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Identification and Intervention Programs for Children of Alcoholics: Implications for Care Providers and Educators

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IDENTIFICATION AND INTERVENTION PROGRAMS FOR CHILDREN OF ALCOHOLICS: IMPLICATIONS FOR CARE PROVIDERS AND EDUCATORS

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INTRODUCTION

Preface

Children of Alcoholics (COA's) are a large population that continues to grow. In research done by Manning (1987), approximately 15 million school-aged COA's were reported to be in the public school system. This figure represents only a portion of the children who are actually affected by parental alcohol use and/or abuse. Many children are not represented in this study because they are below school age or are not in the public school system. In a study done by Lawson, Peterson & Lawson (1983), 28-34 million children were found to be living in homes where alcohol abuse in now, or has at one time been a problem. Reynolds (1987) reported one out of every three persons in the United States came from a family affected by alcoholism.

Statement of the Problem

These statistics suggest that there are a large number of affected children who are not identified as COA's. COA's are difficult to identify and evaluate because alcoholism is often a secret disease. There is a "demand for secrecy", instilled in COA's, this is used to protect the alcoholic in the family (Schall, 1986). This demand causes children to hide their feelings and emotions, they do not discuss their

homes or families with "outsiders" (Schall, 1986). These behaviors are often mistaken for symptoms of other problems and prevent COA's from receiving assistance in handling their stressful lives, within the alcoholic family (Cannariato, 1988). Many COA's that go undetected are of pre-school age. This is because they have limited social contact and are not easily accessed for research. Many children who are COA's come from families of low socio-economic status and are not in pre-school programs (Oyemade & Washington, 1989). This prevents both early identification and intervention for many COA's.

Early identification and intervention is important for a variety of reasons. First, COA's are twice as likely as children of non-alcoholics to develop alcohol abuse, social maladjustment and emotional problems in the teen and adult years (Lawson, Peterson & Lawson, 1983). Second, 52% of alcoholic parents come from families that are plagued by parental drinking problems (Lawson, Peterson & Lawson, 1983). Third, COA's generally feel lonely, isolated and frustrated, they often have very poor self-concepts. These characteristics present a predisposition to emotional, behavioral, and social problems, specifically substance abuse. Early identification and intervention can help children improve their chances of leading a successful, productive life (Oyemade & Washington, 1989).

Unfortunately, most teachers, counselors, and school officials have not been properly trained in the

identification and treatment of COA's (Reynolds, 1987). Undergraduate programs, seldom if ever mention alcoholism or the problems it causes for those influenced by it. Few graduate classes, even in guidance counseling, discuss the subject of COA's and their needs (Reynolds, 1987). A Graduate seminar entitled "Children who are educationally, at risk", taught at SIU does not even discuss the affects of alcoholism on children. COA's are virtually a hidden population that have not been dealt with in the educational system until very recently.

Purpose of the Paper

Some contend that if early intervention occurs, COA's are more likely to escape difficulty in social and emotional adjustment. Therefore, it is essential that teachers and care providers be educated in the identification and intervention process needed to successfully work with COA's.

This paper will examine the characteristics of COA's, the effects of parental alcoholism on the child's development, family dynamics of COA's, recovery for COA's, and inservice training. A model inservice training program for educators and care providers will also be provided.

Next to family, teachers and care providers are the main educators and role models of children. What they teach young children affects them throughout their entire lives. Teachers and care providers can make up the deficit left by alcoholic parents, by providing a stable environment which

will promote growth and success (Oyemade & Washington, 1989).

The goal herein is to bring attention and assistance to COA's who are often left unattended and unable to function successfully in society.

LITERATURE REVIEW

Children of Alcoholics

Characteristics of COA's

The studies of Tharinger and Korarek (1988), Pickens (1984), Cannariato (1988), and Weddle and Wishon (1986) suggest characteristics that are common among COA's. These characteristics may appear singularly or in clusters and are often difficult to identify. COA's have not all had the same experiences, so they do not all have identical problems or needs (Tharinger & Korarek, 1988). If a child displays any or all of these characteristics it is evident that there is a problem. He/she may be a COA or may come from some other type of environment that is causing stress in her/his life. It is important that teachers and care providers be aware of these characteristics and be able to assess the needs of the child. By providing early intervention the child may be saved from future maladjustment.

