

THE USE OF SELF-SELECTION PROCEDURES FOR IDENTIFYING
CHILDREN FROM ALCOHOLIC HOMES IN NONEDUCATIONAL SETTINGS

by

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STATEMENT BY AUTHOR

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ABSTRACT

Parental alcoholism has devastating and enduring effects on children and families. Children who are raised by alcoholic parents commonly suffer cognitive, emotional, and behavioral consequences, and face an increased likelihood of becoming alcoholic themselves. Regardless of the numerous enigmas associated with familial alcoholism, these children are difficult to identify and frequently remain unnoticed and unhelped.

Self-selection is an innovative strategy developed to identify children from alcoholic homes in a nonthreatening and nonstigmatizing manner. This method combines an educational format with the use of groups to reduce the stigma and isolation surrounding familial alcoholism.

Prior research has demonstrated the success of self-selection programs for identifying children from alcoholic homes in school settings. The results of this study conclude that the self-selection process can also be effective in recreational settings. By establishing identification programs in recreational settings in addition to school settings, a greater number of children in need will be reached.

CHAPTER 1

INTRODUCTION

There are approximately 63 million children under the age of 18 living in the United States (U. S. Census Bureau, 1990). Almost 12 percent of these children suffer from mental health problems severe enough to require treatment. Countless additional children at risk of mental suffering due to environmental factors would also benefit from counseling (Dougherty, Saxe, Cross, & Silverman, 1987). One such environmental factor which puts children at risk is parental alcoholism.

Alcoholism, the nation's fourth ranked public health problem (Biek, 1981), has an immense impact on society. An estimated 9.3 to 10 million alcoholics reside in the United States alone (Ackerman, 1983). Although the prevalence may be much greater today, this is still the widely accepted statistic. Since only three to five percent fit the "skid row" stereotype, it is apparent that most alcoholics are our friends, neighbors, and co-workers. In fact, approximately seventy percent of alcoholics are men and women who live in good homes, are employed, and are the parents of children (Ackerman, 1983).

Alcoholism is often referred to as a family disease because every member of the family is affected by the alcoholic to some degree (Robinson, 1989). The literature

presents a diverse array of adverse effects children living in alcoholic homes may suffer. Some of these children display severe behavioral problems (Tharinger & Koranek, 1988), others appear to suffer more serious consequences in the cognitive sphere (Bennett, Wolin, & Reiss, 1988), while still others are most vulnerable to serious emotional disturbance (Hawley & Brown, 1981). Children of alcoholic parents are also at high risk of becoming alcoholic themselves or marrying an alcoholic (Bingham & Bargar, 1985).

With all of the overt consequences children of alcoholics may suffer, the vast proportion of these children appear symptomless because they have chosen coping behaviors which are socially acceptable (Black, Bucky, & Wilder-Padilla, 1986). As a result, many children are not identified as in need of attention by service providers (Gensheimer, Roosa, & Ayers, 1990). Even children displaying overt problems are rarely identified as living in alcoholic homes. Consequently, their symptoms may be treated but the underlying issue remains undetected and they remain at risk for continued problems.

For the special needs of this population to be addressed, they must first be identified. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) lists the

four major purposes for identifying children with alcoholic parents:

(1) So that the nature and extent of service needs can be determined; (2) So that appropriate services can be made available and delivered; (3) So that these children may understand their potential risk level and options and make more informed choices about how they will deal with them; (4) So that the child's sense of isolation, guilt, and stigma can be reduced (1981, p. 7-8).

An estimated fifteen million school-age children live in alcoholic homes (McElligatt, 1986). With 63 million children in the United States, a simple calculation reveals that one out of every four or five of our nation's children reside with an alcoholic parent. Despite the astounding size of this population and the widespread agreement that alcoholism affects the entire family, numerous studies report that children of alcoholics continue to remain underidentified and undertreated (Bingham & Bargar, 1985; Black, Bucky, & Wilder-Padilla, 1986; Hawley & Brown, 1981; Scavnicky-Mylant, 1984; Tharinger & Koranek, 1988).

Children living with an alcoholic may be identified in several different ways (Gensheimer, Roosa, & Ayers, 1990). First, children can be recruited when their parents enter treatment. However, this method would only help a limited number of children since only an estimated ten percent of alcoholics ever enter treatment (Clark & Midanik, 1982). Another strategy is to have school personnel identify

children at risk. This method would reach more children since most children attend schools, however it runs the potential risk of labeling children which could influence teachers' and peers' expectations of them (Blume, 1987). School staff would also need intensive training in order to recognize the variety of signs children with this problem display. Next, children with overt problems can be targeted for services, but as alluded to previously this could overlook more than half of the needy population. Another possible method is the use of screening tests to assess parental drinking patterns and children at risk, but this method also risks negatively labeling people and can be inefficient. A final method designed to identify children of alcoholic parents is through self-referral or self-selection.

The self-referral process overcomes many of the features which limit the other identification methods discussed. This method can reach children who are not exhibiting obvious difficulties and whose parents have not entered treatment (Gensheimer, Roosa, & Ayers, 1990). Through self-selection procedures, children are educated about alcohol and the difficulties it causes for families. Children can then determine for themselves if they are in need of services. This makes the process nonstigmatizing because no one labels them as a child of an alcoholic.

Also, since children decide for themselves when they are ready to access services the process remains nonthreatening.

Self-referral procedures have the additional benefit of providing a group framework for the identification process. Small groups provide the ideal way to work with children of alcoholics for several reasons. Peer groups are very important to children, but children of alcoholics frequently experience social isolation and have problems establishing such groups (Emshoff, 1990). As a member of a small group where safety and trust have been established children are able to reveal their family secrets and express feelings they previously concealed (Bingham & Bagar, 1985). Recognizing that other children in the group face similar dilemmas reduces their sense of shame and isolation. As part of a group, members can develop social support as well as learn problem-solving and coping skills, which are likely to increase members' self-esteem (Emshoff, 1990).

Research on children of alcoholic parents has lacked an adequate theoretical basis from which to interpret existing literature, guide future studies, and make sound identification and treatment decisions (Tharinger & Koranek, 1988). The Adlerian theory of psychology appears to be the most appropriate for this study. The use of groups with children is highly supported by Adlerian theory. Children strive to develop a sense of significance and social

acceptance (Dinkmeyer & Dinkmeyer, 1989). Groups provide an appropriate context in which children can acquire this sense of belonging. The groups used in the self-selection process emphasize imparting information concerning the effects of parental alcoholism on children and families. In support, the Adlerian approach to counseling considers education an important part of therapy with children (Dinkmeyer & Dinkmeyer, 1989), because change, in part, takes place through the development of new skills and knowledge (Sherman & Dinkmeyer, 1987).

The self-selection process for identification of children can be supported by many other basic Adlerian premises. The value of early intervention is inherent in the Adlerian approach (Dinkmeyer & Dinkmeyer, 1989). Adler believed that a person's first six years of life strongly impacts his/her adult personality (Corey, 1991). The family atmosphere, or the climate of the relationships that exist between family members, during these early childhood years is a primary influencing factor on the development of personality (Sherman & Dinkmeyer, 1987). If a person grew up in a home with a family atmosphere of inconsistency, chaos, and distrust (as is likely in an alcoholic home) it is probable that intervention at a young age will not only help the child cope in the present situation, but will also impact his/her stability and well being as an adult.

Identification procedures can take place in a variety of different settings, each with its problems and opportunities. Possible settings include child guidance clinics, child abuse agencies, medical offices, juvenile courts, youth organizations, churches, alcoholism treatment facilities, shelter homes, recreation centers, and schools (NIAAA, 1981). No individual setting is most appropriate for identifying all children everywhere. The NIAAA recommends considering two criteria when choosing a setting in which to identify children from alcoholic homes. They consider the best choice to be the location that can reach the greatest number of children and that is the most accepting of implementing identification procedures. Participants of the NIAAA symposium (1981) concluded that schools and recreation programs best meet these criteria. However, the research published regarding children from alcoholic homes consistently studied school-based identification programs (DiCicco, Davis, Travis, & Orenstein, 1983/84; Emshoff, 1990; Morehouse, 1979; Newlon & Furrow, 1986; Roosa, Gensheimer, Ayers, & Short, 1990). In fact, while reviewing the literature not a single study was found using subjects from a recreational setting.

Based on the NIAAA recommendation, this study was designed to determine if elementary-aged children residing in alcoholic homes could be identified by a self-selection

process outside the traditional educational setting. Identification is a necessary prerequisite to providing early intervention and prevention services to these children. The abundance of information on the treatment needs of children from alcoholic homes is useless without the development of successful strategies for identifying the children in need. More research needs to be completed in order to improve current methods of identifying children residing in alcoholic homes.

Purpose of the Study

The purpose of this study was to determine if the self-selection process for identification of school aged children of alcoholics was as effective in recreational settings as it has proven to be in school settings (Furrow, 1982). By expanding the list of possible settings in which to use identification procedures service providers will be able to reach more children in need.

Questions for Consideration

The following questions have been proposed for consideration by this study:

1. Can self selection procedures successfully be used in recreational settings to identify school aged children from alcoholic homes?

2. Do all children, regardless of whether they disclose parental alcoholism, learn valuable information

concerning alcoholism and its effects on families from the initial presentation?

Definitions of Terms

For the purpose of this study the following terms have been defined:

Adlerian Psychology - This theory of psychology, founded by Alfred Adler in 1912, believes that children's actions are influenced by their search for significance and social acceptance. All people, including young children, are seen as individuals with the ability to make purposeful and goal oriented choices and decisions (Dinkmeyer & Dinkmeyer, 1989).

Alcoholic - A person whose alcohol consumption has interfered with their family's daily functioning according to one of the children's perception. This definition was necessary for this study because the self-selection process depends on children's nonvalidated belief that their parent(s) has a drinking problem. This definition is similar to much of the literature which defines an alcoholic as any person whose loss of control over their drinking has produced a negative impact in one of the following areas: job, school, finances, physical health, or relationships with family and friends (Tharinger & Koranek, 1988).

Alcoholism - "A disease process that is characterized by repetitive abusive drinking, personality changes while

drinking, and a process that affects the entire family system" (Bingham & Bargar, 1985, p. 13).

Children - For the purposes of this study children are defined as male and female youth from the ages of 9 to 13, as opposed to the literature which includes any person age 18 and under.

Group Discussion - A process involving a group of people talking and thinking together about an issue which provides opportunities for emotional and intellectual participation and reassurance that one is not alone. It is a respectful interchange of ideas and opinions that facilitate learning (Dreikurs, Grunwald, & Pepper, 1982).

Parent - Either a natural parent or another adult who has or is currently filling the role of parent for a child (Biek, 1981).

Self-esteem - A belief one has about their own value as a human being.

Self-referral - An identification process which allows participants the freedom to decide for themselves whether to disclose parental alcoholism following their attendance at a presentation on the same topic.

Self-selection - An identification process which allows participants the freedom to decide for themselves whether to join a small group to discuss parental alcoholism following their attendance at a presentation on the same topic.

