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THE EFFECT OF EDUCATIONAL BACKGROUND ON THERAPISTS'
CHOICE OF TREATMENT MODALITIES FOR CHILDREN
OF ALCOHOLICS

A Thesis

Presented for the

Degree of

Master of Science

in Social Work

The University of Tennessee, Knoxville

Lisa A. Bevins

August 1988

DEDICATION

To my grandparents, Robert L. and Pearl M. Kirtley, whose consistency, stability, love, and support has allowed my freedom for personal growth and for the pursuit and accomplishment of my life's goals.

ACKNOWLEDGEMENTS

I would like to express my gratitude to those people who donated their time and knowledge to the development of this thesis. In particular, I would like to thank my major professor, James D. Orten, and committee members, Reginald Avery and Thomas Cruthirds, for their encouragement and other valuable contributions. A special thank you is extended to committee member Maryanne Lynch for her patience , consistent availability, and willingness to share her knowledge throughout the research process.

ABSTRACT

The purpose of this study was to determine if there is a significant relationship between the educational backgrounds of therapists and their choice of modalities by which they treat children of alcoholics (C.O.A.s). The current literature is lacking in studies in this area. A large amount of this literature about C.O.A.s is based on the issues of this population or on the treatment modalities recommended for use with them.

Therapists surveyed for this study included psychiatrists, psychologists, and licensed social workers residing in Knox County, Tennessee. Information was gathered from these therapists through the use of a 26 item questionnaire. There was a total of 116 questionnaires returned.

The responses from the therapists surveyed indicate a difference in treatment modalities they espouse for C.O.A.s and the modalities recommended by the literature. The respondents also reported treating many of the same C.O.A. issues as identified in the literature.

Information received about the therapists indicates that most

work in private practice and spend up to 50 percent of their professional time in therapy. Half of the respondents report 1-10 percent of their clients are chemically dependent. One-third of those cases did not include children of the clients in the treatment process even though half of the respondents stated that they would include the family in treatment whenever possible. Most of the C.O.A. clients seen in treatment are adults with individual therapy being the most popular treatment modality used for any age group. A large percent of the respondents believe that chemical dependency is a disease while only half of them use the primary disease model as orientation toward treatment.

Of the seven hypotheses formulated about the topic of study, two were found to be significant when tested with chi square tables. The first significant hypothesis states that a therapist's type education is correlated to his inclusion of family therapy in treatment of the chemically dependent adult. The second hypothesis that was supported states that a therapist's belief in chemical dependency as a disease is correlated to his use of the disease model as orientation toward treatment of chemical dependency.

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CHAPTER I.

INTRODUCTION

Alcoholism* is a disease which affects an estimated 10 million Americans (Chafetz, 1979). It has been described as a disease in that it is progressive, chronic, and fatal. As noted by Larson, (1983, p. ix)

Alcoholism currently ranks third, behind cancer and heart disease, as America's leading health problem. It can even be argued that alcoholism is the nation's leading health problem because it is often a direct factor in both cancer and heart disease.

Not only does the disease of alcoholism affect the alcoholic but it has a profound effect on the people around him**. It is estimated that for every alcoholic there are five or six persons associated by family or business who are also adversely affected by his disease

*Throughout this paper, the term "alcoholism" will be used in reference to chemical dependency and the use of chemicals other than and including alcohol.

**The pronoun "he" will be used throughout this paper when referring to the alcoholic for consistency and is not used to imply that most alcoholics are male.

(Hecht, 1979). As the alcoholic's dependency progresses, more of his time and attention is devoted toward the acquisition and use of the drug. This means that less of his time and attention is devoted toward the support and maintenance of his family.

The family unit then becomes unstable. Each member of the family slowly loses his own identity as he becomes focused on taking care of the alcoholic. By covering up for him or by spending most of their time trying to anticipate what the alcoholic will do next, the family avoids seeing how the disease has affected them too (Shaef, 1986).

Children of Alcoholics

There are an estimated 28 million children of alcoholics in the United States (NACOA, 1983). The identification of these children is important in that, like the alcoholic parent, they need treatment too. Not only do they have a higher risk of becoming alcoholics than children with non-alcoholic parents do, but they have learned many coping skills to help them survive in the alcoholic home that could be destructive to their emotional health (Morehouse, 1984).

What exactly are the problems of Children of Alcoholics (C.O.A.s)? According to the National Association of Children of Alcoholics (1983), a list of facts have been established (Figure 1). Included in this list are facts such as, 1) more than half of alcoholics have an alcoholic parent, 2) C.O.A.s are at high risk of developing alcoholism themselves, 3) in up to 90 percent of child abuse cases, alcohol is a significant factor, and 4) C.O.A.s are prone to experience a range of psychological difficulties. The list of problems these children face is long. Many of these problems will remain invisible because the children's behavior is usually directed toward pleasing others (NACOA, 1983). The difficulty in this is that, again, they tend to lose sight of themselves in the attempt to serve the alcoholic.

How do these problems come about? Life in the home with an alcoholic may be inconsistent, chaotic, and unpredictable. Sometimes it is filled with physical abuse. But more often than not, it is filled with psychological abuse (Larson, 1983). As stated before, children learn to survive by developing coping skills. Some become overly responsible to make up for a parental deficiency in this area. Some learn to be very controlling so that they may

- More than half of all alcoholics have an alcoholic parent.
- Children of alcoholics are at the highest risk of developing alcoholism themselves or marrying someone who becomes alcoholic.
- Medical research has shown that children born to alcoholics are at the highest risk of developing attention deficit disorders, stress-related medical problems, fetal alcohol syndrome, and other alcohol-related birth defects.
- In up to 90 percent of child abuse cases, alcohol is a significant factor.
- Children of alcoholics are also frequently victims of incest, child neglect, and other forms of violence and exploitation.
- C.O.A.s often adapt to the chaos and inconsistency of an alcoholic home by developing an inability to trust, an extreme need to control, excessive sense of responsibility and denial of feelings, all of which result in low self-esteem, depression, isolation, guilt, and difficulty maintaining satisfying relationships. These and other problems often persist through adulthood.
- C.O.A.s are prone to experience a range of psychological difficulties including learning difficulties, anxiety, attempted and completed suicide, eating disorders, and compulsive achieving.
- The problems of most C.O.A.s remain invisible because their coping behavior tends to be approval seeking and socially acceptable. However, a disproportionate number of those entering juvenile justice systems, courts and prisons, mental health facilities, and referred to school and authorities are C.O.A.s.

(National Association for Children of Alcoholics, 1983)

Figure I

FACTS ESTABLISHED BY THE NATIONAL ASSOCIATION OF CHILDREN
ALCOHOLICS ABOUT C.O.A.s

achieve some consistency in their own lives. Still yet, some do not learn to trust others because so many promises are made and broken by the alcoholic parent. These coping skills work very well in the home for the child, but when he leaves the home, these skills are brought with him and are applied to daily life with non-alcoholics (Deutch, 1982).

There are five central issues that C.O.A.s face as noted by Gravitz and Bowden (1984, p.27),

It is their contention that control-control of environment, self, and others-is so pervasive that it dominates the other major issues, which include mistrusting, ignoring personal needs, denying feelings, and being unable to define or limit responsibility, particularly with the alcoholic parent.

These are not issues that would automatically bring someone to the attention of a professional. But that does not mean that these issues do not make life very uncomfortable for the C.O.A. More often than not these C.O.A.s do not realize the origins of their discomfort. All they know is that for some reason things in life do not work out for them. Inevitably, they feel that they will be left alone and without support, assuming everything that has turned bad is their fault (Gravitz and Bowden, 1984).

It has been estimated that "only five percent of the 12 to 15 million school-aged children of alcoholics are identified and treated" (Pilat and Jones, 1984/85, p.27). These children usually come to the attention of professionals because they have been acting out and are not coping or adjusting to the alcoholic home life. In a sense, C.O.A.s who act out and are brought in for treatment are fortunate because they will receive help. They will have a chance to rebuild their lives in a constructive way with the help of professionals who understand their issues and know what they need for recovery.

Another way in which C.O.A.s receive treatment is dependent upon the treatment of the alcoholic parent. Many alcoholism treatment professionals include family therapy as a part of the alcoholic's treatment plan. Even then, some do not consider family treatment mandatory and neglect the children as a result. The identification of C.O.A.s through parental treatment and through acting out behavior leaves a large amount of this population unidentified.

One difficulty lies in the identification of Adult Children of Alcoholics (A.C.O.A.s). This group is no longer in the home to act out

or be included in the parent's treatment plan, thus, another large percentage of the C.O.A. population remains untreated. Identification, whatever the age of the C.O.A., appears to be the initial obstacle to treatment.

Once identified, treatment of the C.O.A. is needed to help them understand why they feel the way they do and to help them use these learned coping behaviors in a more productive and less destructive way. "Now, despite the widespread recognition and acceptance of alcoholism as a family disease, the children of alcoholics continue to be ignored, misdiagnosed, and undertreated" (Bingham and Barger, 1985, p.13).

Statement of the Problem

It has been established that many children who grow up in alcoholic homes develop problems. It has also been established that only a small percent of this population will be identified and will receive treatment.

Although identification of this population is needed, it is

important to know what the treatment modalities that therapists* use once the C.O.A. has been identified and is in the treatment setting. It will also be important to know what, if any, influence their type education has on their choice of treatment modalities for C.O.A.s. A variety of modalities have been espoused for this population e.g. individual therapy, group therapy, support groups, and family therapy. Many therapists' choices of treatment modalities are based on the therapists' own educational background, exposure to working with alcoholics, orientation toward treatment of chemical dependency, and identification of being C.O.A.s themselves.