The six most prevalent characteristics described in these studies are:

1. Suspicion:

   COA's are suspicious of the alcoholic in the family. The alcoholics' behaviors cannot be predicted, therefore the child learns that the adult cannot be trusted. Alcoholic parents make promises

that are broken, argue over minor details and lie about their actions. This teaches the child that parents and other authority figures are unpredictable and are not worthy of the child's trust. This mistrust often continues into the adult life of the COA and causes life long intimacy and relationship difficulty (Cannariato,1988).

2. Feelings of Isolation:

COA's feel alone and isolated from others. The family does not discuss the secret ("Alcoholism" 1986). COA's must learn to cope on their own, they do not have support from parents or peers. This leaves them feeling alone and uncared for. There is often a complete break-down in family communication which when carried into adult life causes maladjustment in social and work situations (Cannariato, 1988).

3. An Overdeveloped Sense of Responsibility / Guilt:

COA's feel guilty and ashamed. They feel responsible for the alcoholics' drinking and the families' problems surrounding the drinking. COA's feel that if they were better children, worked harder or did more to help parents, the drinking would stop. These feelings are often perpetrated by

the alcoholic parent. If the parents can put the responsibility on the child then they do not have to admit their problem. COA's accept this guilt and responsibility and feel selfish when they ask to get their needs met. They often go unfulfilled and are left feeling unworthy of love and affection (Weddle & Wison 1986).

4. Stress Related / Psychosomatic Illness:

Many COA's suffer from ulcers, headaches or depression. COA's hide their feelings, they do not trust, do not talk, and do not feel. These emotions are bottled up and usually surface as an illness. Sometimes illness is the only way COA's can get the attention they want and need. The child finds that if they are ill the parent may take time to care for them. This serves as a positive reinforcer for the COA and causes the behavior and illness to be repeated (Pickens, 1984).

5. Hyperactivity / Inability to Relax:

Because COA's are surrounded by inconstancy and turmoil, they are always on edge, waiting for the next alcoholic episode. Hyperactivity is very common in COA's between the ages of 3 and 13. Most children outgrow hyperactivity by age 16. However adults who suffered hyperactivity as children are

often nervous, tense, and carry a large amount of stress throughout their lives. Children may be faced with physical, emotional, or verbal abuse during the alcoholic parents' drinking. After the episode the parent feels remorseful and is apologetic, the child enjoys attention and love. But the COA is always alert, waiting for the end of the good and the beginning of the bad. COA's must keep their defenses intact to cope with the reality of their environment (Tharinger & Korarek, 1988).

6. Depression:

COA's feel helpless and hopeless. They feel as if their lives are out of control. COA's do not get their basic needs met. Many alcoholic parents allow children to go hungry, to wear dirty clothes and to be unattended for long periods of time. These parental behaviors leave COA's feeling unimportant and depressed. Many COA's have suicidal thoughts and often in severe cases make suicidal gestures or attempts. These children feel trapped in a life that they cannot control or tolerate (Weddle & Wishon, 1986).

These six characteristics are among the most commonly described by research studies. COA's are usually identified by their overt behaviors and often mis-diagnosed. They are treated for the symptoms rather than the cause. These six

characteristics also represent behaviors of children from families of serious health or emotional problems, divorce, or child abuse and neglect. If these characteristics are displayed, but no alcoholism is present in the family the child probably is not a COA. However, the child still needs support. There is always a chance that the alcoholism is well hidden or that the parents themselves are COA's. Parents who are COA's often show the same characteristics as alcoholics, even though they are not drinking (Ackerman, 1983).

The Family Process and Family Dynamics

In an alcoholic family the family members band together to help the person having trouble. This is unhealthy in the alcoholic family even though, it is a healthy trait for "normal" families. Family members cover up for the alcoholic to protect the family from shame. There is an overdeveloped sense of loyalty to the alcoholic, the family "secret" must be kept, no matter what. Children keep their feelings of fear, anger, guilt and loneliness bottled up inside. This is the child's way of preventing further pain ("Children, 1985). Family life in the alcoholic home is inconsistent. There may be times of family harmony but, most of the time the atmosphere is disruptive and disorganized. Some families fall apart. The divorce rate of alcoholic families is 4 to 11 times that of non alcoholic families (Tharinger & Korarek, 1988). If the family is kept intact the roles are often confused and there is constant anxiety (Edwards & Zander, 1985).