Assumptions

This study rests on several assumptions. The first is that children of alcoholics must first be identified before they can be helped. It is believed that a child cannot receive proper treatment if familial alcoholism remains undetected and only symptoms of the actual problem are treated. The second assumption is that early intervention and treatment can benefit children from alcoholic homes even when the alcoholic continues to drink. Research suggests that helping children develop social support and survival skills can moderate the effects of living in an alcoholic home (Emshoff, 1990). Lastly, it is assumed that given the right conditions children will be willing to truthfully disclose that one or both of their parents has a problem with alcohol.

Limitations

The generalizability of this study is limited by several factors. The sample used in this study was not randomly chosen. Volunteers who participated in this study were all from recreation centers in the Southwest. Participation was limited to subjects from age 9 to 13 who obtained parental permission.

Summary

This chapter outlined the problems associated with parental alcoholism and the need for early identification of

children residing in alcoholic homes. Appropriate locations for identification procedures to take place and the self-selection process of identification to be used in this study were introduced. The Adlerian theory of psychology was presented as the preferred theoretical basis for the study. The purpose of the study was clarified and relevant definitions, assumptions, and limitations were listed. Information regarding children of alcoholics and the self-selection process, introduced in this chapter, will be reviewed in more detail in the next chapter.

CHAPTER 2

REVIEW OF THE LITERATURE

In this chapter, the major literature regarding the effects of parental alcoholism on children and families is reviewed. The cognitive, emotional, and behavioral consequences children face when living with an alcoholic parent are examined. The barriers which make this vast population of at risk children difficult to identify and treat will be discussed along with an innovative identification system. The utilization of groups, an important component of this identification system, will be described in detail.

Effects of Parental Alcoholism on Children

Alcohol, ironically one of the most accepted drugs in our society has insidious effects on both the alcoholic and close family members, especially children. The atmosphere of alcoholic homes is chaotic and unpredictable due to the inconsistency of the alcoholic's mood and behavior. Mood swings between drunk and sober states leave the children with mixed feelings of love and hate towards the parent (McAndrew, 1985). Since they never know what to expect they are scared to invite friends to their house. Alcoholic parents are inconsistent in limit setting, discipline, and in the expectations they have for their children (Bepko, 1985). With constantly changing parental expectations

children feel they cannot do anything right and continually seek approval and affirmation (Leerhsen & Namuth, 1988).

Alcoholic families lack nurturing and love. These families rarely laugh and have fun together (Giglio & Kaufman, 1990). The children judge themselves without mercy and take themselves so seriously that they have difficulty having fun (Leerhsen & Namuth, 1988). Frequently their primary needs are not met. They receive little or no help with meals, laundry, homework, or social plans. With the added responsibility of caring for themselves they do not have as much time to play as other children. This uncaring atmosphere creates feelings of sadness and depression in children. To them the world appears to have an aura of hostility and fear.

The disordered environment of children of alcoholics includes poor communication among family members. Communication is filled with lies and denial. In fact, they become so accustomed to using denial as a way to hide the family problem that they often lie when it would be just as easy to tell the truth, even about nonfamily issues (Leerhsen & Namuth, 1988). The distrust created by alcoholism within the family damages open, honest communication (Tharinger & Koranek, 1988). Arguments are common between parents, as well as, between siblings (Robinson, 1989). The high rate of conflict within these

families creates a great deal of stress which may be the primary contributing factor to the development of mental health problems among children of alcoholics (Roosa et al., 1990).

Children in alcoholic families feel responsible for their parent's drinking (McAndrew, 1985). Many children, not understanding what is happening in their home, feel responsible for the family's problems and develop a belief that something must be wrong with them. They are unsure of themselves and feel they are somehow different from other children. Many children with an alcoholic parent truly believe their parent would not drink if they loved them, so they must not be lovable (McAndrew, 1985).

In homes with one alcoholic parent it is not uncommon for children to feel the nondrinking parent is more difficult to get along with than the alcoholic (Robinson, 1989). The nonalcoholic parent is affected by the alcoholic just as the children are. Robinson (1989) refers to the phenomenon as "battle fatigue" (p. 25), where the nonalcoholic parent, feeling worried, nervous, and tense misdirects these emotions onto their children. Children may also feel angry at the nonalcoholic for not making things better and for not protecting them from the alcoholic's physical and emotional violence. Despite their feelings

these children tend to remain extremely loyal to their parents even when they know it is undeserved.

For many children of alcoholics, their parent's drinking is the single greatest influence on their psychological development. "Their feelings, personalities, behavior, educational progress, and social adjustment are influenced more by that one reality than by any other" (Tharinger & Koranek, 1988, p. 167). It is not surprising then, that being raised in an alcoholic home has been correlated with the development of behavioral, school, and emotional problems, in addition to a predisposition to alcoholism.

An increased risk of becoming alcoholic is the most well documented effect of having an alcoholic parent. Children with at least one biological, alcoholic parent are around four times more likely to become alcoholic themselves than a control group, even if they were raised by nonalcoholic parents (Monmaney, Springen, & Hager, 1988). This is evidence of a genetic link. However, many scientists agree that people inherit varying degrees of susceptibility to alcoholism, not the disease itself. Research suggests that alcoholism is probably due to some unknown interaction between environmental and genetic variables (Tharinger & Koranek, 1988). Children being raised by alcoholic parents are especially susceptible to

the disease, since they are both genetically and environmentally predisposed. Alcoholic parents teach their children that drinking is the way to cope with life's stresses. The probability of becoming alcoholic appears to be equal or slightly higher for women with a family history of the disease than for men (Tharinger & Koranek, 1988). Interestingly, a review of 39 studies showed that children of alcoholic mothers were more likely to become alcoholic than children of alcoholic fathers (Giglio & Kaufman, 1990).

Serious behavior problems are considerably more prevalent in children of alcoholics than their peers. In fact by age 18, 30% of children from alcoholic homes have records of repeated delinquency (Tharinger & Koranek, 1988). A review by West and Prinze (cited in Emshoff, 1990) discovered that six out of seven studies reported higher rates of attention deficit disorder or hyperactivity in children with alcoholic parents. Tharinger and Koranek (1988) found that many of the subjects described as hyperactive actually display a behavioral pattern consistent with conduct disorder. Thus, it seems that parental alcoholism is not a risk factor specific to hyperactivity alone, but to hyperactivity in combination with conduct disorder. Children of alcoholics labeled with conduct disorder have a significantly greater chance of becoming

alcoholics in adulthood than children with alcoholic parents in general (Tharinger & Koranek, 1988).

School difficulties in children from alcoholic homes manifest themselves in a variety of ways. According to a literature review (Giglio & Kaufman, 1990) children living with alcoholic parents perform at lower cognitive levels than controls. This contradicts other studies which report that alcoholic parent or not, children have similar cognitive skills (Tharinger & Koranek, 1988). A greater incidence of learning disabilities has also been reported in children of alcoholics (McAndrew, 1985). Any learning problems that do exist may be due to prenatal exposure to alcohol and not family environment itself (McElligatt, 1986). Regardless, the environment in alcoholic homes is often poor for studying and these children tend to receive little encouragement and support in their school and homework endeavors (Emshoff, 1990).

School performance is also affected by poor attendance and discipline problems common to these children. Suspensions and referrals to counseling for disciplinary reasons are more common to students living in alcoholic homes. These children are less likely to complete high school and are more likely to be expelled from school than other children (Tharinger & Koranek, 1988).

A study by Pilat and Jones (1984/85) contradicts other reports. They found that the majority of children from alcoholic homes achieve at or above what is expected for their grade level. This finding supports the belief that many children of alcoholics survive their situation by using achievement to gain a sense of control over themselves and to bring pride to the family.

Children of alcoholics commonly suffer from depression (Black et al., 1986). With a lack of positive coping skills they may develop serious mental health problems which can lead to suicidal tendencies. By age 18, 41% of children of alcoholics show serious coping problems and 25% have mental health problems serious enough to require either inpatient or outpatient care (Tharinger & Koranek, 1988). 17% of adolescent children from alcoholic homes describe themselves as being depressed in contrast to 5% of other adolescents (Giglio & Kaufman, 1990). Affective disorders are especially common in daughters of alcoholics, 51% versus 6% of sons. Interestingly, 74% of daughters with alcoholic mothers have affective disorders versus 32% of daughters with alcoholic fathers (Giglio & Kaufman, 1990).

In addition to depression other emotional consequences of parental alcoholism exist. Several studies cited by Giglio and Kaufman (1990) indicate a general state of increased anxiety among children living with alcoholic

parents. These children learn early in life to survive by not talking and repressing their feelings. As a result they frequently appear emotionally detached and many suffer from low self-esteem (Bennett, Wolin, & Reiss, 1988). Children of alcoholics also tend to present with passive-aggressive traits, insomnia, and nightmares, and are more prone to eating disorders.

No causal link can be made between parental alcoholism and the many consequences listed because there are many potential confounding variables. For example, the divorce rate is between 4 and 11 times higher in alcoholic families than the general population and husbands are statistically more likely to divorce their alcoholic wives than vice versa (Tharinger & Koranek, 1988). Since custody of the children is generally granted to women, children of alcoholic mothers frequently have to deal with divorce in addition to the alcoholism of their custodial parent.

Abuse is another potential consequence of being raised by an alcoholic parent. According to a review by Famularo, Stone, Barnum, and Wharton (1986) several studies have associated child maltreatment with alcoholism. The National Association for Children of Alcoholics (cited in Bingham & Bargar, 1985) believes that alcohol is a significant factor in up to 90% of child abuse cases (physical, sexual, and neglect). Many different factors have been associated with

the risk of child abuse, but Famularo et al. (1986) believes parental alcoholism is the most destructive risk factor since drinking has a dramatic effect on parenting abilities. Even moderate drinking can cause parents to emotionally and physically neglect their children (Famularo et al., 1986).

Physical abuse by an alcoholic parent is equally prevalent during both drunk and sober periods (Black et al., 1986). The past history of alcoholism alone, may increase the potential for severe child maltreatment even if the parent is in recovery (Famularo et al., 1986). Alcoholism has a major impact on parental functioning beyond the immediate effects of the alcohol itself. It is unlikely that abuse is caused by the disinhibiting factor of alcohol, since the abuse seems to be present whether the parent is currently drinking or not.

Children with alcoholic parents are not all affected the same way. Each child takes on a role or a combination of roles to serve as their personal survival strategy. Although the roles are all very different each serves the same purpose, to achieve a sense of individual security and stability while disguising the problem of familial alcoholism (Robinson, 1989). The birth order (i.e. first born, second born, baby, etc.) of each child will influence the role he/she chooses to fulfill (Giglio & Kaufman, 1990).

Some children choose roles that tend to identify them as disciplinary problems (Wegscheider, 1981). The scapegoat, often the second born child, becomes the focus of the family's problems by removing the focus from the alcoholic. These children typically do poorly in school, become delinquent, and use drugs or alcohol. The mascot, often the youngest child, uses charm and humor to relieve the families tension. These hyperactive children become disruptive class clowns. These roles provide children with an important way to belong in the family, despite the negative means.

