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Group therapy for latency-age children of alcoholics: A treatment outcome study

Davis-Susser, Shirl Ann, Psy.D.

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U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

Group Therapy for Latency-Age Children of Alcoholics: A Treatment Outcome Study

by

Shirl Davis-Susser

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NAME: Shirl Davis-Susser

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DOCTORAL PROJECT COMMITTEE:

PROJECT ADVISOR: John Stokes, Ph.D.
(Name)

Associate Professor, Psychology Dept.
(Title) (Affiliation)

PROJECT CONSULTANT: Lynn Passy, Ph. D.
(Name)

Assistant Professor, Psychology Dept.
(Title) (Affiliation)

FINAL APPROVAL OF COMPLETED PROJECT:

I have read the final version of the doctoral project and certify that it meets the relevant requirements for the Psy.D. degree in School-Community Psychology.

John Stokes
(Project Advisor's Signature) 3/26/90
(Date)

Lynn E. Passy
(Project Consultant's Signature) 3/26/90
(Date)

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ABSTRACT

The present study evaluated the effectiveness of an eight-week prevention-oriented group treatment program for children of alcoholics (COAs) between the ages of 6 and 11. There were 30 children in the treatment group and 10 in the comparison group.

Personality and behavioral data were collected at pre-test and post-test via three self-report scales and one parent rating scale. The Revised Children's Manifest Anxiety Scale (RCMAS), the Children's Depression Inventory (CDI), and the Nowicki-Strickland Locus of Control Scale (N-SLCS) were used to assess the children's experience of anxiety, depression and locus of control. Parents completed the Revised Behavior Problem Checklist (RBPC) as well as a COA Behavior Scale. Demographic data were collected on each child. Behavioral observations were recorded on each child in each session in an effort to identify the "active ingredients" related to "good outcome" on each of the outcome variables. Both parent and child feedback on program effectiveness was elicited at post-test for those children in the treatment group.

Analyses of covariance using pre-test scores as covariates were used to compare the treatment and comparison

groups on each variable. No statistically significant between group differences were found. Evaluation of the behavioral observations and the parental feedback, however, did provide some support for use of COA groups. Analyses of the behavioral observations did identify "active ingredients" related to "good outcome" on the RCMAS, the CDI, and the N-SLCS. That is, children who identified with the "COA experience" evidenced greater reduction in anxiety and depression. Children who perceived the drinking as the parent's issue evidenced increased internalization in locus of control. Participation was seen by the parents as having fostered the children's verbal expressiveness and improved parent-child communication.

Regression analyses were conducted in an effort to identify extra-group factors predictive of change on the outcome variables. Findings indicated that exposure to parental relapse was predictive of higher scores on the RCMAS and the CDI. Scores on the RBPC indicated that contact with an actively alcoholic parent correlated with behavioral problems whereas established parental sobriety was predictive of reduced behavioral problems.

Implications of the study as it relates to school-community psychology were discussed. Recommendations for further research were proposed.

Chapter I

Introduction

Alcoholism treatment programs have traditionally provided services for the alcohol abuser and have generally neglected the treatment needs of other family members (Bingham & Bargar, 1985). Influenced at least in part by systems theory, the alcohol treatment community has in recent years begun to more carefully assess the impact that the alcoholic's drinking has on the involved parents, spouses, and children and to attend to each family member's need for therapy (Dulfano, 1981; Steinglass, 1981; Tharinger & Koranek, 1988; Wegscheider, 1981; Weir, 1968).

The effect of the alcoholic behavior permeates the physical and emotional environment of the family. Over time, issues related to the drinking increasingly dominate the family life. In order to maintain some semblance of homeostasis, family members adapt to the situation by compensating for and coping with the behavioral and emotional changes in the alcoholic. As the functioning level of the alcoholic deteriorates, other family members develop more and more of a crisis mentality and gradually allow the drinking behavior to control their lives

(Ackerman, 1983; Brown & Sunshine, 1982; Deutsch, 1982; Dulfano, 1978; Jackson, 1954; Steinglass, 1980).

Denial is one of the most primitive defenses and dominates the defensive structure of the alcoholic and his/her family. Discussion of the alcohol abuse becomes taboo; family members collude with the alcoholic's denial of the problematic drinking. To reveal one's concerns within the family is subtly forbidden; to reveal them outside the family can be a betrayal of a shameful family secret. The family gradually becomes more and more isolated, less interactive with outside resources which could help the family in maintaining a realistic perspective on the family's difficulties and the contributing factors (Brown & Sunshine, 1982; Deutsch, 1983).