Co-alcoholism or co-dependency (Black, 1981,) are terms used to explain the non-alcoholics preoccupation with the alcoholic and his/her behaviors. The non-alcoholic parent often takes on the role of the enabler. The enabler saves the alcoholic from the consequences of their behavior. The enabler or co-dependent takes on the responsibility ignored by the alcoholic (Tharinger and Korarek 1988). This condition combined with alcoholism causes both parents in an

alcoholic family to be inaccessible to children. COA's are deprived of attention, consistent discipline/guidance, and a loving trustworthy environment. Children living in homes where there is constant parental conflict feel confused, guilty, rejected, and isolated (Black,1981)

Family roles and boundaries constantly change and become intermeshed. Behaviors that one day are acceptable may be punished the next. Many roles are reversed, the parent takes on the helpless role while the COA becomes the responsible person and takes responsibility for the alcoholic and the needs of the entire family (Edwards & Zander, 1985).

Black (1981) identifies four roles that children typically adopt in alcoholic families. Children adopt one or a combination of these roles as a way of coping with their environment. These roles set behavior and self-esteem patterns that may predispose COA's to future alcoholic and emotional problems.

1. <u>The Responsible One:</u>

This is the role usually taken by the eldest or only child. The children take responsibility for themselves, siblings, parents, and household chores. These children are usually over-achievers, they excel in school, are "natural" leaders, are goal oriented, and gain control of their lives through their achievements. The strive to maintain

structure and stability in everything they do. This leaves children rigid, serious, distrustful, and hyper-mature. They must always be in control and have great difficulty relaxing, playing and developing lasting peer relationships.

2. The Adjuster:

These children are the ones who seem to "roll with the punches", they adapt to situations and follow directions easily. Adjusters are flexible and can go from one extreme to another. They play a reactive role rather than a pro-active role. Adjusters seem easy going, relaxed, and calm. Unfortunately these children are followers and have great difficulty taking a standing up for themselves and making choices. Many of these children become involved in negative peer interactions (i.e. gangs). Adjusters have a lack of personal power and feel little control over their lives.

3. The Placater:

Children who feel responsible for the parent's drinking often assume the placater role. The COA's guilt may be lessened by being sensitive to others, socially adjusted, and a good listener. The placater makes life good for everyone.

They do not attempt to meet their personal needs, instead strives to do what is best for others.The goal of the placater is to keep everyone else happy. This takes the pressure off the alcoholic and helps maintain order in the household. The placater often will settle disputes between parents, other siblings and the alcoholic and his/her employer. The placater is the diplomat and peacemaker.

4. The Acting-Out Child

These children display delinquent or problematic behaviors. They usually draw attention to themselves by their behaviors, which many times takes attention away from the alcoholic and helps preserve the family "secret". According to Black (1981) only about 25% of COA's adopt this role. In many ways this is unfortunate. Children who act-out are more likely to be identified as COA's and to receive early intervention. Their chance for recovery is greater than those COA's who take on other previously mentioned roles.

Any of these roles, if taken on for a lengthy period of time may cause difficulty in socialization, peer and adult relationships and intimacy. Children must receive assistance in identifying the role/roles they play and must have help establishing new coping skills. This should be

done by a trained professional. Unfortunately this is very difficult because of the lack of professionals who have been trained to work with the roles children play in the alcoholic family. Most teachers and care providers do not have this knowledge and must be instructed and guided by persons specifically trained to work with alcohol related problems. The family process is the most difficult part of the COA's life to take apart and reassemble in a positive manner (Staff, 1986).

Interruption of the Child's Development

Environment has a strong influence on the physical, emotional, and personality development of children. Many professionals consider environment to be the most influential factor in human development (Ackerman, 1983).

Development is affected by both biological and environmental factors. These factors result in changes in structure, thought and behavior patterns in children. Biological factors are correlated with the processes of physical growth, aging and maturity. Environmental factors affect the child's emotional, social, and personality structure. Human development is a mixture of both biological and environmental factors.

Physical Development

The developmental levels of COA's may not always be normal. These levels may very from child to child and one experience may severely retard development in one child yet, leave another virtually unaffected. Developmental retardation often starts in the pre-natal stages.

If the COA is born to an alcoholic mother "fetal alcohol syndrome" may develop. This syndrome causes under-development of the fetus which is not reversible. Many children of fetal alcohol syndrome have sub-normal intelligence and poor gross and fine motor development (Ackerman, 1983).

The poor physical condition of the mother combined with the ingestion of alcohol into the blood system of the fetus cause low birth weight, premature birth, vitamin deficiency and high rates of infant mortality (Ackerman, 1983).

The physical condition of the fetus can also be affected if the father is the alcoholic in the family. The anxiety and stress put on the expectant mother by the alcoholic spouse drains the psychological resources of the woman. Thus leaving her in an emotionally and physically weakened state (Ackerman, 1983).