Although misbehaving children of alcoholics are usually the ones identified for treatment, well behaved children of alcoholics are in the majority (Black et al., 1986). Tharinger and Koranek (1988) report that 59% of children from alcoholic homes (72% of whom are female) do not develop serious, overt problems by age 18. Despite their appearance of survival, they have been seriously affected by life with the alcoholic.

Claudia Black (cited in Tharinger & Koranek, 1988) describes three roles well behaved children of alcoholics may select. The responsible one, typically the oldest child, assumes parental responsibility where the alcoholic leaves off and becomes a surrogate parent for siblings. They become perfectionists and overachieve in school,

sports, and community activities. Placaters assume emotional responsibility for the entire family and attempt to smooth over conflicts. Both of these roles take on immense responsibility for the family while denying responsibility for themselves and force children into adult roles prematurely. Adjustors put few demands on the family and cope by becoming amazingly flexible and adapting to any situation. In expense, they fail to develop control over their own lives. Although these children seem exceptionally well adjusted on the surface, their survival roles constrict their ability to grow and develop. Since our society rewards the positive behaviors attached to these roles (i.e. overachieving, responsibility, and adaptability), the underlying problem remains unrecognized.

Children of alcoholics are not all affected to the same degree. Children who are reared in stressful environments and manage to cope exceptionally well regardless of their surroundings are labeled resilient or invulnerable. Anthony (cited in Robinson, 1989) describes the difference between vulnerable and invulnerable children by comparing children to three types of dolls; glass, plastic, and steel.

Glass dolls are shattered by the stressful experiences in childhood. Plastic dolls are permanently dented, and steel dolls are invulnerable-resisting the harmful effects of their surroundings. Glass (vulnerable) children break down completely, plastic children sustain some serious injury, and steel, (invulnerable)

children thrive on the trouble and turmoil in their world. (p. 36)

Robinson (1989) lists many characteristics that resilient children tend to possess. They have good social skills and are well liked by others. They have an internal sense of control over their situation and a desire to help others more troubled than themselves. Resilient children feel more independent and are more objective about what is happening in their family. Their high self-esteems and achievement orientations allow them to succeed in school and other areas of their lives. The most common characteristic of invulnerable children is their remarkable ability to cope with and manage stress. Treatment for children living with alcoholic parents should be based on these resiliency factors. If these characteristics help some children to avoid problems, they should likewise be able to relieve children who have developed problems.

Resilient children share many of the characteristics described for the role of the responsible child mentioned previously. The apparent resilience of children in the responsible child role is really a disguise for more deep-seated problems. Many cases of seeming invulnerability may be a means of hiding true inner feelings (Robinson, 1989). In fact, children who appear resilient may be in greater need of help than children who are able to express their burden. It seems sensible then for professionals to help

all children from alcoholic homes regardless of their exterior appearance, instead of wrongly assuming that a particular child has not been affected.

Although some children from alcoholic families may fare better than others it is generally agreed that all children suffer negative consequences. Seemingly well adjusted children are as much at risk as the ones who display overt behavioral problems (Anderson & Quast, 1983). According to Woititz (1983) some children of alcoholics are able to hold their lives together until they are in their 20's or 30's. They appear to remain symptom free until they are exposed to adult stresses that surface painful childhood memories (Scavnicky-Mylant, 1984). The coping skills they develop as children growing up in an alcoholic homes such as, emotional detachment, rigidity, excessive independence, internalization of needs and feelings, and need for control, allow them to survive their childhood environment, but are maladaptive to most other situations throughout life (McElligatt, 1986). It is in adulthood when feeling depressed, unable to express emotions, and unable to maintain intimate relationships that children of alcoholics realize, through the useless aspects of their coping skills, the degree to which the alcoholic parent has affected their life. For many this may be the first time they realize the

negative effects of their upbringing (Scavnicky-Myllant, 1984).

Thus far, the effects that a parent's drinking has on the family and the specific consequences children face living in such an environment have been reviewed. Next, identification and treatment of children from alcoholic homes will be discussed.

Identification of Children from Alcoholic Homes

Children of alcoholics have been neglected as a population in need of services, despite their risk of developing numerous problems throughout life. The ability to identify children living in alcoholic homes is of monumental importance. In order to provide children being raised in alcoholic families with services that are essential to fostering a healthier psychosocial development, it is first necessary to identify them. Surprisingly, the NIAAA reports that only five percent of these children are ever identified and treated (cited in Robinson, 1989). If familial alcoholism is not recognized as the genesis of a child's difficulties, appropriate interventions will not be made available (Blume, 1987). As a result the child's symptoms may be treated, but the underlying issue will endure and the child will continue to cope ineffectively. Regardless of its importance this population remains notoriously difficult to identify for a number of reasons.

Barriers to Identification

A major barrier to the identification of children from alcoholic homes is the massive denial characteristic of alcoholic families (NIAAA, 1981). Alcoholic parents deny that their children are affected by their drinking and therefore, resist any intervention efforts. Due to the social stigma attached to familial alcoholism these children are taught not to talk about the family problem. They feel ashamed and embarrassed and may think that others will treat them differently if they know about the family secret. Possibly for these reasons, children from alcoholic homes rarely seek help for themselves (Ackerman, 1983).

For children who are not in denial about parental alcoholism and who want help, barriers still exist. For example, there is the legal issue of parental consent. Although laws vary from state to state, most professionals in who are in a position to help children must first obtain permission from parents. Parents in denial may refuse to sign consent forms or their children may be too scared to ask. To help alleviate this problem consent forms should be written in as nonthreatening a manner as possible. Also, due to the limited mobility of children, treatment programs must be convenient (Scavnicky-Mylant, 1984).

Children of alcoholics are also neglected due to a general societal ignorance about the effects of parental

alcoholism on children and what can be done (McElligatt, 1986; NIAAA, 1981; Scavnicky-Mylant, 1984). Caregivers do not realize the impact a parent's drinking can have on a child's development. Professional schools (i.e. medical, social work, nursing, education, psychology) offer little or no training on alcoholism and its effects on families. As a result most agencies serving children and families are not aware of the frequency of familial alcoholism in their case loads (Hawley & Brown, 1981). Many professionals feel incompetent handling issues about alcoholism even after they are disclosed. They fear they may stir up trouble, anger the parent, or harm the child by trying to help (McElligatt, 1986). In addition, resources available to these families are not widely known (DiCicco, 1981).

Another obstacle is the widespread belief that children in alcoholic homes cannot be helped unless the alcoholic parent stops drinking (Tharinger & Koranek, 1988). Professionals in the field now realize that children from alcoholic homes deserve and benefit from assistance even if the alcoholic parent is not willing to get help (Ackerman, 1983). The converse assumption is also cautioned against. When the alcoholic stops drinking the family does not magically recover without help (Scavnicky-Mylant, 1984).

A final barrier to the identification of children from alcoholic homes is the diversity of symptoms the population

can potentially develop. There is no characteristic universal to all children growing up with an alcoholic parent. Children who do not behave in destructive ways, such as withdrawn or over-achieving children, are more difficult to identify and consequently tend to be overlooked. In order to overcome this barrier, helping professionals must redefine the meaning of symptomless (Tharinger & Koranek, 1988) and become educated on the variety of characteristics associated with growing up in an alcoholic home.

Identification Strategies

Procedures which can be used to successfully identify children from alcoholic homes early in their lives are crucial. There are several different ways to identify this population (Gensheimer, Roosa, & Ayers, 1990). First, the identification of children of alcoholics has traditionally been contingent upon first identifying and treating the alcoholic parent. Since approximately only ten percent of alcoholics ever receive treatment, the majority of children would never receive services if we relied solely upon this strategy for identification (Clark & Midanik, 1982). Another strategy is to have school personnel identify children at risk. This method would reach more children since most children attend schools, however it runs the potential risk of labeling children which could influence

teachers' and peers' expectations of them (Blume, 1987). School staff would also need intensive training in order to recognize the variety of signs children with this problem display. Next, children with overt problems can be targeted for services, but this could overlook more than half of the needy population. Another possible method is the use of screening tests to assess parental drinking patterns and children at risk, but this method also risks negatively labeling people and can be inefficient. A final method designed to identify children of alcoholic parents is through self-referral or self-selection.

Self-selection is a unique process developed to overcome many of the limitations of other identification methods. Through the self-selection procedures groups of children are first educated on alcoholism and its effects on families in an open and nonthreatening manner. Various media including lectures, discussion, film, and handouts, can all be used to facilitate the education process (Furrow, 1982). Following the educational segment children are invited to attend a small group to discuss the same topics in a more personal and meaningful way. It is emphasized that children do not have to be concerned about their parents drinking to attend the small group. The educational segment and the small group provide an environment conducive to self-disclosure of familial alcoholism by children.

Raising the subject of alcohol use in a neutral and nonthreatening way can provide an important way to identify children living with alcoholic parents (DiCicco, Davis, Travis, & Orenstein, 1983/84).

Self-selection is perhaps the most successful identification method (Robinson, 1989). It provides children with the opportunity to secure treatment on their own. The self-referral process is nonthreatening because the children have control over when and what to disclose about their family secret. It is also nonstigmatizing. Since anybody interested can join the small group, participants are not automatically singled out as children of alcoholics. A study by DiCicco et al. (1983/84) found that most children were not willing to join a group specifically advertised for children with alcoholic parents. Thus, it is important that the program used allows children to conceal their identity. "This approach puts the assurance of psychological safety and anonymity in children's hands" (Robinson, 1989, p. 115).

Children make the decision on their own to enter the groups. Therefore, an added benefit of the self-selection method is that children who enter the groups are motivated to work on the problem and ready to learn more about the effects of alcohol on families (Robinson, 1989). According to Ohlsen, Horne, and Lawe (1988) children who are able to

volunteer for group counseling benefit the most. The group also provides a built in support system for its members.

Children who decide not to join the small groups still benefit from the information presented during the educational segment. This information is important to all children because even children whose families are not personally touched by alcohol may have a friend who needs their support. In addition, all children must at some point in their life make a decision regarding their own drinking behavior.

Medically diagnosing alcoholism is complicated. Therefore it is difficult to identify children of alcoholics by asking children to answer questions regarding their parent's drinking patterns. Even if children had the information to answer these questions, they would be too intrusive for a child who has learned to be secretive about family matters (DiCicco, Davis, & Orenstein, 1984). Many children are probably not sure what actually constitutes alcoholism. For these reasons, the self-referral process depends on a child's own perception that a parent has a drinking problem which is negatively impacting the family's functioning. DiCicco, Davis, and Orenstein (1984) believe:

Children's perceptions may be the more critical variable both in producing behavior and self-image problems and for realistically estimating the need for counseling and other services. (p. 7)

Adlerians would agree with this notion because people do not base their behaviors on reality, but on what they believe to be true (Sherman & Dinkmeyer, 1987).

Locations for Use of Identification Strategies

Identification procedures can take place anywhere children assemble, including: schools, treatment centers, criminal justice system, recreational centers, group foster homes/shelters, and occupational programs (NIAAA, 1981). Each potential location has its special problems and opportunities. The NIAAA (1981) recommends considering two criteria for determining the best setting in which to identify children from alcoholic families. They consider the best choice to be the location that can reach the greatest number of children and that is the most accepting of implementing identification activities. Participants of the NIAAA symposium (1981) concluded that schools and recreation programs, including: Y's, churches, and boys' and girls' clubs, best meet these criteria.