The problem to be studied in this thesis is the relationship of these variables to the treatment modalities used with C.O.A.s. What effect does type of education have on choice of treatment modality used with this population and is this choice reinforced by the literature? Several hypotheses based on these relationships were formulated and will be presented in Chapter III.

*Throughout this paper, the term "therapist" will be used to refer to those people who are registered, in the state of Tennessee, as social workers, psychologists, or psychiatrists.

Importance of the Study

A large portion of the current literature on C.O.A.s describes issues pertinent to this population or treatment modalities suggested for this group. This study is important within the field of chemical dependency in that it investigates what modalities are actually being used within the process of treating C.O.A.s, and also what factors may or may not have an influence on the choice of these modalities. There is a gap in the current literature related to these types of relationships. This study will help to improve our understanding from this new direction.

CHAPTER II

REVIEW OF THE LITERATURE

To obtain a clearer understanding on the problems of C.O.A.s and to examine the various treatment modalities recommended for this population, a review of the literature is needed. The literature can be divided into two categories, research and treatment. Literature which falls into the research category is that which describes identified issues of C.O.A.s. Literature which falls into the treatment category is that which describes recommended treatment modalities for this group. The literature is basically directed toward three groups, 1) the children of alcoholics, 2) adult children of alcoholics, and 3) the family of the alcoholic.

Research

Children of Alcoholics

The NACOA (1986) estimates that there are at least 28 million C.O.A.s in the United States. There are several facts that have been

established about this population concerning their behaviors which are reported in this charter statement. "The NACOA has been founded to support and serve as a resource for C.O.A.s of all ages and those who are in a position to help them". To do this, they have established twelve goals to protect, advocate for, support, encourage, and help C.O.A.s.

Chafetz (1979) states that C.O.A.s have no choice in parentage and are subjected to an "unstable environment" during their "formative years" (p.23). These children are at high risk of becoming alcoholics themselves in that children tend to imitate their parents' drinking behaviors. Other difficulties are associated with being a C.O.A. such as unstable family life, physical and verbal abuse in the home, and problems with school and relationships outside the home. Alcohol education programs and support groups such as Al-Anon and Alateen are beneficial in breaking the chain of alcoholism.

Children of alcoholic parents also have been noted to have "poor self-concept, are easily frustrated, often perform poorly in school, and are more likely than their peers to suffer from adjustment problems, particularly during adolescence" (Hindman, 1975, p.2). Child abuse and neglect are often experienced by these children and

are important factors to consider during treatment.

Garbarino (1986) describes the psychological abuse that happens in many dysfunctional homes as occurring in five forms e.g. terrorizing, isolating, ignoring, rejecting, and corrupting. He offers clues to look for in children to help identify these problems and suggests intervention on a family level. Garbarino also acknowledges the presence of psychological abuse outside of the home in situations such as hospitals, group homes, and institutions.

Nardi (1981) attempted to foster a better understanding of what it is like to grow up in an alcoholic home through use of a psychosocial framework. Role theory is used to describe the "duties and rights she or he (i.e. child) is expected to enact on the basis of her or his position in the system" (p.239). These roles are usually changed when alcoholism is affecting the family. The ways in which these roles are affected are through "role conflict, sex-role development, and role theory" (p.239). Nardi recommends use of a systems framework with role theory to encourage "each member to articulate his or her roles and how they conflict or have been alone as a result of the alcoholism" (p.243).

Children raised in an alcoholic home tend to take on roles which

have certain identifiable characteristics. Black (1982) described three roles as 1) the responsible one, 2) the adjuster, and 3) the placater. Along with roles, C.O.A.s learn rules by which to live. These are "don't talk, don't trust, and don't feel". The non-alcoholic parent is encouraged to take an educative role, with outside help, to explain alcoholism and its components to the child.

Several studies have been conducted to gather information about the C.O.A. Haberman (1966) conducted one of the early studies on the effects of parental alcoholism on children. This was a comparison study of "children of alcoholics, children of parents with stomach ulcers or other chronic stomach trouble, and children of parents with neither pathology . . ." (p.152). The occurrence of eight specific symptoms was measured in each group with C.O.A.s measuring highest of the three groups.

Cork (1969) conducted a study with 115 C.O.A.s. All children were seen separately and by one interviewer. These children expressed a lack of deep friendships, awareness of disunity within the family, a deep feeling of loneliness, and an awareness of parental rejection. The study reports the actual answers given by the children and offers insightful explanations of those answers.

Studies by O'Gorman et al. (1984) conducted at Berkshire Farmand Center for Youth in Canaan, New York, revealed that a "significant proportion of youngsters in the juvenile justice system are children of alcoholics" (p.43). A high percentage of these juveniles also exhibited alcohol and drug problems themselves. Family therapy is indicated for such juveniles but group therapy is also of major importance to the children. The juvenile justice system needs to be educated in identifying this population to prevent misdiagnosing the problems presented at the intake interview.

Chafetz et al. (1971) conducted a comparison study of 100 C.O.A.s and 100 non-C.O.A.s. Both groups were highly similar except in the area of the parent's ability to help the child grow into a "socialized adult" (p.696). This was caused by the disruption in the family system. Other areas affected by the disruption include "self-concept, interpersonal relations, deviant behavior, and achievement orientation" (p.697).

Wilson et al. (1978) conducted a study of eleven families in which one parent was alcoholic and in treatment. Information from these families was gathered from 11 areas, including 1) drinking

behavior and family stress, 2) father-mother relationships, 3) violence, 4) parent-child relationships, and 5) effects on children. Many conclusions were drawn from this study with emphasis being placed on the detrimental effects parental drinking has on the children's ability to form relationships.

Pilat et al. (1985) states that an extremely low percentage of C.O.A.s have been identified as such and introduced into treatment. There are a multitude of places such as schools, youth organizations, and the courts where identification of this population could take place. To aid in the identification process, in the two studies done by Pilat, a screening instrument called the C.A.S.T. was used. This is a "30-item inventory that measures children's feelings, attitudes, perceptions, and experiences related to their parent's drinking behavior" (p. 25). The C.A.S.T. was initially given to 174 high school students. Over 25 percent were identified as C.O.A.s. Findings around these students school achievements and behaviors were also noted. In the second study, the C.A.S.T. was used on helping professionals in the alcoholism field. This was done to determine the rate of A.C.O.A.s who had chosen this field as a profession. A high incidence rate was recorded of A.C.O.A.s in the alcoholism field

with various reasons postulated for this relationship.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) Symposium (1981) detailed the importance of identifying C.O.A.s and discussed the problems associated with the identification process. These children need to be identified so that services can be arranged to meet their special needs. Barriers to this process can include "1) ignorance of why something should be done, 2) avoidance, 3) legal barriers, and 4) attitudes and feelings of the children" (p.9). The symposium participants recommended that to overcome these, more professionals need to be trained, more information needs to be made available to the children, and policies need to be implemented to target legal issues and funding needs.

DiCicco et al. (1984) explained the problems caregivers and researchers have when it comes to asking children about their parents' drinking behaviors. They suggest concentrating on the children's reactions to the parent's drinking as opposed to concentrating on the adult. This article evaluated the use of the Cambridge and Somerville Program for Alcoholism Rehabilitation (CASPAR) Educational Program, which is "part of a comprehensive alcoholism treatment system" (p. 3). This was done by using one

survey item, "Have you ever wished that either one or both of your parents would drink less?" (p. 3). Survey responses were highly useful in identifying C.O.A.s and therefore useful in doing further research on this population.

Other research issues and policy issues concerning C.O.A.s were discussed in Perspectives (1984). Research issues needing attention include the areas of individual and group treatment, diagnostic criteria for co-dependency, biological factors in alcoholism, Fetal Alcohol Syndrome (FAS), and C.O.A.s in the juvenile justice system. Policy issues are concerned with program funding, insurance coverage for treatment, and legal rights of C.O.A.s.

Adult Children of Alcoholics

Seixas (1985) describes the child living in an alcoholic home as living with a "terrible family secret". Their parents' alcoholism is something that is never discussed. This leads the child into feeling alone and unsure about what is real. As an A.C.O.A., these issues carry over from childhood and have negative effects on daily living. Specific areas prone to these side effects are the A.C.O.A. and

alcohol use, marriage and closeness, and relationships with their own children.

Woititz (1983) also saw the need for a way to help the A.C.O.A. In this book, she describes what it is like for a child to grow up in an alcoholic home, what it is like for the A.C.O.A. after leaving the home, ways to stop the uncomfortable behaviors learned as a child, and how to not pass these behaviors on to the next generation. A major portion of the book is devoted to stopping the uncomfortable behaviors. Woititz cites a list of 13 general behaviors A.C.O.A.s tend to exhibit and then goes into detail with each one. This book was written as a self-help guide for A.C.O.A.s working on personal growth individually or within an A.C.O.A. discussion group setting.

"However, there has been little research into the needs of this group (A.C.O.A.s) and little reported by clinicians and practitioners providing guidance on how to adequately diagnose and treat the issues presented by these A.C.O.A.s" (Gravitz et al. 1984, p. 25). Explained here are six stages A.C.O.A.s appear to experience with treatment suggestions for each. These stages range from the Survival stage in which C.O.A.s learn coping skills to the Genesis

stage in which a conscious choice is made through a Higher Power to change.

The Family of the Alcoholic

Wegscheider (1981) describes the family system as being like a machine. All the parts move in certain ways to maintain a balance within the machine. "A distorted balance, such as occurs when one member starts becoming dependent on a chemical, causes psychological and/or biological symptoms in the other members" (p.29). To maintain a certain balance in an alcoholic home, children will assume particular roles. Wegscheider's terms for these roles are, 1) The Enabler, 2) The Hero, 3) The Scapegoat, 4) The Lost Child, and 5) The Mascot.