Effects of Parental Alcoholism: Review of the Literature

Clinical Findings. Authorities estimate that between seven and 20 million children under the age of 18 have at least one alcoholic parent (Black, 1981b; Deutsch, 1982; Deutsch, DiCicco, & Mills, 1979; DiCicco, 1981; Owen, Rosenberg, & Barkley, 1985; Woodside, 1983). Furthermore, the parental alcoholism can have a tremendous impact on the physical, social and psychological development of these children.

As the needs of the alcoholic parent increasingly dominate the family, the resources available for good

parenting decrease. This is especially true when maternal alcoholism is present (Richards, 1980b; Werner, 1986; Williams, 1987). The drinking parent becomes more and more self-centered. The non-drinking parent becomes increasingly preoccupied with the drinking spouse and with the problems generated or exacerbated by the drinking behaviors (Kern, Tippman, Fortgang, & Paul, 1977).

Physical neglect of the children is common. Attention is often diverted away from nutritional, hygiene and medical needs. Family rituals around meal times and sleeping become disrupted. As the family's financial situation worsens, there are often inadequate funds for medical and dental care or for basics such as food, clothing, and shelter. The children are often witness to violence between the parents and are themselves frequently the objects of physical abuse, including sexual abuse (Ackerman, 1983; Black, 1981b; Byles, 1978; Deutsch, DiCicco, & Mills, 1978; Flanzer, 1981; Woodside, 1983).

As the families become more isolated socially, so do the children. Inhibitions about discussing the home situation and the children's feelings about it coupled with the difficulties in having "outsiders" physically present in the home erode potential support systems among both peers and adults (Ackerman, 1983; Wilson & Orford, 1978).

The psychological consequences of parental alcoholism are even more pervasive than the physical and social effects (Deutsch, 1983; Grisham & Estes, 1982). More often than not, the parental functioning of both the drinking and non-drinking parent is impaired by the alcoholism. For optimal psychological development, children need a consistent, on-going emotional relationship with their parents. In an alcoholic family system, the children must often contend with the emotional absences and the ambiguous or unstable role functioning of both parents. The children are often called upon to take on parental roles and subsequently develop pseudoadult behaviors (Hecht, 1973; Nardi, 1981; Wegscheider, 1981). Such precludes a normal childhood and prevents appropriate role acquisition for future adult life as the child is imitating and learning from inappropriate role models (Black, 1981a). The home environment is frequently chaotic; the child learns not to depend on consistency in parental availability, discipline or family routines (Wolin, Bennett, & Noonan, 1979; Wolin, Bennett, Noonan, & Teitelbaum, 1980). Disappointment and frustration become normal experiences (Ackerman, 1983; Bingham & Bargar, 1985; Black, 1981b; Chafetz, 1979; DiCicco, Davis, Travis, & Orenstein, 1983/1984; Knight, 1980; Morehouse & Richards, 1982; Woodside, 1983).

Insomnia, nightmares, depression, anxiety and psychosomatic complaints are often evident. The emotional impoverishment and social isolation make for low self-esteem, an impaired sense of reality, and difficulties in interpersonal relationships (Bingham & Bargar, 1985; Cermak & Brown, 1982; Deutsch, 1983; Deutsch et al., 1978; El-Guebaly & Offord, 1977; Seixas & Youcha, 1985).

Actual interviews with children of alcoholics (COAs) reveal that the children feel unloved and rejected by one or both parents. They feel a lack of self-confidence, are unsure of themselves, and are generally anxious and afraid. The resent not only the drinking parent but also the sober parent whom they perceive as having ignored them in favor of the alcoholic (Cork, 1985; Wilson & Orford, 1978; Woodside, 1983).

The latency years coincide with the child's first real ventures into the world beyond the family. Primary developmental tasks are centered on learning both at school and in the social world. If the child successfully masters the challenges of this period, he can approach adolescence with a stronger sense of self and with feelings of personal competence (Erikson, 1950).

Any child's ability to deal with these new and more complex situations can be hindered by the problems inherent in a dysfunctional family. Alcoholic family systems seem,

however, to make the process even more difficult (Chafetz, Blane, & Hill, 1971). For optimal functioning, a child needs a consistent environment that is adequate in affective nurturance and parental support. The home environment should be intellectually stimulating, emotionally supportive, and provide for the basic biological needs. The alcoholic home, as noted above, is often characterized by inconsistency and chaos. Irregular eating and sleeping patterns coupled with the emotional turmoil in response to the stress in the family make it difficult for the child to concentrate and to learn at school.