Regardless of the NIAAA conclusion, the research published regarding children from alcoholic homes consistently studied school-based identification programs (DiCicco, Davis, Travis, & Orenstein, 1983/84; Emshoff, 1990; Morehouse, 1979; Newlon & Furrow, 1986; Roosa, Gensheimer, Ayers, & Short, 1990). In fact, in a review of

the literature not a single study was found using subjects from a recreational setting.

Schools are considered the most logical by researchers because they reach the greatest number of children. Although some may argue that identification of children from alcoholic homes is not the job of the school, others believe that since parental alcoholism often interferes with children's education, it is the school's duty to become involved (Morehouse, 1979).

Schools, as identification sites, have drawbacks which must also be considered. When a child is identified as from an alcoholic home at school, there is a danger that the individual will become negatively labeled by teachers, peers, and school personnel who have daily contact with the child (Blume 1987). This label, that may stay with the child for several years, could influence others' expectations for, and feelings toward the child. When using the self-selection process for identification purposes in schools there is a possibility that children who are not in need will join the small groups simply to avoid class (Gensheimer, Roosa, & Ayers, 1990).

The drawbacks associated with schools are not problematic in recreational settings. Currently there are too few places where children can safely discuss parental alcoholism (Brown & Sunshine, 1982). By starting

identification programs in recreational settings in addition to the traditionally used school settings, an even greater number of children in need can be reached and helped.

The Use of Groups with Children of Alcoholics

The Adlerian theory of psychology emphasizes the concept of social interest, which refers to individual's attitudes about dealing with other people in the world (Corey, 1990). All people, including children, continually strive to acquire a sense of belonging and of contributing in the family and in society (Sherman & Dinkmeyer, 1987). When cooperative, appropriate behaviors fail to achieve a sense of acceptance, people often develop a faulty perception of belonging through misbehavior (Sherman & Dinkmeyer, 1987). Social interest has important implications for group counseling with children from alcoholic homes. Since these children are frequently isolated and lack a sense of belonging, a beneficial setting in which to help them is group counseling.

The self-selection process for identifying children from alcoholic homes utilizes a group format. Group counseling has several advantages over individual counseling that make it the strategy of choice for working with children of alcoholics (Robinson, 1989). Children living in alcoholic families are taught not to talk about their shameful situation and as a result they think they are the

only one who has an alcoholic parent. By participating in a group, these frequently isolated children learn that they are not alone. This realization increases the likelihood that the silence and denial associated with family alcoholism will be broken (Robinson, 1989). The group process has the potential of providing the safe and trusting environment that children need in order to risk disclosing thoughts and feelings about their family situation (Bingham & Bargar, 1985).

To describe the significance Adlerians place on interpersonal skills, Sherman and Dinkmeyer (1987) write:

Human relationships require effective interpersonal behavior. Social interaction is not an option in life, but a requirement. (p. 5)

Group counseling gives children a chance to experience healthy social interactions and develop friendships, an area in which many children of alcoholics are seriously lacking (Robinson, 1989). They are given the opportunity for group validation and a chance to build confidence and self-esteem. Ohlsen, Horne, and Lawe (1988) believe that another significant advantage of the group process is that members are more likely to accept both positive and negative feedback from peers than from the counselor. With the group's support children are able to practice newly acquired skills and make positive changes in their lives (Robinson, 1989).

Large Discussion Group

The first phase in the self-referral procedure for identifying children of alcoholics is the large group discussion. Dreikurs, Grunwald, and Pepper (1982) conclude that this type of discussion group can be successful with as many as 40 or more participants. By providing discussion material, large groups promote learning. Children can learn information that is directly related to their own life or that will help them understand people from different backgrounds (Dreikurs, Grunwald, & Pepper, 1982).

Bringing up the subject of alcohol in a large group in an open and non-judgmental manner, releases children to discuss a topic which was formerly taboo. Children receive information that can help them make the link between their parent's drinking and what is happening in their lives (Biek, 1981). They can benefit by listening to experiences shared by other group members which are similar to their own. Effective communication in discussion groups leads to problem solving, feelings of support, and feelings of equality and respect (Dreikurs, Grunwald, & Pepper, 1982).

Educating children about alcoholism helps to demystify the forbidden subject (Brown & Sunshine, 1982) and correct distorted perceptions about what is happening in their home environment (McAndrew, 1985). As their knowledge increases, feelings of shame and loneliness for children living in

alcoholic homes decrease. The main goal of this phase is to provide participants with introductory information regarding life with an alcoholic parent in a nonthreatening manner. The large group discussion phase presents all children with facts about alcohol use and abuse.

The CASPAR (Cambridge and Sommerville Program for Alcoholism Rehabilitation) recommends including five key points when presenting children with information about alcoholism (DiCicco, 1981, p. 50):

- 1) They are not alone.
- 2) Their parent's alcoholism is not their fault.
- 3) Alcoholism is a disease
- 4) Alcoholics can and do recover.
- 5) They need and should get help for themselves.

Robinson (1989) lists ten key messages he believes are important to convey to children in alcohol education programs developed for children of alcoholics:

- 1) Alcoholism is a disease.
- 2) Everybody gets hurt in the alcoholic family, including the children.
- 3) Children whose parents drink too much are not alone.
- 4) Children do not cause, cannot control, and cannot cure their parent's alcoholism.
- 5) There are many good ways that children can take care of themselves when parents drink so that they feel better about themselves.
- 6) It is healing for children to identify and express their feelings about parental drinking.
- 7) It is okay for kids to talk about parental drinking to a friend or within the safety of a group.
- 8) Kids of alcoholics are at high-risk of substance abuse themselves.
- 9) It is important for children to identify and use trusted support systems outside the family.

- 10) There are many practical ways of problem solving and coping with parental alcoholism. (p. 129)

Morehouse (1979) recommends that the discussion be focused on the dynamics in a family with an alcoholic parent. She feels the group discussion should acknowledge these points:

- (1) children worry about the health of their alcoholic parent,
- (2) children are upset by the unpredictable and inconsistent behavior of their alcoholic parent,
- (3) children worry about fights and arguments between their parents,
- (4) children are scared and upset by the violence or the possibility of violence in their family,
- (5) children are disappointed by broken promises and feel unloved,
- (6) children feel responsible for their parent's drinking, and
- (7) children are upset by their parent's inappropriate behavior, which can include criminal or inappropriate sexual behavior. (p. 153)

It would be helpful to teach children the various family roles children living in alcoholic homes establish (i.e. scapegoat, mascot, responsible one, placater, and adjustors). With this knowledge they can identify the pattern of coping they have chosen and learn the benefits and the risks associated with it.

To children who grow up around alcoholism there is no such thing as social drinking. All drinking constitutes alcoholism and any amount of alcohol is bad and out of control (Brown & Sunshine, 1982). For this reason it is important to teach children of alcoholics about the entire range of drinking patterns from problem drinking to responsible drinking. This kind of information will help

children accurately judge their own and friends, current or future drinking patterns.

It is possible that not all children affected by familial alcoholism will choose to join the small groups upon completion of the education phase. It is important to make sure that these children have information about how and where to obtain help once they are ready. Time needs to be set aside to discuss community services available for the alcoholic and the family of the alcoholic (Ackerman, 1983).

Small Counseling Group

The second phase of the self-referral process for identifying children from alcoholic homes is the small counseling group. When used as part of a self-identification program the facilitator's overall goal for the small group is to identify the children from alcoholic families so they can be provided with appropriate help for their problem. But through this process the participants receive considerably more than simply a chance to identify themselves.

Social support may be the most therapeutic aspect of groups for children of alcoholics. Since these children are frequently socially isolated the group provides an environment conducive to establishing intimate and trusting relationships which are critical to the positive adjustment of children living with familial alcoholism (Emshoff, 1990).

Social support begins during the large discussion group and intensifies during the small counseling groups.

The group process can facilitate the identification, acceptance, and expression of feelings that children living in alcoholic families have learned to repress. As the group progresses children should be encouraged to describe their personal situation and how it has affected them (Morehouse, 1979). Members should be invited to interact as a group by asking each other questions and offering feedback and support. Evidence suggests that participants who are allowed to receive and provide support have the most positive outcomes (Emshoff, 1990).

Groups can also improve children's coping skills. Coping skills give children a sense of competence and control over their chaotic home environment and help alleviate the negative effects of parental alcoholism (Emshoff, 1990). When appropriately incorporated, decision-making, problem-solving, stress management, conflict resolution, and assertiveness skills can all add to the value of groups designed for children of alcoholics.

Children of alcoholics take themselves very seriously and as a result often have little fun in their lives (Giglio & Kaufman, 1990). Including recreational activities in the group content teaches children how to play. Recreation has the additional benefits of improving social bonding,

reducing tension, and demonstrating an alternative to substance abuse (Emshoff, 1990).

The content of the small group sessions can be organized in a manner that educates, offers a support base, teaches skills, and allows for fun. In order to keep children's attention and make the process fun, groups should be active. Well facilitated groups focused on children of alcoholics have many potential benefits including increasing self-esteem, and helping children adjust positively to their family situation. The content of the small group sessions is beneficial to all children whether or not they are personally dealing with an alcoholic parent (Emshoff, 1990).

Since children living in alcoholic homes often exhibit problems at a young age that can continue throughout life, early identification and intervention is ideal. Early intervention can provide these children with healthier psychosocial development and possibly reduce the inevitable negative impact of living with alcoholic parents (Biek, 1981). Since preschool years are often believed to be extremely important for establishing a foundation for adulthood, these years seem to be ideal for starting treatment. However, at this young age these children are difficult to identify because they have not yet developed the communication skills necessary to talk about the problem. By the teenage years psychological symptomology is

already common (Roosa et al., 1990). It seems appropriate then to focus on preteen children for identification purposes. Although problems are already developing by the preteen years their maladaptive behaviors are not too ingrained and by now they have the cognitive ability to understand parental alcoholism (Roosa et al., 1990). A study by Roosa et al. (1990) showed that children from ages 9 to 13 responded remarkably well to the self-referral identification process.

Within the preteen years the age range is best restricted to children of similar developmental abilities. Although young preteen groups (for example seven, eight, and nine year-olds) are capable of doing similar activities and learning the same coping skills as older preteen groups (for example 10, 11, and 12 year-olds), by separating the ages maturational levels become more uniform. This way the leader can best serve one specific age group rather than try to accommodate all ages (Robinson, 1989). Regardless of which ages are ultimately included, the leader must tailor the group to meet the developmental needs of the children involved (Robinson, 1989).

Small counseling groups consisting of seven or eight participants are preferable. This number is large enough to operate as a group with plenty of interaction among members (Yalom, 1985), yet small enough to facilitate group

cohesion, allow for safe disclosure of feelings and experiences, and for the leader to give each child plenty of attention and feedback (Roosa et al., 1990).