To describe the family members of an alcoholic home, Cermak (1986) offers the term co-dependent.

Co-dependence is a recognizable pattern of personality traits, predictably found within most members of chemically dependent families, which are capable of creating sufficient dysfunction to warrant the diagnosis of Mixed Personality Disorder as outlined in DSM-III (p.1).

Cermak is concerned that without the proper diagnostic criteria, co-dependence may be misdiagnosed and mistreated. He therefore

proposes a definition for Co-dependent Personality Disorder in DSM-III style, outlined clearly for professional use in diagnostic procedure.

Schaefer (1986) describes co-dependence as an addictive process. The characteristics of this process may include 1) external referencing, 2) caretaking, 3) self-centeredness, 4) dishonesty, and 5) gullibility. Systems such as family, schools, and the church tend to support these characteristics by encouraging the non-expression of emotion, instillation of fear of failure, and avoidance of socially unacceptable subjects.

Hindman et al. (1984) discussed research on family environment, genetics, and child abuse and neglect. The family environment involves certain rituals that are based on roles and rules. These rituals can have an effect on whether or not alcohol problems will be carried on in the C.O.A. Genetics are also suspected of playing a large part in the transmission of alcoholism from generation to generation, but this is in need of further research. There is a very high correlation between child abuse and neglect and alcohol problems within a family.

Family systems are not affected by alcoholism overnight.

Straussner (1979) states that

On the average, the progression of alcoholism, from the onset of early, subtle symptoms to the late chronic stage, takes from ten to fifteen years. This time period may be somewhat shorter for an alcoholic woman. During this time, the family gradually adapts and learns to live with the dysfunctional member, thereby maintaining the system's balance. However, such an adaption takes a toll on the members of this system, resulting in the development of certain defenses and even symptoms by all the members of the family. Thus, alcoholism becomes a family disease (p.114)

When the family begins the process of recovery from this disease, professional help is needed to guide the members toward realistic expectations and goals.

Lawson (1983) reviews four etiological theories of alcoholism, 1) the disease concept, 2) physiological, 3) psychological, and 4) sociological, and three approaches to the treatment of alcoholism, 1) Alcoholics Anonymous, 2) transactional analysis, and 3) behavioral. By understanding the background and treatment of the problem of alcoholism, it becomes easier to treat the family as a client. Lawson explains the family dynamics within the nuclear family and the family of origin, and then offers theories of sociological, psychological, and physiological influences on the family.

Day (1961) describes the family as a social unit with definable

roles. "If there is a disruption to these roles in the family to the extent that it interferes with the performance of the accepted tasks and goals of the family, then we have social disorganization" (p.254). Alcoholism is then introduced as a contributing factor in social disorganization. There are two family systems involved in this disorganization, namely the family of orientation and the family of procreation. Certain behaviors are noted as being particular to these two types with both encouraging the development of alcoholism.

Cotton (1979) reported that in reviewing studies of 6,000 alcoholics and 5,000 non-alcoholics, familial alcoholism "was higher in the families of alcoholics" (p.111). Other observations were made in regard to the sex and distance of the alcoholic relative. Implications for further research involve differentiating "between alcoholics with and alcoholics without family histories of alcoholism. This orientation will, no doubt, aid in the identification of children at high risk" (p.112).

Ellwood (1980) conducted a study of 260 parents who were currently receiving therapy for alcoholism at the Norfolk Navy Alcohol Rehabilitation Center. The instrument used was a 40-item questionnaire. The questionnaire contained items about the parents

"potential to abuse", "rearing experiences", "self-image", "perception of children", and "unrealistic expectations". These measure child abuse, family illness, and stability of relationships.

This study would indicate that alcoholism, a family illness characterized by major parenting deficits and destructive psychodynamics, causes problems in child behavior and development, results in physical and emotional child abuse, and is repetitive in familial generations (p. 191).

Treatment

Children of Alcoholics

To help five-12 year old C.O.A.s, Children Are People (CAP, 1985) developed a support group training manual.

Children from chemically dependent families are an overlooked, underserved population. Even though they face up to four times the risk of becoming chemically dependent, these five-12 year olds are generally excluded from treatment programs like Al-Anon and Alateen (p. 3).

To provide education and support to this population, CAP provides in this manual the "how to" of implementing groups through specific techniques/modalities, group format, and lesson plans.

Hastings (1984) developed a workbook for C.O.A.s aged seven through early adolescence. In this workbook, living with an

alcoholic is compared unto living in the same house with an elephant that no one notices. The workbook is designed for group work or for the individual child. Its goals are to help the C.O.A. to understand the disease concept of alcoholism and to help them work on many of their own problems such as self-esteem, proper expression of feelings, isolation, and relationships through examples and problem solving suggestions.

Black (1979) also developed a workbook to be used in treatment with C.O.A.s through age 14. This workbook, filled with numerous illustrations, educates about the disease concept of alcoholism. It encourages the expression of feelings, explains how the alcoholic can become well, and explains how the whole family can become well too. Above all, the book helps the child to understand that he is not alone and that the alcoholic, even though he is sick, still loves the child.

In a study of group treatment with latency-aged children, Brown (1982) suggested group goals of "dissemination of information about alcoholism and the repairing of relationships that may have been damaged in alcoholic families" (p.70). In this study, Brown used a group size of eight C.O.A.s which met for one hour per week during

the school year. Each group began with a social activity but major focus within group time was on a highly structured activity. This was intended to lead the child to more effectively communicate with his family, peers, and leaders.

To help C.O.A.s feel less isolated, Brooks (1981) tells her own story of what it was like to grow up in an alcoholic home. Included is a checklist of ten items for the C.O.A. to identify with. Brooks encourages the reader to seek help and offers suggestions of support groups and counselors. She also includes a chapter for the parent to help them realize that the child is feeling pain and is in need of help.

Manning (1987) suggests the use of bibliotherapy in treating school-aged C.O.A.s. Since the child has learned denial and secrecy around his parent's alcoholism, "a sensitive professional can first open the door to treatment without directly confronting the alcoholism in the child's family by using the intermediary of a book" (p. 37). The process through which this type therapy works includes "identification, projection, catharsis, and insight" (p. 37). Manning gives a list of what to look for in therapeutic books and also offers some suggestions of books for the C.O.A. and for the professional alike.

The NIAAA (1981) symposium defined the treatment of C.O.A.s as "the process of providing the services needed by the child. It is not necessarily a formal therapy program, but it may include activities usually thought of as 'prevention'" (p. 23). Not only is the here and now important, but future problems must be addressed also. Support, education, and motivation for change are the major goals to be achieved through giving the child a safe environment, a trusting relationship, and autonomy. The NIAAA also offers suggestions on how to be a better therapist with this population e.g. have a genuine concern for children, be able to deal comfortably with pain, and be consistent and honest.

Ackerman (1983) offers suggestions for teachers, therapists, and parents when dealing with C.O.A.s. He stresses the importance for teachers to concentrate on the children themselves. Children not only need to be educated about alcohol but they need to have someone with whom they can discuss their feelings. For therapists, Ackerman suggests three crucial areas in which to help the C.O.A. "These areas involve conditions for effecting positive relationships with others, ways of reducing feelings of powerlessness, and strategies for resolving conflict" (p. 135). Parents can help by first

simply acknowledging that there is a drinking problem and that whether or not the alcoholic stops drinking, the children have been affected. Ackerman then urges the parent to seek outside help to build a healthier family environment.

DiCicco et al. (1984) used the Cambridge And Somerville Program for Alcoholism Rehabilitation (CASPAR) alcohol education model to work with children grades seven through 12. Focus was on education about alcohol use and abuse and alcoholism in the BASIC (general alcohol education) groups, with the Children from Alcoholic Families (CAF) groups focusing on the effects of alcoholism on the family and relationships. Data was collected from both groups with the conclusion that "CAF groups are more intimate and more intense and involve greater self-disclosure than the BASIC groups" (p. 23).

DiCicco et al. (1984) reported that CASPAR had as its initial goal the development of an alcohol education program within the schools. When the program was first used in the classroom,

some students displayed unusual behaviors; some normally passive students became very active, others withdrew, one cried, another became very angry in class, and a few suddenly sought help about their problem--alcoholism in their families (p. 29).

This alerted program facilitators to the role the classroom could

play in recruiting these children into education groups. When the group was offered in a non-threatening way, such as teachers supplying indirect information about the CASPAR program, the children were more likely to reach out for help.

Davis et al. (1985) discusses the CASPAR educational model also. This article explains in more detail the program structure, what is taught to the children about alcohol, and what is taught to them about alcoholism. This program is used also as a prevention method. Pretest, intervention, and post-test is the method used for evaluating the program results.

Owen et al. (1985), seeing the need for a treatment group for C.O.A.s , developed a program through the Child and Adolescent Division and the Alcohol Treatment Unit of New York Hospital, Cornell Medical Center. This group consisted of children whose parents were currently receiving inpatient treatment for alcoholism. The children and adolescents were placed in groups together which resulted in interactions beneficial to both. This became a secure place for these children to express their feelings surrounding parental alcoholism, and it was "hoped that this may facilitate their entrance into treatment at a later date, if indicated" (p. 40).

Overall, group treatment was seen to help these children realize that they were not alone and could find support with other C.O.A.s.

Deckman (1982) encourages the use of group treatment for C.O.A.s as a

valuable and effective means for overcoming feelings of isolation, for improving communication of feelings toward one another, for providing an atmosphere of support and caring, and for providing education concerning the disease of alcoholism" (p.77).

