tania, did not want to engage with us. She felt it was Josh's problem and she was doing everything she could to keep the family going. Although Josh was still drinking heavily, we had assurance that he would be sober for the day of an M-PACT session.*

The M-PACT programme manual sets out the aims and objectives and learning outcomes for each two-and-a-half-hour session, together with a detailed timetable, and uses a combination of family and child-focused approaches throughout.

Beccy quickly came to enjoy the opportunity for some time each week with her father while he was sober. They got on quite well together during the journey to M-PACT and both seemed to benefit from the opportunity to focus on their relationship. Beccy showed great talent in her artwork and Josh was attentive and interested when Beccy found her voice to feed back some of the work done in the young people's group.

Each session begins with a social element, offering food and time for adults and young people to make connections with each other. Four facilitators per programme use this opportunity to communicate informally with clients, to model healthy attachment in relationships and offer non-judgmental support in a variety of ways.

Bohart and Tallman[12] suggest that both directive and non-directive forms of therapy work because they 'assist and promote change by helping clients mobilise, focus and use their own resources for self-change'. What therapists do, they say, is to help clients use these resources more efficiently.

In spite of an initial reluctance to be involved with 'professionals', Josh responded well to a more directive approach, his willingness to change increased as his insight grew, and he appreciated he had significant resources and support. This initial half hour was useful for facilitators to check in and hear how the intervening week had been for Beccy and Josh. Beccy was desperate for change and very clear about what she thought needed to change most. She was taking a lot of inappropriate adult responsibility in the family and together she and Josh were able to make plans for a more age-appropriate role at home.

Promoting this capacity for clients to self-heal is continued during the sessions through groupwork. According to Bion[13], in every group there are two groups in the process, the 'work group' and the 'basic assumptions' group. The basic assumptions group functions with primitive childlike views, which build resistance and lead to the avoidance of the aims of the 'work group'. It is the task of the M-PACT facilitator to shift group members to 'healthy' or 'working' group membership.

During each programme, clients will work in a variety of group settings: whole group, individual adult and individual young people's groups, and individual family groups.

Elton Wilson, writing notes for M-PACT supervision[14], says: 'In his writings, Yalom[15] always emphasises the four major existential issues – Death, Aloneness, Freedom and Meaninglessness. I think these are represented in the M-PACT groups by the realisation that time is running out and that there is no rescuer out there or refuge in a mind-altering substance. The reality of individual responsibility for change is one of the positive outcomes, which can result, at least for some participants, from taking part in the M-PACT project.'

For Josh, his deteriorating relationship with Beccy was a significant motivation for change. Within the safety of the adult group he was able to begin to understand his own childhood, gain significant insight into why he was drinking and take responsibility for what he needed to do for both himself and for Beccy.

Themes running throughout the eight core sessions include expressing and managing difficult feelings, and recognition of the systemic aspect of families and relationships, including unhelpful, repetitive patterns of behaviour. A systemic analysis of addiction in families recognises that all family members need help[16]. M-PACT recognises the enmeshed, age-inappropriate relationships in a family and helps bring the whole system into focus, rather than concentrate solely on the 'identified problem'. Participants also gain insight into styles of communication within the family and are offered tools to help them do things differently.

Early on in the sessions, Josh acknowledged the pain he was causing through his drinking, and began to validate the anger and hurt expressed by Beccy. They both understood that any form of good communication had broken down and were able to find ways of improving this.

The genogram exercise identified two siblings in Beccy's family who were over 18. Both were badly impacted by their father's

drinking and accepted appropriate support for themselves. The systemic approach identified that Beccy's mother, Tania, was so focused on the alcohol problem that she had neglected Beccy's needs and also her safety. Tania agreed to a brief residential Family Programme to give herself the chance to reflect on her own needs and her role as a mother. She made significant changes during the Family Programme and was subsequently able to shift her focus from Josh's alcoholism and offer Beccy valuable support.

Promoting resilience also increases the client's capacity to heal. M-PACT offers the opportunity for parents to gain insight and build confidence in their parenting skills, learning how to promote increased self-esteem in their children. For the young people, gaining the understanding that they have not caused addiction in their family, and that they cannot control or cure it, is one of the most important messages we can offer them.

As Josh began to validate Beccy's experience of his drinking, they were able to communicate with each other. Josh's emotional competence increased and he started to take an appropriate parental role. Father and daughter also started to have fun together and enjoy each other's company. In spite of the difficulties in her life, Beccy continued to articulate clearly. At first, she struggled to realise that the problems were not her 'fault', but when the whole family came together to reinforce this message, Beccy started to believe it.

M-PACT is delivered in over 23 sites under licence around the UK and has also been successfully adapted and delivered in two large prisons. It is now in its seventh year and old enough to go to school – something we are currently working on and will report back on in a future article.

* Names and identifying details have been altered to preserve anonymity.