Physical abuse of COA's is another concern regarding the physical development of children. Physical abuse and alcoholism often go hand in hand. Because of the frustration of both the alcoholic and their spouse, many COA's become victims of physical abuse. This can cause mental, physical and emotional damage to children and cannot be easily controlled (Subby, 1987).

Emotional Development

How a child develops emotionally, influences how they see and handle the world and their future. All children experience emotions as they grow and develop.

Through these emotions children learn how to handle future situations productively. When dealing with emotions, especially negative ones like fear and anxiety, children need a sense of security. This security gives them the strength and ability to cope with their environment.

This sense of security is usually found in the family, but is often missing in the alcoholic family. When security is absent many COA's develop destructive or undesirable defense mechanisms (Ackerman, 1983).

Children are constantly confronted with change. They face the challenge of growth and the need to maintain security. COA's meet with enormous growth problems but have little security from the past to draw on. To compensate for this lack of security COA's develop strong defense mechanisms. Among these are regression, repression, sublimation, projection and reaction formation (Papalia & Olds, 1978).

When children face crisis they often regress to an earlier level of emotional or behavioral development, attempting to go back to a prior state of security. When the crisis is past children will return to their normal level of development. Unfortunately COA's have no strong sense of past security and they have great difficulty adjusting to the changes in emotions. Continual repetition of crisis, especially alcohol related crises, compound the complications of COA's emotional development (Papalia & Olds, 1978).

Repression is another problem closely related to stressful situations. COA's learn to suppress or "stuff feelings that are normally expressed in other children. COA's learn to repress feelings so they do not "rock the boat". COA's also often repress actions, they do not do

things they want to or they might be afraid to have company over, because they are afraid of the consequences if the action displeased the alcoholic (Papalia & Olds, 1978).

Many COA's cover feelings of discomfort or anxiety with acceptable attitudes and behaviors. This attempt at sublimation by COA's is usually seen as positive by adults. Unfortunately children become "workaholics" in school and at home. They carry these traits into adulthood (Ackerman, 1986)

Projection is another behavior often seen in COA's. A child in an alcoholic home may ignore his/her own inappropriate behavior and may unrealistically blame another for the same behavior for the same behavior. This allows the child to disassociate from problems and feelings he cannot bear to feel (Ackerman, 1983).

COA's have a tendency to express feelings which are opposite of their true feelings. This behavior is known as reaction formation and is usually characterized by the use of jokes and light-hearted remarks about the child's home situation when the child is truly frustrated and angry (Ackerman, 1986).

The coping skills discussed are all found in the emotional development of most COA's. It is unfortunate that most COA's must handle a variety of emotions and they are usually ill-equipped because of an emotional state that is poorly developed.

Emotional development in a child is very closely related to the child's sense of identity and self-concept. Self concept is usually developed from the child's measuring their adequacy by the comments and reactions of others. COA's often feel unwanted. They see themselves as inferior, inadequate and many times worthless. COA's usually behave in a manner which confirms the opinions of others, then the feed back they receive only helps confirm the COA's negative self-concept. Therefore, COA's become insecure adults with low self-esteem and poor self concepts (Ackerman, 1983)

Recovery for Children of Alcoholics

COA's will always be COA's. Just as there is no cure for alcoholism, there is no cure for being a child of an alcoholic. Fortunately, COA's may recover from the symptoms and situations they encounter because of the alcoholism.

Recovery starts for the COA's when they accept the reality of the parent's illness and accepts the inability to control it. COA's then can begin to work on the core issues of their lives. The COA then can begin to dismantle the denial, re-evaluate basic principles, relinquish illusions, and accept a more realistic identity of self.

If children are given assistance in learning coping skills and are helped to understand their lives and the lives of those around them they may be able to live happy and productive lives (Brake, 1988).

Educators and care providers can help the COA recover by providing counseling, understanding, and guidance. If children are taught to have hope and to feel secure about themselves they will be strong and will overcome the negative affects of alcoholism in the family. With encouragement they will be able to discuss their feelings and cope with the daily termoil in their homes. To recover from their symptoms COA's must perceive themselves as good and worthwhile. They must believe they are capable of succeeding in life and that their lives will be worth living. Care providers and educators are the people who

have the greatest opportunity to fill this need. They can build the self-worth of COA's through daily contact and by building a trusting relationship. COA's can recover, but they need intervention by, and assistance of, those who are close to them (Brake, 1988).