As ambiguous and inappropriate roles within the family have often precluded normal "child" behavior, the youngster may enter the social arena at school unprepared to relate to peers in acceptable and appropriate ways. The inhibitions in discussing the family's problems and the discomfort about having friends at the house because of what might occur with the drinking parent further hinders the possibility of positive peer interactions (Brown & Sunshine, 1982).

As the child's cognitive processes are still grounded in concrete thinking, he cannot conceptualize regarding the scope and intricacies of his situation. Family and school problems are interpreted within a cause and effect framework and from an egocentric position. Subsequently, the child often assumes blame for his and the family's situation.

And, unfortunately, this perception may be reinforced by the displacements and projections of parents who are themselves struggling to cope and by school personnel who may take a critical stance in their efforts to help the child develop more personal control (Bingham & Bargar, 1985; Brown & Sunshine, 1982; Deutsch, 1983).

The picture emerges then of a child who may have problems learning at school, difficulties relating with peers, and who in response to these frustrations can become a "behavior problem" (i.e., hyperactive, "acting-out", or exceptionally withdrawn). Ironically, the child may in essence be unable to utilize what corrective experiences are available in the school and community to compensate for the inadequacies in the home. Development of a healthy self-esteem is thwarted as is the on-going process of separation and individuation both of which serve as preparation for adolescence and adulthood (Bingham & Bargar, 1985; Brown & Sunshine, 1982; Davis, Johnston, DiCicco, & Orenstein, 1985; Hughes, 1977; Weir, 1970).

For adult COAs, the combination of genetic, environmental and psychological influences increases their risk of becoming substance abusers (i.e., COAs are two to four times more likely to develop substance abuse as their peers, 50 to 60 percent of all identified alcoholics were raised in a home with at least one alcoholic parent) or of

marrying alcoholics or other high risk people (Black, 1981a, 1981b; Burk, 1972; Cotton, 1979, Deutsch, 1982, 1983; Deutsch et al., 1978; DiCicco et al., 1983/1984; Donovan, 1986; Lanier, 1984; McKenna & Pickens, 1983; Pollock, Schneider, Garbrielli, & Goodwin, 1987; Schuckit, 1986; Woodside, 1983). COAs are also at increased risk for medical concerns, emotional problems, interpersonal issues and adjustment difficulties as adults (Ackerman, 1983; Black, 1981b; Deutsch, 1982; Jacob, 1980; Miller & Jang, 1977; Steinhausen, Gobel, & Nestler, 1984).

Empirical Findings. Until recently, the literature addressing the effects of parental alcoholism was predominately based on case histories and clinical interviews. There is, however, a growing body of empirical study which tends to support the clinically-based hypothesis that parental alcoholism is associated with increased incidence of emotional problems in COAs. Related to this project are those studies which address issues specific to anxiety, depression and locus of control. For more complete reviews, see El-Guebaly and Offord (1977), Jacob, Favorini, Meisel and Anderson (1978), Tharinger and Koranek (1988) and West and Prinz (1987).

In comparing 39 child and adolescent COAs with 39 children and adolescents whose parents had an identified psychiatric disorder and with a group of normal children and

adolescents, Fine, Yudin, Holmes and Heinemann (1976) found that the COAs between the ages of eight and 12 showed significantly more anxiety and fearfulness and that adolescent COAs showed significantly more anxious self-blame than the normal group. The COAs did not differ significantly from those children whose family contained a parent in whom some psychiatric disorder had been identified. In their study of 50 children (ages six to 12) of alcoholic families involved in a residential treatment program, Anderson and Quast (1983) also found that COAs were more anxious and tended to be more depressed than "normal" children. A recent study by Earls, Reich, Jung and Cloninger (1988) in which children of one alcoholic parent (n=53) and two alcoholic parents (n=17) were compared to children with an antisocial parent (n=35) and with children in a control group found that the children with alcoholic and antisocial parents evidenced higher rates of anxiety. These children did not, however, show an increased rate of depressive disorders.

Tartar, Hegedus, Goldstein, Shelly and Alterman (1984) compared adolescent sons of alcoholic and nonalcoholic fathers (n=16, n=25 respectively, mean age=15). Results showed the group with alcoholic fathers to have significantly higher depression scores than the children of nonalcoholic fathers. In a more recent study by Roosa,