This was concluded after studying a group of 13-17 year olds for eight weeks. Guest speakers were used to educate and Gestalt and Rogerian techniques were used for targeting feelings and behaviors. Upon completion of the group, members considered their experience to have been very helpful, especially in "overcoming feelings of isolation" (p.76).

Bingham (1985) also saw the benefits of working with C.O.A.s in a group treatment approach. Even in working with latency-aged children, "the major treatment goal for the therapy group is to provide information about the disease of alcoholism, and to repair the relationships that may have been damaged in the alcoholic families" (p. 15). By doing this, other issues such as isolation and the inability to express feelings will be worked through.

Morehouse (1979) suggests the school system as a logical place to intervene with C.O.A.s. "The teacher may be the first significant adult in an elementary school student's life who offers a consistent secure environment" (p. 152). Teachers should begin educating these children through classroom discussions about alcohol and alcoholism. This can be followed by individual counseling to encourage the child to express his feelings but should definitely lead to group sessions. Groups will initially "focus on parents and eventually (the group) will discuss their own needs" (p. 158).

In conducting an alcohol education program with 421 high school students, Weir (1970) noted differences between the children with family alcohol problems and those without. Not only were there differences in absenteeism, socio-economic status, and family structure, but personality differences were apparent between these two groups. Volunteers were elicited for individual counseling with results consisting "of an improvement in communication, improved family involvement, greater feelings of self-worth, and an opportunity to be a more adequate adolescent" (p. 17).

Ryerson (1985) directed the contents of his book toward teen-aged C.O.A.s. This is an educational book in that it explains the

disease concept of alcoholism, that alcoholism effects the whole family, and ways in which to improve life in a home with an alcoholic parent. Ryerson emphasises the three C's for teenagers to understand, "you didn't cause your parent's drinking, you can't control it, and you can't cure it. Planting these concepts into your mind will do a lot to clear your head and ease some of the load you're carrying around" (p. 14).

Deutsch (1982) recognized the presence of barriers in treating C.O.A.s, but mainly describes those found within the therapist and the C.O.A. himself. Once therapy has begun, realistic expectations and goals must be outlined on the part of the helper. The helping role can be filled by many people e.g. teachers, guidance counselors, clinicians, probation officers, or personal friends. Community strategies, such as school education programs on alcoholism, are very important but basic twelve-step programs such as Al-Anon and Alateen are essential to treating C.O.A.s.

Adult Children of Alcoholics

The roles and rules children learn while living in the alcoholic home will carry over into adulthood if intervention does not occur.

Black (1982) strongly encourages A.C.O.A.s to seek out some form of help. She recommends Al-Anon or A.C.O.A. support groups. Also given are exercises for the identification of feelings and the reshaping of childhood roles.

McConnell (1986) developed a workbook for the A.C.O.A. This workbook was designed to help the reader to locate the origin of many difficulties they are now experiencing such as impulsiveness, distrust, dependence, and the need to control. This workbook helps take the A.C.O.A. back into his past by having him draw pictures of rooms from his childhood home, pictures of family members, and pictures of specific childhood memories. McConnell not only helps the A.C.O.A. to understand what is happening in the present because of his past, but she offers exercises in healing to aid the A.C.O.A. in changing unhealthy behaviors.

The Family of the Alcoholic

To treat the family, Lawson (1983) first suggests the diagnosis of the alcoholic family through observations of behaviors, family reports, and assessment of the family structure. Lawson further suggests initial focus on family therapy in conjunction with

Alcoholics Anonymous. Within this family therapy, different techniques may be used, such as the communication model, systems model, structural model, and social learning model. Lawson then breaks down specific treatment issues such as abuse, sexual dysfunction, divorce, and C.O.A.s with treatment suggestions for each.

After defining the diagnosis of co-dependency, Cermak (1986) discussed treatment procedure.

The recovery from co-dependence and the recovery from chemical dependence are remarkably similar and can be seen to pass through the same four general states: The Survival Stage (I), The Re-Identification Stage (II), The Core Issues Stage (III), and The Re-Integration Stage (IV) (p. 68).

It is through these stages that Cermak recommends treating the co-dependent. He suggests that this treatment include a family education program, self-help groups, and psychotherapy. Family education is used to help the family understand dependency and co-dependency through the disease concept; self help groups which follow a twelve-step program will help place emphasis on a spiritual life; and psychotherapy will treat specific issues through individual and group therapy.

"Even after death draws the curtain on the dependent, the

tragedy continues for his children and his children's children"

(Wegscheider, 1981, p. 150). Wegscheider shows that with proper intervention, this does not have to be true. She offers strategies for getting the dependent into treatment and encouragement for treating the family as a system. Also explained are treatment goals and techniques to be used with the specific roles being played within the family. The treatment process is primary care, after-care, and continued recovery through support.

To summarize, Children of Alcoholics are a population at risk of developing numerous problems. These problems range from emotional to behavioral and can be inhibiting to psychological growth and well-being. Children of all ages, from infancy to adulthood, are affected by parental alcoholism. Family systems are also disrupted and chaotic in that alcoholism is a family disease.

Many forms of treatment are recommended for use with this population. Overall, educative and support groups are recommended as the most effective means by which C.O.A.s may be treated. Other modalities such as bibliotherapy, workbooks, and individual therapy work well with specific issues. In treatment of families, a systems framework is most useful.

CHAPTER III.

METHODOLOGY

Hypotheses

The purpose of this study was to determine if there was a statistically and substantively significant relationship between the educational backgrounds of therapists and the modalities by which they treat children of alcoholics. Several hypotheses were established. These hypotheses were:

1. A therapist's belief in chemical dependency as a disease is correlated with his use of the disease model as orientation toward treatment of chemical dependency.
2. A therapist's type of education is correlated with his use of the disease model as an orientation toward treatment of chemical dependency.
3. A therapist's being an A.C.O.A. is correlated to his choice of an alcohol and drug work setting.
4. The number of chemical dependency workshops a therapist has attended is correlated with his belief that chemical dependency is a disease.

5. A.C.O.A. therapists' personal treatment is correlated with the treatment modalities they espouse for their C.O.A. clients.

6. The type education a therapist has is correlated with the treatment modality he espouses for C.O.A.s.

Instrumentation

A questionnaire was developed to study the relationship between these variables and a therapist's choice of treatment modality for working with C.O.A.s (see Appendix). The questionnaire consisted of 26 questions and was mailed to all psychiatrists, psychologists, and state licensed master level social workers residing in Knox County in the state of Tennessee. The names and addresses of these professionals were provided by the Tennessee Department of Health and Environment and by the chapter membership roster of the National Association of Social Workers, Tennessee Chapter.

The questionnaire was designed to gather the following information:

1. The practice setting in which the therapist has experience.
2. How much exposure the therapist has had in working with chemically dependent clients.

3. How the therapist would describe his orientation to the treatment of chemically dependent clients.
4. What percentage of clients are C.O.A.s.
5. What treatment modalities does he espouse for C.O.A.s.
6. What is the therapist's educational background and exposure to classes and workshops on chemical dependency.
7. To determine if the therapist is an A.C.O.A., whether he has received treatment, and if so, what kind.

The questionnaire was printed on canary yellow paper. This was done to increase its visibility to the therapist should it become mixed with other papers before completion. Posted with the questionnaire was a cover letter personalized for each therapist. The information gathered was intended to be anonymous, therefore, the personalized cover letter was not stapled to the questionnaire. This would decrease the chance of its return with the completed questionnaire, which would identify its source.

A total of 307 questionnaires were mailed to the designated therapists on December 4, 1987. Within one week, by December 11, 1987, 76 questionnaires had been returned. Within two weeks, by December 18, 1987, 103 had been returned. On January 21, 1988, eight weeks after the initial mailout date, a reminder postcard was sent to each therapist. This postcard requested the return of the completed questionnaire, if not previously done, and extended

appreciation for information given. By February 2, 1988, a total of 116 questionnaires had been returned. This was a response rate of 37.8 percent. All returned questionnaires were used in the study.

Of the 307 therapists to which questionnaires were sent, 134 were psychologists, 130 were licensed social workers, and 43 were psychiatrists. The response rate of psychiatrists and psychologists were 27.6 percent and 25.6 percent respectively. Almost 44 percent of those in social work responded.

Of those therapists responding, there was a fairly even division between males and females (Table I). Almost fifty-one percent of the respondents were female and 48.3 percent were male. One respondent chose not to identify himself as male or female. Ninety-two percent of those responding listed their race as white with the remaining eight percent being Native American, Asian, or Black. Ages ranged from 29 to 66 with 48 percent of the therapists falling into the 36-45 age group and 87 percent falling between 26-55.

Frequency distributions were run on all questionnaire items. Chi square tables were used to test for statistically significant relationships between variables.

Table I

THE GENDER, RACE, AND AGE OF THE RESPONDENTS.

Characteristics	Frequency (n=116)	Percent
Gender		
Female	59	50.8
Male	56	48.3
Missing	1	0.9
Race		
White	107	92.2
Native American	4	3.4
Asian	1	0.9
Black	1	0.9
Missing	3	2.6
Age		
26-35	20	17.2
36-45	56	48.3
46-55	25	21.3
56-65	10	8.6
66 and older	1	0.9
Missing	4	3.4

Limitations

In conducting this research project, a number of limitations were noted. First, the population surveyed was not all inclusive of the professionals who work with C.O.A.s. Others who could have been included are school counselors, ministers, and community service organizers. To include all these groups was not within the scope of this study although it might have yielded some valuable information.

Another limitation of the project resulted from the time period in which materials were mailed. The questionnaires were mailed four days following the Thanksgiving holiday. This is a busy time of year for people to take the time to complete a survey. Had the questionnaire been mailed at another time the return rate possibly would have been higher. The number returned also limits the significance of results and limits generalization of the findings.