Sessions of 90 minutes each would be appropriate for this type of preteen children's group. Some researchers believe group counseling sessions should be shorter for children this age given their attention span and social maturity (Ohlsen, Horne, & Lawe, 1988). However, if emphasis is placed on active techniques and sufficient time is to be provided for fun activities a full 90 is necessary. It is assumed that if emphasis is placed on activity and fun children's interest will be maintained longer than if emphasis is on verbal counseling techniques.

Having two group leaders would allow each child more individual adult attention, something most children being raised by an alcoholic do not get much of at home. This complete attention from two adults may be therapeutic in itself. The leaders must continually reinforce members efforts and accomplishments and behave as positive adult role models (Roosa et al., 1990).

Joining the small counseling group is completely voluntary and children are not required to disclose whether they are in fact living in a home with an alcoholic. Some children from alcoholic homes may participate, but choose not to self-identify. Although these children will

consequently not receive additional help with their problem, the seeds have been planted. Regardless of whether they choose to self-identify, these children may be significantly helped by being exposed to information regarding the impact of alcohol on their lives, and by having been taught valuable skills which will help them survive in a difficult environment.

Summary

Being raised by an alcoholic parent is one of the most widespread, stressful living conditions children endure. This chapter discussed the chaotic home life that exists in alcoholic families and the problems children growing up in these families consequently experience. Several methods used for identifying children from alcoholic homes were briefly explained. The self-selection process of identification was explored in detail. An explanation for the use of large discussion groups and small counseling groups as part of the self-selection process were given. Information regarding potential group format and content was also included.

CHAPTER 3

PROCEDURES

This chapter was written to provide a detailed description of the procedures developed in order to complete this study. Specific information regarding the study's population, instrumentation, methods, and design will be included. The procedures are presented with enough detail so this study may be accurately replicated in the future.

Population

The target population to be included in the large general discussion group consisted of male and female children between the ages of 9 and 13. All participating children were members of youth recreation programs in the Southwest. Only children with signed parental consent (Appendix A) and children's assent (Appendix B) forms were allowed to participate in the study. There were three large discussion groups of approximately 20 children each from which children volunteered to join small groups.

Instrumentation

This study utilized two methods for obtaining the data that was used to determine the usefulness of the self-selection process for identifying children living in alcoholic homes. These methods, the children's version of the Children of Alcoholics Information Test (COAT) and verbal self-report, are discussed in this section.

The children's version of the COAT (Appendix C) is composed of 25 sentences which children read and respond to based on whether they agree, do not know, or disagree with the statement (Robinson, 1989). It was designed to measure the test taker's knowledge of the types of issues children with alcoholic parents face (Robinson, Post, Webb, & Smith, 1990). The instrument was developed based on ten key points that can help children cope effectively with parental alcoholism. It was created to be administered either individually or in groups with children ages nine and older (Robinson, 1989).

The children's version of the COAT has been used in psychoeducational programs to measure the effectiveness of the program curricula (Robinson, 1989). By administering the COAT at the beginning of the group and then again at the end of the group, the following questions would be answered: What knowledge did children already possess on the subject? What information were they in need of? How much did they learn from the group?

Due to the nature of the study, the main objective was to document the number of children who were from alcoholic homes. In order to make the identification process nonstigmatizing and nonthreatening, the self-selection method of identifying children living in alcoholic homes requires that children decide for themselves whether to

disclose their family secret. Therefore, in order to determine the number of participating children who were living with alcoholic parents, the study depended on verbal self-report during the course of the group. According to Corey (1990), by the working stage of a group most members have developed enough trust to risk the self-disclosure of this type of threatening personal material.

The COAT was designed with an internal reliability scale to determine how carefully children responded to the questions (Robinson, 1989). A high score on the scale verifies that the child has read and consistently answered the test questions. The test-retest reliability of the COAT is .76 after a two week interval suggesting that it is a reasonably consistent measure over time. Results of a pilot study indicate that the children's rendition of the COAT is a reliable and valid measurement of knowledge of familial alcoholism (Robinson, 1989). Permission to use the COAT in this study was granted by Bryan E. Robinson (Appendix D).

Due to the uniqueness of the self-selection identification process, information on reliability and validity is scarce. With regard to validity, one study by Gensheimer, Roosa, and Ayers (1990), found that "the self-selection approach was partially effective in sparking the interest of at risk children" (p. 719).

Although no research was found on the reliability of children's self-disclosure of parental alcoholism, studies have been done on the veracity of children's disclosures of sexual abuse. This research shows that false allegations are infrequent and represent only 1% to 4% of complaints (Faller, Froning, & Lipovsky, 1991). Faller (1984) suggests it is important to realize that children place themselves in considerable jeopardy by admitting to molestation because the entire family becomes disrupted and shamed. For this reason it is not in children's best interest to fabricate stories about being molested. Similarly, children would not be motivated to falsely admit to familial alcoholism because of the stigma and shame it would place on them and their families.

Procedures

Prior to starting the data gathering process, this study was approved by the University of Arizona's Human Subjects Committee. Once approved, arrangements were made with various recreation programs in the Southwest to use their facilities and members in the study. A brief presentation was done at each recreation site in order to invite children who met the participation criteria to join a large discussion group on alcohol in the family. Information regarding what members should expect from participating and the benefits of participation were

discussed. It was emphasized that participation would be voluntary and confidential, and that members reserved the right to withdraw at any time. At the end of the presentation parental consent forms were distributed for all interested children to have signed by a parent and returned prior to the scheduled group discussion date.

A one and one-half hour presentation was planned for each large group of children. This time frame was expected to allow sufficient time to cover the lesson plan. A short break was included to give the children a chance to stretch, since one and one-half hours is a fairly long time to expect children to remain attentive.

The group content included lecture, film, group discussion, and handouts. A variety of teaching modalities were employed in order to maintain children's interest. Decisions regarding the type of material to include in the discussion group were made based on suggestions found in the literature and discussions with professionals.

A brief introduction and welcome started each large discussion group. This was directly followed by the first administration of the children's version of the COAT. The COAT took approximately ten minutes to complete then the film, Lots of Kids Like Us, was shown. This film was chosen because it is an excellent introduction for children to the effects of alcohol on families (Robinson, 1989). This film

uses children in a camp setting to educate viewers on the problem of alcoholism in families and to highlight some of the crises these children commonly experience.

The remainder of the large group was more lecture/discussion oriented. General concepts presented included:

1. Alcoholism is a family illness.
2. Children with parents who drink too much are not alone.
3. It is okay to talk about familial alcoholism with friends of trusted people.
4. Alcoholism versus responsible drinking behavior.
5. Common characteristics of children growing up in alcoholic homes.
6. Consequences of having a parent who drinks too much.

This discussion was designed to help children understand alcoholism and its effects on families and to help them see that children with alcoholic parents need and deserve help even when the alcoholic refuses it for him/herself. The large group presentation was developed based on a compilation of information from related literature (DiCicco, 1981; Furrow, 1982; Gensheimer, Roosa, & Ayers, 1990; Morehouse, 1979; Robinson, 1989). A detailed

description of the large group presentation is provided in Appendix E.

At the end of the group discussion time was set aside to make children aware of the community resources available for the alcoholic and the family of the alcoholic. It is important that the children know how and where to get help if they decide they need it after this type of presentation. A written list of community services available to children and families was provided for participants (Appendix F).

After the presentation was completed the COAT was administered for the second time. Before the group was excused, members were invited to attend a small group to be scheduled for another date and time to discuss the same subject matter in more detail. It was stressed the group was not for children in alcoholic families, but for all interested children. This way children would not fear being labeled by simply volunteering for the small group. Volunteers were asked to stay a few extra minutes to arrange the time and place for the first meeting.

The small counseling groups were designed to continue educating participants about alcoholism in families, facilitate in the expression of feelings, increase social support and self-esteem, develop appropriate coping skills, and to have fun. To meet these objectives various methods were employed including; discussion, role-playing, art

therapy, family sculpting, and games. The small group curriculum was established based on suggestions found in the literature regarding the needs of children living with alcoholic parents (Brown & Sunshine, 1982; Emshoff, 1990; Hawley & Brown, 1981; Roosa, Gensheimer, Ayers, & Short, 1990). Although specific activities and topics were planned for each session (Appendix E) the group focus always remained flexible to the particular needs of its members.

The actual process of identifying children from alcoholic homes started at the beginning of the small groups. The main objective of these groups was to document the number of children who joined who were indeed from alcoholic homes. At this point, the researcher did not know how many children would volunteer for the groups. It was decided that if more children were interested in the small groups than could be adequately handled, two groups would be scheduled and participants would be randomly placed in one of the groups. The small groups were an hour and a half each and met once a week for 5 weeks. Small group participants were given the COAT a third time at the end of the last group.

Data Analysis

This study utilized a descriptive research design. There was no attempt to control or manipulate variables for ethical reasons because the research involves a very

secretive and personal subject, familial alcoholism. This type of research is limited by the clients' right to privacy (Hopkins & Antes, 1990). The study explains and implements a unique identification process then examines the data gathered to determine the efficacy of the procedures.

Data will be analyzed by comparing the percentage of children in the study who identify themselves as being from alcoholic homes to the percentage of children estimated to be from alcoholic homes in the general population. Individual COAT scores will be calculated for each child. Pre-group and post-group scores will be compared to determine if children learned information from the presentation regardless of whether or not they joined a small group. A mean COAT score will be calculated for the entire group to discover the amount of knowledge participants acquired on the average. All of this information combined will help determine the efficacy of the self-selection identification process in recreational facilities.

Summary

This chapter outlined the methods which were designed to gather the data for this study. Children from recreation programs in the Southwest who met the participation criteria were included in the study. The use of self-report measures and the children's version of the COAT were discussed along with their respective reliability and validity. Specific

procedures regarding the development and content of the large discussion group and small counseling groups were outlined. Finally, the descriptive design of the research study and the non-statistical data analysis were briefly explained. The next chapter will describe what actually happened in the data gathering process and the results of the study.

CHAPTER 4

RESULTS

This chapter will report the findings obtained from the research. First, the recreation sites used to recruit the sample and the sample itself will be described. Then the results regarding participation during various phases of the research, including the number of children who chose to disclose familial alcoholism, will be given for each site before being combined into overall results. Finally, the results of the COAT will be presented for each separate site and for the entire sample.

Population

The sample of children used for this study were recruited from recreational settings in the Southwest. A wide variety of different types of settings could potentially be described as recreational; such as Boys and Girls clubs, YMCA programs, Girl Scouts and Boy Scouts, church youth groups, day camps, summer camps, after school programs, and sports programs. The researcher wanted to include a few of the different types in the study. The specific sites that were chosen each had a program director who was supportive of the research and the site served a comparatively large number of children within the specified age range.

The first recreation site chosen for the study was a YMCA after school program. The program takes place on school grounds, but it is facilitated solely by YMCA staff. It is designed to care for children during the late afternoon hours while their parent(s) are at work. The program consists mainly of unstructured, supervised play. Participants in this program are both boys and girls and range in age from six to twelve, however only those nine and over were eligible for the study.