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For a short DVD clip about M-PACT, visit www.actiononaddiction.org.uk/Family-Support/M-Pact-Programme.aspx and for more information about the work of Action on Addiction, see www.actiononaddiction.org.uk

References

1 Advisory Council on the Misuse of Drugs [ACMD]. Hidden harm: responding to the needs of children of problem drug users. The report of an inquiry by the ACMD. 2003.
2 Brandon M, Sidebotham P et al. New learning from serious cases reviews: a two-year report for 2009-2011. www.gov.uk/government/uploads/system/uploads/attachment_data/file/198919/DFE-RB226_Research_Brief.pdf
3 Manning V, Best D, Faulkner N et al. New estimate of the number of children living with substance misuse parents: results from UK national household survey. BMC Public Health. 2009; 9:377.
4 Velleman R, Templeton L. Understanding and modifying the impact of parents' substance misuse on children. Advances in Psychiatric Treatment. 2007; 13:78-89.
5 4Children. Over the limit: the truth about families and alcohol. 2012. www.4children.org.uk/Resources/Detail/Over-the-Limit.
6 Adamson J, Templeton L, Clifton J. Silent voices: supporting children and young people affected by parental substance misuse. 2012. www.childrenscommissioner.gov.uk/content/publications/content_619
7 Cleaver H, Unell I, Aldgate J. Children's needs – parenting capacity, child abuse, parental mental illness, learning disability, substance misuse and domestic violence. 2nd edition. The Stationary Office; 2011. www.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf
8 Dunn MG, Tarter RE, Mezzich AC et al. Origins and consequences of child neglect in substance abuse families. Clinical Psychology Review. 2002; 22:1063-90.
9 Velleman R, Orford J. Risk and resilience: adults who were the children of problem drinkers. Amsterdam: Harwood Academic Publishers; 2001.
10 Kroll B. A family affair? Kinship care and parental substance misuse: some dilemmas explored. Child & Family Social Work. 2007; 12(1):84-93.
11 Menzies IEP. A case study in the functioning of social systems as a defence against anxiety. In: Colman AD, Bexton WH. (eds) Group relations reader. Portland, OR: AK Rice Institute; 1975.
12 Bohart A, Tallman K. How clients make therapy work. Washington, DC: American Psychological Association; 1999.
13 Bion WR. Experiences in groups. Human relations vols. I-IV, 1948-1951. Reprinted in: Experiences in groups and other papers. New York: Routledge; 1961.
14 Elton Wilson J. Notes for M-PACT supervision. 2012.
15 Yalom ID. Therapeutic factors of group therapy: the theory and practice of group psychotherapy. 3rd edition. New York: Basic Books; 1985.
16 Dallos R, Draper R. An introduction to family therapy: systemic theory and practice. Maidenhead: Open University Press; 2010.

Dialectical behaviour therapy for self-harm

A pilot project by KOOTH to harness the power of Dialectical Behaviour Therapy to tackle self-harm in young people has met with sufficient success to be spreading into other areas. ***Elaine Bousfield*** *explains*

Self-harm is undoubtedly on the rise amongst young people and is now the fifth most often presented issue to KOOTH practitioners, who work online and face to face with young people aged 11 to 25. Epidemiological studies[1] bear this out, also suggesting that incidences of self-harm are becoming more prevalent amongst vulnerable children and young people. With the Royal College of Psychiatrists claiming that one in 10 young people will self-harm[2], it has never been more important to tackle this issue. However, it was becoming clear to KOOTH practitioners that traditional approaches simply weren't effective, and an empathic, person-centred approach alone was inadvertently feeding self-harming behaviours in young people, who could see their actions resulting in a positive response and an increase in attention.

A recurring theme at KOOTH's monthly practitioner meetings now concerned how best to address self-harm in young people. Counsellors – many of whom are trained in person-centred counselling – reported that they felt they were making little or no headway. In fact, the phrase 'we feel like we're banging our heads against a brick wall' was used more than once, and there was a growing feeling of being helpless as helpers. It was therefore vital to create a model for working with self-harm at Tier 2, before young people's self-harming behaviours escalated and required the involvement of CAMHS.

Inspired by Marsha Linehan, original developer of the psycho-educational therapeutic model Dialectical Behaviour Therapy (DBT), KOOTH explored the potential of adapting Linehan's mode of working to sessions with children and young people who self-harm. Linehan specialised in working with adult women who chronically self-harmed, presented suicidal tendencies and who were diagnosed as having borderline personality disorders, so the synergy and possibilities were clear.

More about DBT

Seeking to achieve a balance between acceptance and change, dialectics has been described by Marsha Linehan as a complex concept that has its roots in philosophy and science: '[It] involves several assumptions about the nature of reality: 1) everything is connected to everything else; 2) change is constant and inevitable; and 3) opposites can be integrated to form a closer approximating to the truth (which is always evolving).'[3]

DBT is built on the premise that the client is not responsible for what has happened to them but that they *are* responsible for changing their responses to external stressors and pressure points. It arms people with techniques and skills to allow them greater control of themselves. Working with DBT skills, responsibility is placed on the counsellor to help young people change their thinking as a basis for breaking the cycle of self-harm, which can, for some of them, become an extremely counterproductive, addictive and habitual response to negative emotions, which can lead to indelible scars and even accidental death.

KOOTH takes on DBT

In 2008, four KOOTH counsellors, along with two associate colleagues, undertook intensive DBT training with British Isles DBT Training[4], whose Dr Michaela Swales is senior lecturer at Bangor University, and a clinical practitioner leading a programme for adolescents self-harming at Tier 3. KOOTH, keen to develop a modality for Tier 2, which would stop behaviours escalating to Tier 3, saw this as the perfect fit.

Once the team was fully trained, the powerful benefits of using DBT skills to help young people to help themselves became even clearer. KOOTH rapidly became an active advocate of DBT and began using DBT skills in its online work.

In one area where KOOTH's online counselling services were already commissioned, practitioners across the children's workforce anecdotally reported high levels of identified or self-reported self-harm, and so, in 2013, KOOTH was asked to develop a pilot scheme around self-harm, for the region.

During the pilot scheme, a research paper by the University of Salford[5] explored what young people and guardians of young people who self-harm think they need in terms of help and support. At the core of the research was the aim of making sure