The majority of the questions on the questionnaire were closed-ended. This was done for precision in analysis and yet many therapists felt the need to write an explanation for some of their answers. This subjective information would have been valuable but

its use was not possible within a limited research project.

Also, not all questions were answered on every questionnaire. Some therapists left several questions blank, therefore, most percentages have been based on a total that includes missing data.

CHAPTER IV

FINDINGS

Practice Settings

Table II shows the practice settings the respondents are presently working in and the practice settings they have worked in the longest. Almost half, 48.3 percent, are presently working in private practice with 74.2 percent working in private practice, psychiatric social services, and community mental health combined.

In looking at the practice setting worked in the longest , 28.4 percent worked the longest in private practice with 67.2 percent having worked the longest in private practice, community mental health, and psychiatric social services combined. Both present practice setting and practice setting worked longest in have high response rates within the same categories. More respondents are now working in private practice with less of them working in other settings.

In order for a write-in "other" practice setting to merit its own

TABLE II

RESPONDENTS' PRESENT PRACTICE SETTINGS AND PRACTICE
SETTINGS WORKED IN THE LONGEST.

Practice Setting	Present Practice Setting		Practice Setting Worked Longest In	
	Frequency (n=116)	Percent	Frequency (n=116)	Percent *
Private Practice	56	48.3	33	28.4
Psychiatric Social Services	17	14.7	21	18.1
Community Mental Health	13	11.2	24	20.7
Medical Social Services	7	6.0	7	6.0
Alcohol & Drug Services	4	3.4	6	5.2
School Counseling	2	1.7	2	1.7
Child Protective Services	1	0.9	2	1.7
Juvenile Corrections	1	0.9	2	1.7
Adoption	0	0.0	2	1.7
Public Welfare	0	0.0	1	0.9
Other	15	12.9	15	12.9
Missing	0	0.0	1	0.9

*Percentages will not combine to equal 100 due to rounding.

category, its response must be five percent of the total response. Although the "other" categories under present practice setting and practice setting worked longest in are 12.9 percent each, included in these were several responses such as university counseling, government agencies, pain management, residential programs, and neuropsychology.

Table III shows the percentage of professional time the therapist devotes to therapy. They report a fairly even distribution with 36 respondents reporting spending 76-99 percent of their professional time in therapy. Almost 40 percent of the respondents spend up to 50 percent of their professional time in therapy with clients.

Clients

Table IV shows the percentage of clients that are chemically dependent adults. Over half of those responding to this question, 50.9 percent, reported having 1-10 percent of their clients falling into this category. Of these therapists responding, it was reported that 33.3 percent did not include children in the treatment of the

TABLE III

PERCENTAGE OF PROFESSIONAL TIME DEVOTED TO THERAPY BY
FREQUENCY AND PERCENT.

Percent of Time	Frequency (n=116)	Percent	Cumulative Percent
0	5	4.3	4.3
1-25	24	20.7	25.0
26-50	17	14.7	39.7
51-75	22	19.0	58.7
76-99	36	31.0	89.7
100	12	10.3	100.0

TABLE IV

PERCENTAGE OF CLIENTS THAT ARE CHEMICALLY DEPENDENT ADULTS,
BY FREQUENCY AND PERCENT.

Percent of Clients	Frequency (n=116)	Percent *
0	8	6.9
1-10	59	50.9
11-20	17	14.7
21-30	10	8.6
31-40	7	6.0
41-50	6	5.2
More than 50	6	5.2
Missing	3	2.6

*Percentages will not combine to equal 100 due to rounding.

chemically dependent adult. Another 32.4 percent reported inclusion of the children in 1-10 percent of the cases (Table V). In this case, it would seem unlikely that the children would be included in the treatment process.

Treatment

Of the 86 therapists who chose to respond to the question, "In what situations would you treat the whole family of the chemically dependent adult?", 36.2 percent reported as their response always/whenever possible. Seven percent reported whenever there is obvious family conflict, and 30.8 percent responded in the "other" category. This was an open-ended question and the therapists were allowed to respond more than once. Included in the other category were many responses, but none repeated often enough to equal five percent of the total responses. Some of these responses stated that family was included 1) when family issues are the presenting problem, 2) when the chemically dependent person is an adolescent, 3) when the chemically dependent person requests it, 4) when the chemically dependent person is stabilized, and 5) never (Table VI).

TABLE V

PERCENTAGE OF CHEMICALLY DEPENDENT ADULT CLIENTS INCLUDING THEIR CHILDREN IN THE TREATMENT PROCESS, BY FREQUENCY AND PERCENT.

Percent of Cases	Frequency (n=108)	Percent *
0	36	33.3
1-10	35	32.4
11-20	9	8.3
21-30	5	4.6
31-40	0	0.0
More than 40	17	15.7
Missing	6	5.5

*Percentages will not combine to equal 100 due to rounding.

TABLE VI

FREQUENCY AND PERCENT OF SITUATIONS IN WHICH THE WHOLE FAMILY OF THE CHEMICALLY DEPENDENT ADULT IS TREATED.

Situation	Frequency (n=116)	Percent *
Always/Whenever Possible	42	36.2
When there is obvious family conflict	9	7.8
Other	35	30.2
Missing	30	25.9

*Percentages will not combine to equal 100 due to rounding.

Hypothesis seven states that a therapist's type of education is correlated to his inclusion of family therapy in treatment of the chemically dependent adult. When the chi square statistical test was used to test the relationship between education and inclusion of family therapy in treatment, it was found to be significant at the .05 level with $\chi^2=4.7$, $df=1$, and $p < .05$ (Table VII). Numbers would indicate that there is a substantive relationship within the hypothesis tested.

Of those responding about their inclusion of family in the treatment process, 24.8 percent were therapists educated in social work and who responded that they would include the family always/whenever possible. Of therapists educated in psychology, 12.4 percent responded that they would treat the family always/whenever possible. Responses of psychiatrists have been excluded to allow comparison of responses of therapists with social work backgrounds and responses of therapists with psychology backgrounds.

The therapists were asked to state what they felt were the most important factors in the treatment of C.O.A.s. Table VIII displays those responses. Again, this was an open-ended question

TABLE VII

THE CORRELATION OF A THERAPIST'S TYPE EDUCATION TO HIS INCLUSION OF FAMILY THERAPY IN TREATMENT OF THE CHEMICALLY DEPENDENT ADULT.*

Frequency Percent of Total	Inclusion of Family in Treatment			Total
	Always/Whenever Possible	Other	Missing	
Social Work	26 24.8%	15 14.3%	16 15.2%	57 54.3%
Psychology	13 12.4%	21 20.0%	14 13.3%	48 45.7%
Total	39 37.2%	36 34.3%	30 28.5%	105 100.0%

Note:

$$\chi^2 = 4.7, df = 1, p < .05$$

*Responses of psychiatrists have been excluded to allow comparison of responses of therapists with social work backgrounds and responses of therapists with psychology backgrounds.

TABLE VIII

FREQUENCY AND PERCENT OF FACTORS CONSIDERED MOST IMPORTANT
IN THE TREATMENT OF C.O.A.s.

Factors	Frequency (n=116)	Percent *
Therapist's knowledge of chemically dependent/dysfunctional families	15	12.9
Patient's recognition of C.O.A. issues and how they relate to present behavior	14	12.0
Patient's motivation	12	10.3
Coping skills development	11	9.5
Assessment of the whole patient	9	7.8
Peer support/Support counseling	7	6.0
Education of patient and family of family dynamics	5	4.3
Other	42	36.2
Missing	1	0.9

*Percentages will not combine to equal 100 due to rounding.

with the therapists being allowed to respond more than once. Twelve percent stated that the therapist's knowledge of chemically dependent families was the most important factor. Twelve percent stated that the client's recognition of his C.O.A. issues and how they relate to his present behavior was most important. A large percentage of the respondents, 36.2 percent, reported other factors as being most important. Other responses included 1) the patient/therapist fit, 2) the individual's self-worth, 3) the need to please others/responsibility issues, 4) control issues, 5) trust issues, and 6) the patient's own addiction potential.

Chemical Dependency

Of the therapists responding to question nine, 62.9 percent stated that they believed chemical dependency is a disease (Table IX). Fifty percent reported using the disease model as their orientation toward treatment (Table X). Hypothesis one states that a therapist's belief in chemical dependency as a disease is correlated to his use of the disease model as orientation toward treatment of chemical dependency.

TABLE IX

FREQUENCY AND PERCENT OF RESPONDENTS' BELIEF THAT CHEMICAL
DEPENDENCY IS A DISEASE.

Belief	Frequency (n=116)	Percent
Yes	73	62.9
No	27	23.3
Missing	16	13.8

TABLE X

DESCRIPTION OF THERAPISTS' ORIENTATION TOWARD THE
TREATMENT OF CHEMICAL DEPENDENCY, BY FREQUENCY AND
PERCENT.

Orientation	Frequency (n=116)	Percent
Primary Disease Model	58	50.0
Psychoanalytic Model	34	29.3
Both	9	7.8
Neither	8	6.9
Missing	7	6.0

When the chi square statistical test was used to test the relationship hypothesized, it was found to be significant at .05 level with $X^2=32.2$, $df=1$, and $p < .05$. Fifty-four percent of those stating that they believed chemical dependency is a disease use the primary disease model in treatment (Table XI). Again, numbers would indicate a substantive relationship within this hypothesis.