The second site was a Girl Scout troop. This particular troop meets after school once a week on the grounds of the elementary school the members attend. Although it meets on school property it is considered completely separate from the school. This group is designed to teach girls leadership and decision making skills. Members participate in organized activities such as games and art projects. Members of this group were all female and ranged in age from six to eleven, but again only those nine and over were eligible for the study.

The final recreation site was the junior high youth group of a Jewish congregation. Members of this group meet one evening a week at the temple. Participants socialize and play games, as well as organize fund raisers and other events for the congregation. Members of this setting were both male and female and ranged in age from 12 to 14.

In the first recreation setting, the YMCA after school program, ten children met the criteria for participation and all ten requested permission forms. Six of these children returned signed permission forms and attended the large discussion group. All six decided to join the small counseling group also. Six of the ten eligible children claimed to have an alcoholic parent.

Similarly, ten members of the Girl Scout troop met the eligibility requirements. Eight of them requested permission forms. Two were returned signed and both of these girls participated in the large and small groups. Five of the Girl Scout troop's ten eligible members identified themselves as from alcoholic homes, even though many did not obtain parental permission to participate in the study.

Finally, 20 members of the junior high youth group met the eligibility requirements and 15 permission forms were distributed, nine of which were returned signed. Seven children attended the large discussion group, and five planned on joining the small counseling group, but only four actually attended. None of the 20 eligible participants identified themselves as from alcoholic homes, although one disclosed that an uncle has an alcohol problem.

Combining all three recreational settings there were a total of 40 eligible children and 33 of them were interested

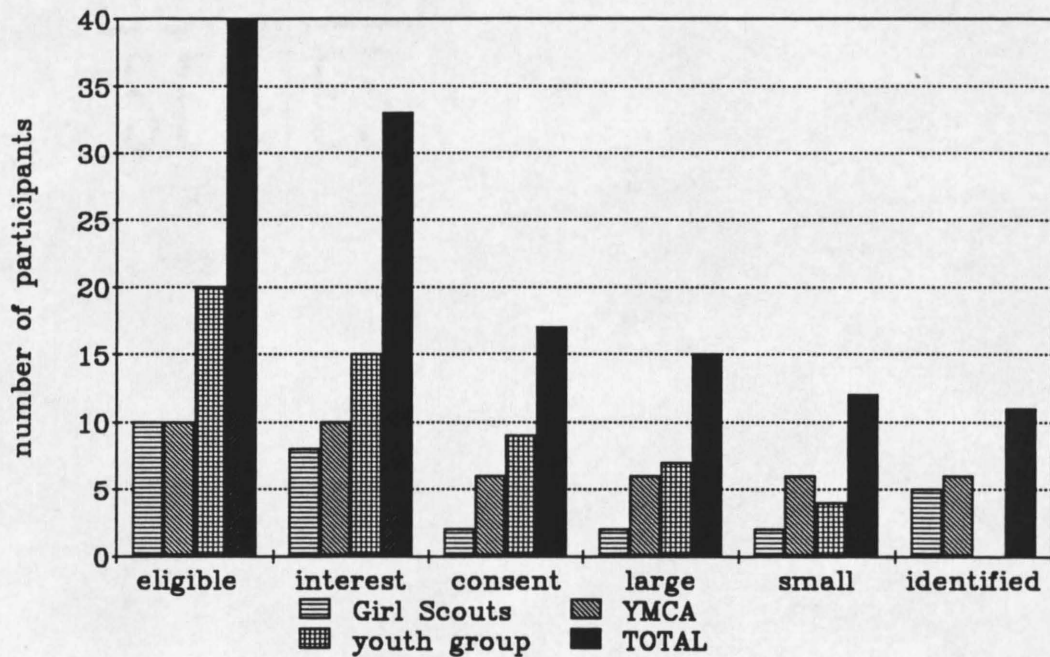
enough to obtain parental permission forms. Seventeen of these forms were signed by parents and returned to the researcher. Fifteen children participated in the large discussion groups and 12 of the 15 chose to continue in the program by joining the small counseling groups.

Of the original 40 children, eleven identified themselves as having alcoholic parents. All eleven were members of either the YMCA or Girl Scout groups. Only six of these eleven children obtained the permission necessary from their parents in order to participate in the study. The other five identified themselves as being from alcoholic homes during a brief presentation designed to invite children to participate in the study and to distribute parental consent forms to those who were interested prior to the beginning of the research process. Although all five expressed interest in the program, they were unable to secure the parental consent needed to participate.

In terms of percentages for the entire sample, 83% of eligible children had enough interest in the program to request parental consent forms, 43% returned signed consent forms, 38% attended the large discussion group, and 30% joined the small counseling group. Forty-eight percent of the children who showed interest in the program (by obtaining parental consent forms) did not return signed consent forms. Of the children who returned signed forms,

88% attended the large discussion group, and 70% chose to join the small counseling group. In the YMCA group and the Girl Scout troop, 100% of the children who secured parental permission joined both the large and small groups.

**Table 1: Participation of Children
by group and phase of study**



Fifteen million (McElligatt, 1986) of this country's 63 million children (U. S. Census Bureau, 1990) are affected by parental alcoholism. Using these figures it is calculated that approximately 24% of children are living in homes where parental drinking is a problem. This means that of the 40 children eligible for this study 9 or 10 would be expected to be from alcoholic homes. The actual results revealed

that 11 children (28%) self-identified as having alcoholic parents. Since all of the children who self-identified were members of the YMCA or Girl Scouts, this means that 55% of the eligible participants from these two settings disclosed parental alcoholism. Of the 17 children who received parental consent to participate in the study, six (35%) identified themselves as having alcoholic parents. Interestingly, this means 65% of the group members were not known to be dealing with problems of alcohol in their families, but chose to participate in a group about alcohol and families instead of attending their usual recreational programs.

Instrumentation

The children's version of the COAT (Appendix C) was administered to determine the amount of knowledge children had on the subject of familial alcoholism before the study, how much they learned from the large discussion groups, and how much knowledge was retained over several weeks during the small counseling groups. To simplify the presentation of the results of the COAT the first administration prior to the large discussion group will be referred to as the "pre-test", the second administration following the large discussion group will be referred to as the "post-test", and the third administration following the five week small

counseling group will be referred to as the "final-test". All scores are based on a total of 100 points.

The decision was made to drop five of the COAT's original 25 questions; numbers 3, 4, 11, 12, and 15. These questions were frequently and consistently answered incorrectly by participants, whether they had disclosed living in a home with an alcoholic parent or not. Possibly because they are written in the first person, it is difficult to tell whether these five questions should be answered based on how a child in an alcoholic family probably feels or how they ought to feel. All COATs that had internal reliability scores below 60% were excluded from the results.

Few participants were present for all three administrations of the COAT. Some members either came late or left early from the large discussion group and consequently did not take both the pre- and post-administrations of the test. Others did not take the final-test because they chose not to join the small counseling group or because they were absent or left early from the last small counseling group during which the final administration was completed. Of the 15 large group participants, 13 completed the pre-test and 14 completed the post-test administration of the COAT. Only 6 of the 12

members of the small counseling group completed the final-test administration.

Because the same participants did not take each administration of the COAT it was decided that two separate mean score calculations for the post-test would be needed in order to compare the results of the post-test to other administrations without distorting the data. To calculate the first mean the post-test scores from all participants who also had pre-test scores would be used. By comparing this mean to the mean of the pre-test scores it could be determined how much was learned from the large discussion group. The second mean was calculated using only the post-test scores of participants who also had final-test scores. This mean can be compared to the mean of the final-test scores to determine the amount of knowledge retained over a several week period during the small counseling groups.

In the YMCA group one participant's scores were dropped due to low reliability. Another member had to leave the large discussion group early and therefore did not have a post-test score. Among the four remaining members, pre-test scores ranged from 35 to 70 with a mean of 50. Post-test scores ranged from 75 to 85 with a first mean of 79. The score change from the first to the second administration ranged from +15 to +40 with a mean increase of 29 points.

Only three of the six members of the YMCA group were present at the time the COAT was administered for the final time. The final-test scores ranged from 65 to 85 and the mean was 77. The second post-test mean was also 77. The change in scores from the post-test to the final-test was 0.

In the Girl Scout troop each of the two members completed the pre and post-test. Pre-test scores ranged from 45 to 50 with a mean of 48. Post-test scores ranged from 70 to 80 with a first mean of 75. The score change from the first to the second administration ranged from +20 to +35 with a mean increase of 28 points.

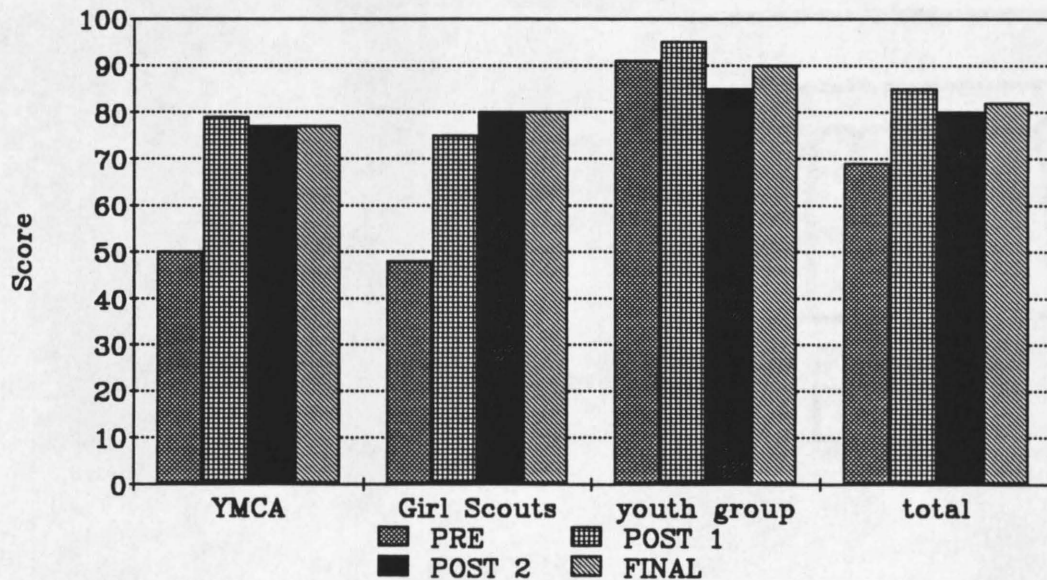
Only one of the two members of the Girl Scout troop attended the last group when the COAT was administered for the final time. This member scored 80 on the final-test, the same as on the post-test. Therefore, the second mean for the post-test was also 80 and the mean change in scores from the post-test to the final-test was 0.

In the youth group, two members arrived late so they did not have pre-test scores. For the remaining five participants the pre-test scores ranged from 85 to 95 with a mean of 91. Post-test scores from 85 to 100 with a first mean of 95. The score change from the first to the second administration ranged from -10 to +10 with a mean score increase of 4 points.

Two of the four members of the youth group were present for the last group. The final-test scores ranged from 80 to 100 and the mean was 90. The second post-test mean was 85. The mean change in scores from the post-test to the final-test was an increase of 5 points.