Inservice Training

What is Currently Offered

The majority of educators and care providers who work with COA's do not have formal training or education in dealing with the problems of COA's (Reynolds, 1987).

Many schools are now beginning to conduct extensive training programs for educators which examine the use and abuse of alcohol by students. Unfortunately there are still very few programs that deal with the impact of family alcoholism on children (Reynolds, 1987). Some of these alcohol programs touch on the subject of COA's but in no way prepare teachers and care providers to cope with the severity of the symptoms COA's present.

Needs of Educators and Care Providers

Educators and care providers must become knowledgeable about alcohol and alcoholism. They need not be experts but they must have a working knowledge of the effects of alcohol on the alcoholic and the family. According to Reynolds (1987) educators and care providers must:

1. Understand alcoholism as a family disease that calls for family recovery;
2. Understand the stages of alcoholic dependency and the physical effects at each stage;
3. Understand the psychological aspects: the denial, the myths, co-dependency, insecurity, guilt

disappointment, isolation, resentment, fear and anger;

4. Understand the family roles: caretaker, hero rescuer, rebel, scapegoat, placator, adjuster, blamer;
5. Understand enabling (p.43).

This seems to be a lot of information, but to assess and intervene in the lives of COA's, care providers and educators must have an understanding of the lives of COA's not just information from a book to pass on to children.

A Model

Inservice training is a complicated task. Training is an attempt to teach skills and knowledge to others with a specific set of goals and objectives in mind. These goals and objectives must be directed at trainees and should teach specific skills or techniques that can be used on the job. This is easily related to the training of educators and care providers who work with COA's (Donaldson & Scannell, 1986). According to Donaldson and Schannell in 1986:

An effective training program must consist of:

A systems approach.

This style of approach includes the use of an organized plan and design which covers all aspects of the problem at hand. It does not just look at on aspect but

examines the entire dynamic structure of the problem to be solved.

A needs analysis.

A needs analysis is the most important part of the training program. If a problem is not well defined it will be difficult to solve. This step is often time consuming but is well worth the effort. Very few programs can be successful if they do not have a complete needs assessment which shows the direction the training must take.

A complete set of training requirements.

In order to develop a set of requirements the person in charge of designing the training program must; develop an overview of the problem, examine the changes that have happened just before the problem occurred, list the most likely causes of the problem and evaluate the role training can play in solving the problem.

A set of objectives and goals.

When designing a set of objectives and goals it is important to use behavioral terms which show the desired behavior and performance standards the program will achieve. The objectives outline the quantity of performance, whereas the goals outline the quality of performance.

A complete curriculum design.

There are a great deal of effective training methods which are available in designing a program curriculum. These may be lectures, role plays, case studies, games, and group discussions. Each method should be evaluated as to its possible effectiveness for your specific program. It is important that you study your needs assessment closely before designing the curriculum.

An actual presentation of the program.

This stage of the program will be the most fruitful or the most frustrating. This is the time that you find out if you have designed your program correctly and what you must do to make it more productive .

A program evaluation.

Although you conduct evaluation on an ongoing basis, an end-of-course formal evaluation should be in each program. Evaluation may take different forms, they may be tests, on-the-job performance or personal evaluations.

An evaluation is a feedback system that measures the effectiveness of the training program and should be used to correct errors.

A follow-up plan.

There must be a follow-up plan to all inservice programs. There must be a way to assure that the knowledge gained is not lost and that new knowledge is gained in a consistent fashion. The follow-up plan should consist of

ongoing plans for continued training, networking information and a plan for trainees to receive reinforcement for the training previously received.

Conclusions

It is never too late to help COA's. They can gain strength and a positive outlook. This can be done even if the alcoholic parent is still drinking and refuses treatment. The child can be helped to understand the disease of alcoholism and the effect it has on his/her life. Children can learn new coping mechanisms and skills from peers and adults. The adults that are most capable of teaching children these skills are educators and care providers.

Educators and care providers must however be knowledgeable about the subjects of alcohol and alcoholism. This knowledge should be gained through training programs which are developed by trainers within a certified substance abuse program. The training programs must be detailed and productive. They must be specific and must contain strong networking, follow-up and evaluation components.

If COA's are identified and assessed at an early age by care providers and educators the chance for their success is much greater. There is a great need for an increase in early identification and intervention. Early identification and intervention can be increased greatly through thorough training and awareness programs. More schools and

communities need to take an active part in the lives of COA's. COA programs should be developed in all schools and are as important to prevention as alcohol use and abuse program themselves.

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