Hypothesis two states that a therapist's type of education is correlated to his use of the disease model as orientation toward treatment of chemical dependency. Chi square was again used to test this relationship and it was not found to be statistically significant. Those with an education in social work were not found to be different in their orientation toward treatment than those with an education in psychology. Responses of psychiatrists have been excluded to allow comparisin of responses of therapists with social work backgrounds and responses of therapists with psychology backgrounds.

Children of Alcoholics

Table XII indicates that 34.5 percent of the therapists report

TABLE XI

THE CORRELATION OF A THERAPIST'S BELIEF IN CHEMICAL
DEPENDENCY AS A DISEASE TO HIS USE OF THE DISEASE MODEL
AS ORIENTATION TOWARD TREATMENT OF CHEMICAL DEPENDENCY.*

Frequency Percent of Total		Orientation Toward Treatment of Chemical Dependency			Total
		Primary Disease Model	Other	Missing	
Belief that Chemical is a Disease	No	2 1.9%	23 21.9%	1 0.9%	26 24.7%
	Yes	47 44.8%	16 15.3%	2 1.9%	65 62.0%
	Missing	3 2.9%	7 6.6%	4 3.8%	14 13.3%
Total		52 49.6%	46 43.8%	7 6.6%	105 100.0%

Note:

$$X^2 = 32.2, df = 1, p < .05$$

*Responses of psychiatrists have been excluded to allow comparison of responses of therapists with social work backgrounds and responses of therapists with psychology backgrounds.

TABLE XII

PERCENTAGE OF RESPONDENTS' CLIENTS THAT ARE C.O.A.s, BY
FREQUENCY AND PERCENT.

Percent of Clients	Frequency (n=116)	Percent *
0	2	1.7
1-20	40	34.5
21-40	23	19.8
41-60	22	19.0
61-80	12	10.3
81-100	2	1.7
Missing	15	12.9
Mean = 34.2		
Median = 25.0		

*Percentages will not combine to equal 100 due to rounding.

that 1-20 percent of their clients are C.O.A.s. The range of C.O.A. clients reported was from 0-100 percent. The mean was 34.2 percent with the median being 25.0 percent. Table XIII indicates that those C.O.A.s seen in therapy by the respondents largely fell into the adult category. Sixty-two percent of the therapists reported 76-100 percent of their C.O.A. clients were adults while 19 percent of the therapists reported 1-25 percent of their C.O.A. clients were children.

Treatment of Children of Alcoholics

Therapists were asked to identify, by age group, how they used several treatment modalities with their C.O.A. clients. The responses to use of these modalities were low. Overall, they show a trend in what modalities are used but the numbers are not strong enough to imply that these responses may be generalized.

Table XIV shows the percentage of C.O.A. clients, by age group, participating in family therapy with the C.O.A. as the primary client. Of the 29 respondents reporting using this type treatment modality with adults, 22 use it with only 1-25 percent of these clients. Of

TABLE XIII

PERCENTAGE OF C.O.A. CLIENTS, BY AGE GROUP, BY FREQUENCY AND PERCENT.

Percent of Clients	Adult (Over 17 yrs.)		Adolescent (12 yrs. to 17 yrs.)		Children (Under 12 yrs.)	
	Frequency*	Percent**	Frequency*	Percent**	Frequency*	Percent**
	(n=114)		(n=114)		(n=114)	
0	9	7.9	43	37.7	71	62.3
1-25	11	9.6	35	30.7	22	19.3
26-50	10	8.8	11	9.6	5	4.4
51-75	8	7.0	3	2.6	1	0.9
76-100	62	54.4	8	7.0	1	0.9
Missing	14	12.3	14	12.3	14	12.3

*Frequency of respondents

**Percentages will not combine to equal 100 due to rounding.

Table XIV

PERCENTAGE OF C.O.A. CLIENTS, BY AGE GROUP, PARTICIPATING IN FAMILY THERAPY: C.O.A. AS PRIMARY CLIENT AND FAMILY THERAPY: C.O.A. NOT AS PRIMARY CLIENT.

C.O.A. as Primary Client C.O.A. not as Primary Client

Percent of Clients	C.O.A. as Primary Client				C.O.A. not as Primary Client			
	Adult Frequency* (n=29)	Adolescent Frequency (n=21)	Children Frequency (n=10)	Adult Frequency (n=16)	Adolescent Frequency (n=11)	Children Frequency (n=10)	Adult Frequency (n=16)	Adolescent Frequency (n=11)
1-25	22	6	5	8	5	3		
25-50	3	2	0	2	3	2		
51-75	1	2	1	1	1	1		
76-100	3	11	4	5	2	4		

*Frequency of respondents

the 21 respondents who use this type with adolescents, 11 use it with 76-100 percent of these clients. It would appear to be used more often with adolescent clients.

Also shown in Table XIV, are the percentages of C.O.A. clients, by age group, participating in family therapy with the C.O.A. not as the primary client displayed. Numbers are low with 8 of the 16 responses in the adult category, used with 1-25 percent of these clients.

Table XV shows the percentage of C.O.A. clients, by age group, that participate in group therapy. Of the 32 responses in the adult category, 16 use this type with 1-25 percent of these clients. Of the 17 responding in the adolescent category, 11 reported using this modality with 76-100 percent of these clients.

The percentage of C.O.A. clients, by age group, participating in individual therapy is displayed in Table XV also. There was a higher number of responses from therapists reporting use of this modality than other modalities. In all three age groups, it was reported to be used the highest in 76-100 percent of the cases. In adults, 46 of the 70 respondents use this modality with 76-100 percent of the cases.

Table XVI displays the percentage of C.O.A. clients, by age group,

Table XV

PERCENTAGE OF C.O.A. CLIENTS, BY AGE GROUP, PARTICIPATING IN
GROUP THERAPY AND INDIVIDUAL THERAPY.

Percent of Clients	Group				Individual		
	Adult Frequency * (n=32)	Adolescent Frequency (n=17)	Children Frequency (n=3)	Adults Frequency (n=70)	Adolescents Frequency (n=30)	Children Frequency (n=15)	
1-25	16	3	1	15	4	5	
26-50	6	2	1	7	7	2	
51-75	4	1	0	2	3	3	
76-100	6	11	1	46	16	5	

*Frequency of respondents

Table XVI

PERCENTAGE OF C.O.A. CLIENTS, BY AGE GROUP, PARTICIPATING IN SUPPORT THERAPY.

Percent of Client	Adults Frequency* (n=36)	Adolescents Frequency (n=12)	Children Frequency (n=4)
1-25	18	6	3
26-50	8	1	0
51-75	2	2	0
76-100	8	3	1

*Frequency of respondents

participating in support therapy. This was reported in higher numbers to be used in 1-25 percent of cases in all three age groups. Eighteen of the 36 respondents using this with adult clients use it with 1-25 percent of these cases. Six of the 12 respondents using this with adolescents use it with 1-25 percent of these clients.

Hypothesis six states that the type education a therapist has is correlated to the treatment modality he espouses for his C.O.A. clients. Repeated measures were used to measure type of degree by type of therapy used. The effect of degree type on choice of treatment modality used was not found to be statistically significant. Respondents with a degree in social work and those with a degree in psychology both frequently chose individual therapy as the preferred modality to use with C.O.A. clients. Here again, psychiatrists' responses were excluded so as to compare social work education with psychology education.

Educational Characteristics of the Respondents

Table XVII shows the educational characteristics of the respondents. Approximately forty-nine percent report having a

TABLE XVII

FREQUENCY AND PERCENT OF EDUCATIONAL CHARACTERISTICS OF THE RESPONDENTS.

Characteristic	Frequency (n=116)	Percent *
Highest Degree		
Master of Social Work	57	49.1
PhD in Clinical Psychology	37	31.9
MD of Psychiatry	11	9.5
PhD in School Psychology/ Counseling Psychology	9	7.8
Master of Psychology	1	0.9
Other	1	0.9
Number of Chemical Dependency Classes Attended		
0	79	68.1
1	20	17.2
2	6	5.2
3	4	3.4
4 or more	7	6.0
Internship or Residency Program in Chemical Dependency		
No	96	82.8
Yes	20	17.2
Tennessee Certified Alcoholism Counselor		
No	114	98.3
Yes	2	1.7

*Percentages will not combine to equal 100 due to rounding.

Master of Social Work degree and 31.9 percent have a PhD in Clinical Psychology. Sixty-eight percent report having had no classes on chemical dependency and 96 percent have had no internship or residency program in the chemical dependency field. Only 1.7 percent of the respondents are Tennessee certified alcoholism counselors.

Table XVIII displays the break down of the number of chemical dependency classes respondents have attended. This break down is according to their educational background. A little more than thirty-four percent of the respondents had an education in social work and had no classes in chemical dependency. Thirty-one percent of the respondents had an education in psychology and had no classes in chemical dependency. Thirteen percent had an education in social work which included one class in the area and 5.7 percent had an education in psychology which included one class.

Table XIX displays the involvement of those therapists with an education in social work and those with an education in psychology who had an internship or residency program in chemical dependency. Seven percent of the respondents had an internship and were educated in social work. This was 14 percent of all the social work

TABLE XVIII

THE NUBER OF CHEMICAL DEPENDENCY CLASSES ATTENDED BY
THERAPISTS WITH SOCIAL WORK BACKGROUNDS AND THERAPISTS
WITH PSYCHOLOGY BACKGROUNDS.*

Frequency Percent of Total	Number of Classes						Total
	0	1	2	3	4 or more	Missing	
Social Work	36 34.3%	14 13.3%	2 1.9%	2 1.9%	2 1.9%	1 1.0%	57 54.3%
Psychology	33 31.4%	6 5.7%	4 3.8%	2 1.9%	1 1.0%	2 1.9%	48 45.7%
Total	69 65.7%	20 19.0%	6 5.7%	4 3.8%	3 2.9%	3 2.9%	105 100.0%

*Responses of psychiatrists have been excluded to allow comparison of responses of therapists with social work backgrounds and responses of therapists with psychology backgrounds.