Overall, pre-test scores ranged from 35 to 95 with a mean of 69. Post-test scores ranged from 70 to 100 with a first mean of 85. The score change from the first to the second administration ranged from -10 to +40 with a mean score increase of 17 points. The final-test scores ranged from 65 to 100 with a mean of 82. The second post-test mean was 80. The mean change in scores from the post-test to the final-test was an increase of 2 points.

Table 2: Average COAT Scores
by group and test



Summary

This chapter reported the findings obtained from the research. The recreation sites which were used in the research and the sample of children recruited from each of the three different sites were described. The findings regarding participation and the results of the COAT were provided for each location and for the study as a whole. The next chapter will discuss the conclusions and recommendations which can be drawn from the results and will summarize the importance of this study.

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS, AND SUMMARY

Conclusions

This study successfully implemented the self-selection process for identifying children from alcoholic homes in recreational settings. Children in the recreational settings seemed anxious to talk when the subject of familial alcoholism was raised. An astonishing number of children voluntarily gave up precious recreation time to discuss the effects of alcoholism on families.

Bringing up the topic of parental alcoholism in a safe environment is enough to break down the wall of silence and allow children, possibly for the first time, to disclose their own personal situation regarding alcohol and their family. Surprisingly, many children in this study identified themselves as being from alcoholic homes after only a five minute presentation intended to inform children about the study and invite them to participate. In fact, all of the children who ultimately identified themselves as having alcoholic parents did so early in the self-selection process, by the end of the large discussion group. This suggests that many children are ready and waiting to talk as soon as they feel permitted.

The results of this study also suggest that children, particularly those under the age of 12, are in need of

information regarding alcohol and its affects on families. When this information is presented to them, children are able to learn a considerable amount in a short period of time and retain this knowledge over a period of several weeks. All of the children involved in the study regardless of whether they were known to be living in an alcoholic home learned valuable information regarding alcoholism. The information learned may not directly and immediately benefit children who are not experiencing alcohol problems in their families, but it may help them to assist a friend with a family alcohol problem or make a more informed decision about their own alcohol use in the future.

The self-selection process appeared to have greater success with the children from the Girl Scout troop and the YMCA group. Results of the first administration of the COAT for children in these groups revealed a need for a great deal of information about the effects of alcohol on families. Consequently these children also learned more from the large discussion group than the children from the youth group.

Children from the Girl Scouts and the YMCA also seemed more interested in the topic. A greater percentage of these children obtained permission forms and of those who returned them signed every child remained in the program until the end, as opposed to less than half of the children from the

youth group. In addition, all of the self-disclosures of familial alcoholism came from children in the Girl Scout and YMCA settings.

There are two significant differences between the YMCA/Girl Scout groups and the youth group which could explain the variance in the results obtained. The first is the youth group was a religious group. In a religious setting, where the entire family often has membership, participants may be less willing to discuss a personal family problem such as alcoholism. The second is an age difference. The participants from the YMCA and Girl Scout groups ranged in age from 9 to 12, while participants from the youth group were 12 to 14. It seems logical that younger children would have less knowledge of alcoholism than older children.

Although this study did not specifically look at gender differences in terms of the success of the self-selection strategy, unofficial observation indicated a fairly equal representation between male and female children throughout the process, with exception of the Girl Scout troop. This conflicts with a study by Gensheimer, Roosa, and Ayers (1990) whose participants were mostly female.

By testing the self-selection strategy in recreational settings the researcher discovered that this method of identifying children from alcoholic homes could be

successfully used outside of the traditional education setting. In fact, the percentage of children from all of those eligible who were interested in attending the small counseling group matched exactly that of the results of Furrow's (1982) study in the educational setting and succeeded in identifying an even greater percentage of children believed to be from alcoholic homes. However, in addition to determining its value, this study made several problems associated with the use of self-selection procedures in recreational setting salient.

For several reasons, it was extremely difficult to find recreational settings to utilize as research sites. First of all, not all recreation programs are conducive to running a six week program. For example, recreation facilities such as Boys' and Girls' clubs are organized in a kind of open door manner in which members may not attend at regularly scheduled times each week. Many programs which offer more structured schedules meet in small groups and may include a diverse spectrum of ages. For example, Girl Scouts meet in small troops all around town and after school recreation programs include children from kindergarten through age 12. This process can still be applied to these programs, but many groups would be needed if a large number of children were to be reached or transportation would need to be arranged in order to combine small groups into larger ones.

Lastly, the directors of many recreation programs, especially church youth groups, are apparently unaware of the prevalence of alcoholism in families. Many think that their facility does not have a need for such a program because they mistakenly believe they do not have any children from families with alcohol problems.

Since it was difficult to find large groups of children who met participation requirements it was decided that the 14 year old children from the youth group would be allowed to participate. The ages could not be expanded any lower to include more children from the Girl Scouts and YMCA groups because of the age nine reading level of the COAT. However, many younger children did approach the researcher and request to participate in the study.

Once suitable recreation sites were chosen and plans were made to start the groups a second problem arose. The recreation sites used in this study did not have facilities available which were appropriate for running counseling groups. The group leaders made the best out of rooms which were much too large, filled with distractions, and not very private.

Attendance is another problem encountered when implementing self-selection programs at recreation sites. Unlike school, attendance is not mandatory in recreation programs. Consequently members sometimes arrived late or

were picked up early by their parents, or would be absent completely. This was more of a problem in the YMCA after school program than the others.

Probably the most significant problem with this study was the ability of children to obtain written parental consent. Although the wording of the Parental Consent Form was as nonthreatening as possible, because of regulations by the University of Arizona's Human Subjects' Committee the form disclosed more information and as a result was more threatening than was recommended by other researcher's who have worked with this population (Biek, 1981; DiCicco, 1981; Emshoff, 1990).

Two of the five children who disclosed familial alcoholism and obtained parental permission had parents who were receiving treatment for alcohol abuse. Children who have a parent(s) who is actively drinking and in denial about their problem may fear asking their parent for permission to join a group about alcoholism or have parents who are more likely to refuse permission. It appears that the need for parental consent inhibited a large portion of the target population from participating in the program.

On the other hand, many children not known to be living in alcoholic homes received parental permission and joined the groups. Although this corresponds with the results of similar studies completed in school settings (Furrow, 1982;

Gensheimer, Roosa, & Ayers, 1990) it is unknown why so many children would be willing to give up play time to discuss familial alcoholism if they are not dealing with such a problem in their home. It is possible these children are faced with other types of family stresses and believe that information on life in an alcoholic home may be relevant to their situation as well. Although none of the members of the religious youth group disclosed familial problems with alcoholism, all of them had concerns about the alcohol and drug use of classmates and friends.

Overall more children than statistically expected disclosed problems with parental alcoholism, especially in the YMCA and Girl Scout groups. It was emphasized in the brief presentation before the groups began that *anyone* could participate regardless of whether they had alcoholic parents. Hence, a misunderstanding that they must be living with alcoholic parents as a prerequisite to participation was not likely to have caused false disclosures. This leaves the question of whether or not these children understood the meaning of alcoholism, especially since about half made their disclosure prior to the large discussion group on alcoholism and its effects on families.

Recommendations

Thus far, this chapter has suggested many conclusions which can be drawn from the results of the study. Based on

these conclusions this part of the chapter will outline several recommendations regarding future research, training programs for all types of professional who work with children, and government policy.

More research needs to be completed on identification procedures for children living with alcoholic parents. Research using this process in similar types of recreational settings is needed to validate this study. It should also be tested in other types of recreational settings to determine which ones are the most appropriate. The ideal age for the use of the self-selection process needs to be studied further. Procedures to adapt this process for use with younger children should be developed and other types of identification strategies experimented with for use with all ages.

Although the small counseling groups were valuable for teaching children coping skills, they may be unnecessary for the identification process itself. Research is needed to determine if a large discussion group alone could serve identification purposes. This would shorten the process so it could be applied to a wider variety of recreational programs. If an abbreviated program is developed it would be important to have a good referral system in place, so children have support available once they make their self-disclosure.

Longitudinal studies should be completed to study the long term benefits of early identification and treatment of children from alcoholic homes. The type of support and guidance for children living in alcoholic homes that is most useful in alleviating social, emotional, and alcohol problems in adolescence and on into adulthood needs to be investigated.

It is recommended that mandatory training programs are developed for all professional staff who work with children. This includes not only recreation facility staff, but also counselors, social workers, juvenile law enforcement agents, physicians, nurses, and educators, and clergy. It seems the prevalence of the familial alcoholism is greatly underestimated in all professions. These training programs need to educate professionals on the problems associated with parental drinking, teach them the signs to look for in children and families that suggest that alcoholism may be a problem, and familiarize them with the community resources available to help these families.

Professionals must learn that because of the secretism and denial surrounding alcoholism, the subject will not likely come up unless they bring it up themselves. They must be taught strategies of approaching the subject that will lessen the fear professionals often feel about bringing up such a difficult topic. The more professionals who are

aware of the problems caused by parental drinking and understand the signs to look for, the greater chance children will have of being identified so the silence can be broken and children at risk can be helped.

It is recommended changes be made in governmental policies that require children to have parental permission in order to receive counseling services. Further, laws need to be developed to protect professionals and agencies who wish to offer services to children in need without parental involvement. Many children who need and are ready to accept support and assistance to deal with difficult family issues are denied the right to services which are vital to their healthy psychological development simply because they are unable to obtain parental permission. The denial around alcoholism is part of the disease, so many parents will not help their children to receive outside services. These children should not be punished because of their parent's affliction.

Most importantly, it is recommended the self-selection process and other programs designed to identify children from alcoholic homes be perfected and implemented, not just researched and discussed. Developing and studying quality programs does not ensure they will be utilized as intended, to reach those in need. Researchers, counselors, and other professionals who are informed about familial alcoholism and

identification procedures must take responsibility for educating others and implementing identification programs within their community or organization. Professionals must begin taking responsibility for identifying the many children in their setting who need help surviving life in an alcoholic family with as few scars as possible.

Summary

Parental alcoholism has devastating and enduring effects on children and families. Children raised by alcoholic parents face more than their share of problems with little support. These children commonly suffer cognitive, emotional, and behavioral consequences, and face an increased likelihood of becoming alcoholic themselves. Regardless of the numerous enigmas associated with familial alcoholism, these children are difficult to identify and frequently remain unnoticed and unhelped. Since it is difficult, if not impossible, to tell which children will ultimately be the most negatively impacted by parental drinking, it is imperative they all be identified and treated at a young age.

Self-selection is an innovative strategy developed to identify children from alcoholic homes in a nonthreatening and nonstigmatizing manner. This method combines an educational format with the use of groups to teach coping skills and reduce the stigma and isolation surrounding

familial alcoholism. The objective is to create an atmosphere in which children feel comfortable disclosing their problem and discussing their distress with others, often for the first time. This method teaches all interested children important information, including those who are from alcoholic homes, but are too guarded to identify themselves and those who are not from alcoholic homes, but will someday be confronted with an alcohol related concern of their own or of a friend.

Schools have traditionally been left with the responsibility of identifying children from alcoholic homes. Prior research has demonstrated the success of self-selection programs designed for identification purposes in educational settings. Schools may seem to be the ideal location for identification programs to be implemented because they have the advantage of reaching the greatest number of children. However, in the educational setting there is also the greatest danger of a child becoming negatively labeled by teachers and personnel whom they see on a daily basis over a long period of time.