TABLE XIX

THERAPISTS' INVOLVEMENT IN AN INTERNSHIP OR RESIDENCY PROGRAM IN CHEMICAL DEPENDENCY.*

Frequency Percent of Total	Internship or Residency Program		Total
	No	Yes	
Social Work	49 46.7%	8 7.6%	57 54.3%
Psychology	42 40.0%	6 5.7%	48 45.7%
Total	91 86.7%	14 13.3%	105 100.0%

*Responses of psychiatrists have been excluded to allow comparison of responses of therapists with social work backgrounds and responses of therapists with psychology backgrounds.

respondents. Five percent of the total respondents also had an internship but were educated in psychology. This was 12.5 percent of all the psychology respondents.

Table XX displays the response to the question, "How many workshops on chemical dependency have you attended within the last five years?". Of those responding to this question, 30.2 percent have attended no workshops while 25 percent have attended four or more.

Table XXI displays the number of chemical dependency workshops attended within the last five years by therapists with social work or psychology backgrounds. Seventeen percent were respondents who had an education in social work and who had attended no workshops. Thirteen percent were respondents who had an education in psychology and who had attended no workshops. Nineteen percent were educated in social work and had attended four or more workshops while 6.6 percent were educated in psychology and had attended four or more workshops.

Hypothesis four states that the number of chemical dependency workshops a therapist has attended is correlated to his belief that chemical dependency is a disease. When chi square tables were used

TABLE XX

FREQUENCY AND PERCENT OF WORKSHOPS ON CHEMICAL DEPENDENCY
ATTENDED WITHIN THE LAST FIVE YEARS.

Number of Workshops	Frequency (n=116)	Percent
0	35	30.2
1	19	16.4
2	16	13.8
3	13	11.2
4 or more	29	25.0
Missing	4	3.4

TABLE XXI

THE NUMBER OF CHEMICAL DEPENDENCY WORKSHOPS ATTENDED
WITHIN THE LAST FIVE YEARS BY THERAPISTS WITH SOCIAL WORK
BACKGROUNDS AND WITH PSYCHOLOGY BACKGROUNDS.*

Frequency Percent of Total	Number of Chemical Dependency Classes Attended						Total
	0	1	2	3	4 or more	Missing	
Social Work	18 17.2%	8 7.6%	7 6.6%	3 2.9%	20 19.1%	1 1.0%	57 54.4%
Psychology	14 13.3%	10 9.5%	9 8.6%	6 5.7%	7 6.6%	2 1.9%	48 45.6%
Total	32 30.5%	18 17.1%	16 15.2%	9 8.6%	27 25.7%	3 2.9%	105 100.0%

*Responses of psychiatrists have been excluded to allow comparison of responses of therapists with social work backgrounds and responses of therapists with psychology backgrounds.

to test this relationship, statistical significance was not found at the .05 level.

A.C.O.A. Therapists

Table XXII shows the responses of therapists who considered themselves to be A.C.O.A. and their own involvement in therapy.

Nineteen percent of the respondents consider themselves to be A.C.O.A.s. Of those respondents, 54.5 percent have sought treatment for their A.C.O.A. issues. One hundred percent of those who sought treatment obtained individual therapy. Forty-one percent obtained treatment through support groups. Also, of those receiving therapy, 58.3 percent reported being very satisfied with the treatment they obtained.

Hypothesis three states that a therapist's being an A.C.O.A. is correlated to his choice of an alcohol and drug work setting. This relationship, when tested by chi square, was shown to have no statistical significance at the .05 level. The reason for the lack of statistical significance was probably that the sample size for this hypothesis was very small. Only four respondents indicated that

Table XXII

INFORMATION ABOUT THERAPISTS WHO CONSIDER THEMSELVES TO BE A.C.O.A. AND THEIR OWN INVOLVEMENT IN THERAPY, BY FREQUENCY AND PERCENT.

Information	Frequency (n=116)	Percent **
Do you consider yourself an A.C.O.A.?		
No	92	79.3
Yes	22	19.0
Missing	2	1.7
Have you ever sought treatment for A.C.O.A. issues?		
No	10	45.5
Yes	12	54.5
* What type treatment did you obtain?		
Individual Therapy	12	100.0
Support Therapy	5	41.7
Group Therapy	4	33.3
Family Therapy: C.O.A. not as primary client	3	25.0
Family Therapy: C.O.A. as primary client	0	0.0
How satisfied with the treatment were you?		
Very Dissatisfied	3	25.0
Somewhat Dissatisfied	1	8.3
Neither Satisfied nor Dissatisfied	0	0.0
Somewhat Satisfied	1	8.3
Very Satisfied	7	58.3

*Note: Responses will exceed n due to multiple responses.

**Percentages will not combine to equal 100 due to rounding.

they presently work in alcohol and drug with only one of these respondents reporting himself to be A.C.O.A.

Hypothesis five states that A.C.O.A. therapists' personal treatment involvement is correlated to the treatment modalities they espouse for their C.O.A. clients. The relationship within this hypothesis was not appropriate for testing due to small sample size

Discussion of the Findings

Of the issues that the respondents identified as important factors in the treatment of C.O.A. clients, many were previously discussed in Chapter I. The C.O.A.'s difficulty in maintaining healthy relationships is one such identified issue. Cork (1969) and Wilson et al. (1978) discuss the detrimental effects parental drinking has on the child's ability to form interpersonal, significant relationships. Seixas (1985) shows how this may be carried on through life and causes complications in marriage and possibly problems in closeness with their own children.

Poor self-esteem in C.O.A.s is another area that is affected by parental alcoholism (Chafetz et al. 1971 and Morehouse 1984).

These children have difficulty in knowing who they are or how to identify themselves. This leads to the issue of role confusion. Family dynamics in these homes are such that the family rituals are based on roles and rules (Hindman et al. 1984). The children will assume particular roles with identifiable characteristics. These roles are survival mechanisms and can lead to intergenerational alcoholism (Wegscheider 1981, Black 1982, Day 1981, and Deutsch 1982).

Being a C.O.A. puts the client in a high risk category for alcohol abuse or alcoholism (Deutsch, 1982). This may be due in part to the fact that children tend to imitate their parents drinking behavior (Chafetz, 1979).

Morehouse (1984) and the NIAAA (1981) are in agreement with the respondents in stating that motivation is a major goal in working with this population. Clients have to become aware of their discomfort and be willing to work at making a change.

Another issue reported by respondents is neglect. Many A.C.O.A.s tend to neglect their own needs due to parental neglect and rejection they received while growing up in the alcoholic homes (Hindman, 1975). It is common for psychological abuse to occur in

dysfunctional homes, with the children being aware of the rejection and neglect (Garbarino 1986, Cork 1969, and Davis et al. 1985).

Education of the C.O.A. was also identified as an important factor. Education with a focus on the disease concept and family dynamics is beneficial in breaking the chain of alcoholism through prevention (Chafetz 1979, DiCicco et al. 1984, and Davis et al. 1985).

The treatment modalities espoused for the C.O.A. client by the respondents appear to differ from those recommended in the literature. In treating adult C.O.A.s, the respondents indicated a high use of individual psychotherapy. Only once in the literature was individual therapy recommended for this group, and then only in combination with family therapy and self-help groups (Cermak, 1986). Support groups were also suggested for the adults in the literature but not suggested by high numbers of respondents in the study (Black 1982 and Deutsch 1982). This would indicate that therapists are not making use of the studies done in this area and are not following study recommendations.

In treating adolescent C.O.A.s, both the respondents and the literature suggest family therapy as an appropriate modality

(Morehouse 1984 and O'Gorman et al. 1984). Another commonality in recommended treatment by these two sources is the use of group therapy. Group therapy helps give the adolescent a reference group and reduces the feeling of being alone (Deckman 1982, Owen et al. 1985, and Bingham 1985). The respondents, again, highly recommended individual therapy and support groups for this age C.O.A. (Black 1982 and Deutsch 1982).

According to O'Gorman et al. (1984), C.O.A.s that are still children would benefit most from group therapy. Brown (1982), Bingham (1985), Owen et al. (1985), and Morehouse (1984) also encourage group therapy with children, especially if the alcoholic parent is in recovery. This modality helps to educate the children and help them to become more expressive about their feelings. The respondents did not rate this modality as strongly as does the literature.

Both the respondents and the literature highly recommend family therapy for C.O.A.s with children. This is to work better with family structures and roles which have been dysfunctional in the alcoholic home (Lawson et al. 1983, and Hindman et al. 1984). Important to the outcome of this type modality is the alcoholic

parent's involvement in recovery (Morehouse, 1984).

An important treatment modality strongly recommended in the literature, but not suggested by the respondents, is the use of bibliotherapy. Workbooks have been written by Hastings (1984), Black (1979), Manning (1987), Ryerson (1985), and McConnell (1986) to help the C.O.A. regardless of his age. Such books are instrumental in educating the C.O.A. about the disease concept, family dynamics, and expression of feelings without being too confrontational.

The literature indicates there may be a high incidence of parental alcoholism in the families of helping professionals (Pilat et al. 1985). According to information gathered in this study, 19 percent of the respondents consider themselves to be C.O.A.s. Hecht (1973) states that "one out of every 13 male adults over 20 years of age is an alcoholic" (p. 1764). In comparing the respondents to Hecht's estimates, Pilat et al. would appear to be correct in this instance. Further study in this area is recommended.