The results of this study conclude that the self-selection process can be an effective tool for gaining access to this hard to reach population in recreational settings as well as in schools. Thus, schools no longer have to take sole responsibility for identifying these

children. Based on the number children from alcoholic homes identified by this study, recreational settings may be less threatening environments than schools for children to discuss personal family issues. Of course, as described in the conclusions above, recreational settings have problems of their own when it comes to facilitating identification strategies within them. Nevertheless, by establishing identification programs in recreational settings in addition to school settings, a greater number of children in need will be reached.

Despite the fact this population is difficult to reach, there are programs, such as self-selection, which can successfully identify children who are ready to receive help with familial alcoholism. Helping children with alcoholic parents understand and cope with family problems is an important step in the prevention of future alcoholism as well as a plethora of other related problems. All places where there are children need to be involved in the process of identifying, referring, and treating at risk children. The identification of children from alcoholic homes must not be made secondary to treatment of the parents' problem. There is great wisdom in intervening with children from alcoholic homes early instead of waiting for serious consequences to develop.

APPENDIX A
PARENTAL CONSENT FORM

PARENTAL CONSENT FORM

My name is Rachelle Booth. I am a graduate student in the Counseling and Guidance department at the University of Arizona. My master of arts degree curriculum includes the writing of a thesis. The research being conducted for this thesis is designed to assess the usefulness of alcohol prevention programs in recreational settings. The study has two parts. For the first part a large group of children is needed to volunteer to participate in a general discussion on families and the affects alcohol can have on them. This discussion will last approximately 2 hours. Participants in the second part of the study will be children who attended the large discussion group and are interested in continuing to discuss the same topics in a small group. The small groups are designed to increase participants self-esteem and teach coping skills which are essential to the healthy development of children. These small groups will last approximately 8 hours and will be broken into 5 one and a half hour sessions. All groups will be facilitated by a trained graduate counselor. The identity of all children will be kept confidential in reporting results of the study. However, should your child report or indicate that he/she has been abused, by law, the information shared by the child as well as his/her identity must be reported to Child Protective Services or the police.

I _____ (parent/guardian) give permission for my child _____ to participate in both parts of the research study described above which includes discussion on families and the affects that alcohol may have on them. I understand that my child's identity will be kept completely confidential, except in the case that my child reports or indicates he/she has been abused. I also understand that my child may withdraw from participating at any time.

 Parent/Guardian Signature

Date

APPENDIX B
CHILDREN'S ASSENT FORM

CHILDREN'S ASSENT FORM

(To be read to children)

My name is Rachelle Booth. I am a graduate student in Counseling and Guidance at the University of Arizona. I am doing a study to find out how useful alcohol prevention programs are in recreational settings.

I will talk to you about alcohol and what it can do to families, then ask you if you would like to be part of a small group to talk about this subject more.

If you do not want to talk, you do not have to. If you decide you do not want to be in the study anymore, you can drop out at any time.

I will not let anyone know what you talked about. I will not even tell anyone that you were in my study.

The things that we talk about are interesting and may be helpful to you. I want you to be in my study.

Child's Name - signed by self

Date

Witness

Date

APPENDIX C

COAT

Children's Version of the COAT

_____Age _____Sex _____Date _____Initials

Below are 25 sentences about children whose parents drink too much. Read each one and answer "yes", "no", or "don't know" beside each sentence. Put an X under "yes" if you agree with the statement, an X under "no" if you disagree, or an X under "don't know" if you are not sure of the answer.

Yes No Don't
Know

- | | | | |
|-------|-------|-------|---|
| _____ | _____ | _____ | 1. Alcoholism is a disease. |
| _____ | _____ | _____ | 2. Alcoholism hurts everybody in the family, including the alcoholic's children. |
| _____ | _____ | _____ | 3. Sometimes I feel that I am the cause of my parent's drinking. |
| _____ | _____ | _____ | 4. I feel alone, like I'm the only person in the world with problems because their parent drinks too much. |
| _____ | _____ | _____ | 5. I can help my parent stop drinking by doing good in school and helping out around the house. |
| _____ | _____ | _____ | 6. Children should not talk to others outside the family about their parents drinking. |
| _____ | _____ | _____ | 7. The best way to deal with my parent's drinking is to look on the bright side and pretend it isn't happening. |
| _____ | _____ | _____ | 8. When parents drink, it hurts the kids and everybody in the family. |
| _____ | _____ | _____ | 9. I know how to take care of myself if my parent drinks too much and gets angry and upset. |
| _____ | _____ | _____ | 10. Children whose parents drink too much sometimes pretend nothing's wrong when there really is, but this is their way of hiding their feelings. |
| _____ | _____ | _____ | 11. It is hard for me to get close to other people. |
| _____ | _____ | _____ | 12. Sometimes I feel like it is my fault that my parent drinks. |

- | Yes | No | Don't
Know | |
|-------|-------|---------------|--|
| _____ | _____ | _____ | 13. Children will feel better inside when they get help even if their parent doesn't stop drinking. |
| _____ | _____ | _____ | 14. There is a big chance that children of alcoholics will grow up to be alcoholics too if they are not careful. |
| _____ | _____ | _____ | 15. It is hard for me to talk about my feelings. |
| _____ | _____ | _____ | 16. Children with alcoholic parents all behave the same way. |
| _____ | _____ | _____ | 17. There are millions of other children like me whose parents drink too much. |
| _____ | _____ | _____ | 18. It is hard for children of alcoholics to like themselves. |
| _____ | _____ | _____ | 19. I can help my parent stop drinking if I try hard enough. |
| _____ | _____ | _____ | 20. Alcoholism can make children sad, mad, afraid, and confused. |
| _____ | _____ | _____ | 21. Children need to get help for themselves whether or not their parent stops drinking. |
| _____ | _____ | _____ | 22. Children should not talk to others outside the family about their parent's drinking. |
| _____ | _____ | _____ | 23. It helps to have someone to talk to about your problems. |
| _____ | _____ | _____ | 24. Going to Alateen and Al-anon can help me deal with my parent's drinking. |
| _____ | _____ | _____ | 25. Sometimes children act like nothing's wrong when their parent's drink, but it's just their way of keeping their feelings inside. |

APPENDIX D

PERMISSION TO USE THE COAT



UNC CHARLOTTE

The University of North Carolina at Charlotte
Charlotte, N.C. 28223

College of Education and Allied Professions
Department of Human Services
September 21, 1997
704/547-2171

Rachelle Booth
1628 E. Water Street
Tucson, AZ 85719-3347

Dear Rachelle:

Thank you for your letter of September 15th regarding use of the COAT in your research. I grant you permission to use the test in any research endeavor you undertake. The best version is the one in the book. I don't have a more standardized version to share with you. I am, however, enclosing as per your request an article establishing the test-retest reliability of the instrument.

Thank you for your positive comments on the book. I wish you good luck with your research and hope you will share the results with me.

Sincerely,

Bryan E. Robinson, Ph.D.

Professor

APPENDIX E
DESCRIPTION OF GROUPS

LARGE DISCUSSION GROUP

- A. Introduction / Welcome to group
- B. First administration of the COAT
- C. Show movie - Lots of Kids Like Us
- D. Lecturette on the effects of alcohol on families
 - 1. Alcoholism is a disease.
 - 2. Alcoholism hurts the whole family, including the children.
 - 3. Everyone in the alcoholic family needs and should get help, including the children.
 - 4. Children whose parents drink too much are not alone.
 - 5. Children do not cause, cannot control, and cannot cure their parents alcoholism.
 - 6. There are many good ways that children can take care of themselves when parents drink, so that they feel better about themselves.
 - 7. It is okay for kids to talk about parental drinking to a friend or within the safety of a group.
 - 8. It is healing for children to identify and express their feelings about parental drinking.
 - 9. Kids with alcoholic parents are at high risk of substance abuse themselves.
 - 10. It is important for children to identify and use trusted support systems outside the family.
 - 11. There are many practical ways for children to problem solve and cope with parental alcoholism.
 - 12. Children in alcoholic homes:
 - a. Worry about their parent's health

- b. Are upset by their parent's inconsistent and unpredictable behavior
 - c. Worry about fights and arguments between their parents
 - d. Are scared of parent's angry behavior
 - e. Feel responsible for their parent's drinking
 - f. Are disappointed by broken promises and feel unloved
- E. Brainstorm the difference between alcoholic drinking and responsible drinking.
 - F. Provide participants with a list of community resources available to alcoholics and their families.
 - G. Second administration of the COAT
 - H. Invite participants to join the small counseling group.

SMALL COUNSELING GROUPS
Session 1

- A. Establish group rules.
- B. Discuss the children's ideas regarding the most important or interesting information they learned in the large discussion group.
- C. Ask children what they hoped to learn in the small counseling group.
- D. Do "feelings" activities.
 - 1. Play a charades game with names of feelings.
 - 2. Have participants draw and discuss pictures representing various feelings.
- E. Have participants state positive affirmations about themselves.

Session 2

- A. Review group rules.
- B. Talk about making choices and do forced choice activity.
- C. Do sociogram of drinking attitudes and discuss responsible drinking vs. problem drinking.
- D. Have participants draw a drunk person and a sober person and discuss them.
- E. Do positive affirmations.

Session 3

- A. Discuss problem-solving steps and do examples.
- B. Role play difficult situations.
 - 1. Grandma offers you a sip of wine.
 - 2. New kids tell you that all kids drink beer and they won't be your friend if you don't also.
 - 3. A relative has been drinking and is angry and yelling. You are afraid of getting hit.
 - 4. You are feeling bad and think a drink might make you feel better.
- C. Play a game (participants choice).
- D. Do positive affirmations.

Session 4

- A. Discuss various methods of coping with emotions.
- B. Practice a relaxation technique.
- C. Experiment with ways of expressing anger through clay.
- D. Explain the importance of fun in our lives. Have the groups choose a game to play for fun.

- E. Do positive affirmations.

Session 5

- A. Do a social atom activity to identify each member's support system.
- B. Reiterate the community services available to help children living in alcoholic homes.
- C. Discuss the various roles of children of alcoholics.
 - 1. Responsible One
 - 2. Scapegoat
 - 3. Mascot
 - 4. Adjustor
 - 5. Placater
- D. Summarize and review what we learned from the group.
- E. Do positive affirmations.
- F. Final distribution of the COAT.

APPENDIX F
COMMUNITY RESOURCE LIST

COMMUNITY RESOURCE LIST

Talk Lines: (if you just feel like talking to someone)

Kidline - (open 3:00-8:00 weekdays).....795-8855

Help on Call - (open 24 hours a day)....323-9373

Groups for children and families affected by alcoholism:

Al-Anon - (for ages 12-18).....323-2229

Alateen - (for ages 9-12).....323-2229

Counseling for children and families affected by alcoholism:

Tucson Council on Alcoholism and Drug Dependence
(TCADD).....620-6615

Pima Alcohol and Substance Abuse Rehabilitation
(PASAR).....884-0003

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