In looking at the percentage of clients who have been reported as being chemically dependent, 52 percent of the respondents stated that 1-10 percent of their clients fell into this category. Cummings (1979) reports that 23 percent of psychotherapy patients have

addictive problems. Responses in this study are a bit short of his percentage rate.

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

The purpose of this study was to determine if there is a significant relationship between the educational backgrounds of therapists and the modalities by which they treat children of alcoholics. The literature is lacking in studies on this topic, therefore, findings in this study are not supported or refuted through it.

Of the seven hypotheses formulated about this topic, two were found to be significant when tested with chi square tables. The first significant hypothesis states that a therapist's type education is correlated to his inclusion of family therapy in treatment of the chemically dependent adult. The second hypothesis that was supported states that a therapist's belief in chemical dependency as a disease is correlated to his use of the disease model as orientation toward treatment of chemical dependency.

A third hypothesis appeared to have significance but to avoid manipulation of the small sample size to assume its significance, this hypothesis was not considered to be supported or unsupported. This hypothesis states that A.C.O.A. therapists' personal treatment involvement is correlated to the treatment modalities they espouse for their C.O.A. clients.

Conclusions

The picture painted about the respondents is that most work in private practice, spending up to 50 percent of their time in therapy. Half of them state that 1-10 percent of their clients are chemically dependent. One-third of those cases did not include children in the treatment process even though half of the respondents stated that they would include family in treatment whenever possible. This would indicate that therapists reported the inclusion of families in treatment more often than they actually did or that a high number of these chemically dependent clients were not cooperative in allowing the involvement of their families.

In discussing their involvement with C.O.A.s as clients, the

respondents stated that the therapist's knowledge of chemically dependent families and the client's recognition of their C.O.A. issues are the most important factors in treatment of this population. Most of the C.O.A.s seen in treatment are adults with individual therapy being the most popular treatment modality used for any age group.

Seventy-three percent of the therapists believe that chemical dependency is a disease while only half of them use the primary disease model as orientation toward treatment. This would indicate inconsistency and would generate concern that some therapists are not treating clients by a model that they believe in.

A large percent of the respondents were Masters in Social Work or Doctors of Philosophy in Psychology. About one-third of the therapists have been to four or more workshops on chemical dependency while the majority have had few or no workshops, classes, or internships in the field.

Through these responses, it was concluded that

1. Individual therapy for C.O.A.s is the highest used modality within this survey.
2. Social workers are more likely than psychologists to include family therapy in the treatment of chemical dependency.

3. Therapists who believe that chemical dependency is a disease are more likely to use the primary disease model as their orientation toward treatment of the chemically dependent adult.

4. The therapists surveyed are treating a population with little background study of relevant issues e.g. workshops, classes, and internships.

Implications for Further Research

Within this study, therapists were asked to list, by percentage, with which age group of C.O.A.s they used certain treatment modalities. This left little room for discussion of why they used the modalities in this manner. Further research into which modalities are actually being used and for what reasons would be of importance. Are the clients being placed in the various treatment modalities because the therapist feels more comfortable in using them or because background study by the therapist shows the usefulness of them with this population? One might suspect that therapists choose modalities on the basis of their own comfortableness with them, due to the differences indicated by this survey.

Another area in which further research is indicated would be that of program implications. Since a large number of the

respondents in this study are in private practice, it would be important to compare their use of treatment modalities as independent practitioners to those used by alcohol and drug centers. Is there a significant difference in policies?

Another area open to further research is in looking at what professions are being chosen for careers by A.C.O.A.s. Pilat et al. (1985) conducted a study indicating that A.C.O.A.s were pulled toward helping professions. It would be useful to attempt replication of their study.

Also, within this study, where one would expect a difference in treatment orientation between respondents in social work and in psychology, little was found. Further research into this could clarify why the two separate disciplines are appearing to be similar. Do they appear similar only in working with this population or are the two beginning to merge in other areas also? This would be important for practice implications. Would there be significant differences in treatment orientation or results? This study would lend itself to further research in many directions.

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APPENDIX

THE UNIVERSITY OF TENNESSEE
KNOXVILLE

December 1, 1987



College of
Social Work

The University of Tennessee College of Social Work is continuously involved in researching topics believed to be relevant to society today. We are now conducting a research project designed to gather information concerning treatment modalities, specifically those used with Chemical Dependency.

Treatment modalities within the field of Chemical Dependency have undergone several changes within the last decade. To better understand how therapists within Knox County are effected by these changes, we are asking three hundred selected therapists to provide us with the important information we need. Would you cooperate by completing the attached questionnaire? Your help would be a great contribution to the knowledge base of treatment modalities used with Chemical Dependency.

It is not required that you work within the Chemical Dependency field to participate in this study. Information received from those working in other fields is needed as well. All responses will be treated confidentially. The data will be reported in aggregate form only, so that your name will never be used in any report. To assure anonymity, please remove this cover letter before returning your completed questionnaire to us in the stamped envelope provided. Your help with this project is greatly appreciated.

If you would like a copy of our research findings, please send a separate note of request to this address:

The University of Tennessee
College of Social Work
Henson Hall
Knoxville, TN 37996-3333
Attn: Lisa Bevins

Sincerely,

A handwritten signature in cursive script that reads "Lisa A. Bevins".

Lisa A. Bevins
Research Assistant

Henson Hall/Knoxville, Tennessee 37996-3333/(615) 974-3351

An Investigative Study of Treatment Modalities

Please print the most appropriate response number in the blanks provided.

General Treatment Information

1. _____ In which practice setting are you presently working?

- | | |
|-------------------------------|---------------------------------|
| 01. Adoption | 09. Juvenile corrections |
| 02. Adult corrections | 10. Medical social services |
| 03. Adult protective services | 11. Private practice |
| 04. Alcohol and drug services | 12. Psychiatric social services |
| 05. Child protective services | 13. Public welfare |
| 06. Community mental health | 14. School counseling |
| 07. Foster care | 15. Terminal care |
| 08. Geriatrics | 16. Other, please specify _____ |

2. _____ Years _____ Months How long have you worked in this setting?

3. _____ In which setting have you worked the longest?

- | | |
|-------------------------------|---------------------------------|
| 01. Adoption | 09. Juvenile corrections |
| 02. Adult corrections | 10. Medical social services |
| 03. Adult protective services | 11. Private practice |
| 04. Alcohol and drug services | 12. Psychiatric social services |
| 05. Child protective services | 13. Public welfare |
| 06. Community mental health | 14. School counseling |
| 07. Foster care | 15. Terminal care |
| 08. Geriatrics | 16. Other, please specify _____ |

4. _____ Years _____ Months How long did you work in this setting?

5. _____ What percentage of your professional time is devoted to therapy?

6. _____ Throughout your career, what percentage of your clients were/are chemically dependent adults?

If 0 percent, please go to question 8.

7. _____ In your treatment of these chemically dependent adults, what percentage of cases included their children in the treatment process?

8. In what situations would you treat the whole family of the chemically dependent adult?

9. _____ Do you believe that chemical dependency is a disease?

1. No

2. Yes

10. _____ How would you describe your orientation to the treatment of chemical dependency?

1. Primary disease model (Chemical dependency is the primary disease)
2. Psychoanalytic model (Chemical dependency is treated as an underlying symptom of a psychiatric disorder)

Children of alcoholics

11. _____ What percentage of your clients are children of alcoholics?

12. Of these children of alcoholics, (C.O.A.), what percentage are:

_____ Adults (18 years and older)
 _____ Adolescent (12 years to 17 years)
 _____ Children (11 years and younger)

13. Please list the percentage of you C.O.A. clients participating in the following therapy modalities by age group. (For example: If eight-five percent of your adult C.O.A.s participate in support groups, place 85% in the blank under adult next to that treatment modality, etc.)

Children	Adolescent	Adult	
_____	_____	_____	Family therapy: C.O.A. as primary client
_____	_____	_____	Family therapy: C.O.A. not as primary client
_____	_____	_____	Group therapy
_____	_____	_____	Individual therapy
_____	_____	_____	Support group
_____	_____	_____	Other, please specify _____

Background information

14. _____ What is your highest completed degree?

- | | |
|----------------------------|--------------------------------|
| 1. Bachelor of Psychology | 5. PhD in Clinical Psychology |
| 2. Bachelor of Social Work | 6. PhD/DSW in Social Work |
| 3. Master of Psychology | 7. MD of Psychiatry |
| 4. Master of Social Work | 8. Other, please specify _____ |

15. _____ Please list the number of classes on chemical dependency you attended during your higher education academic programs.

16. _____ Did you have an internship or residency type program in chemical dependency?

- | | |
|-------|--------|
| 1. No | 2. Yes |
|-------|--------|

17. _____ Are you a Tennessee Certified Alcoholism Counselor? (C.A.C.)

- | | |
|-------|--------|
| 1. No | 2. Yes |
|-------|--------|

18. _____ How many workshops on chemical dependency have you attended within the last five years?

19. _____ Gender

- | | |
|-----------|---------|
| 1. Female | 2. Male |
|-----------|---------|

20. _____ Your race

- | | |
|-------------|--------------------------------|
| 1. Asian | 4. Native American |
| 2. Black | 5. White |
| 3. Hispanic | 6. Other, please specify _____ |

21. _____ Year of birth (List last two digits.)

22. _____ Do you consider yourself an adult child of an alcoholic?

1. No

2. Yes

If no, please go to question 26.

23. _____ If yes, have you ever sought treatment for C.O.A. issues?

1. No

2. Yes

If no, please go to question 26.

24. _____ If yes, did you obtain (check all that apply)

_____ Family therapy: C.O.A. as a primary client

_____ Family therapy: C.O.A. not as primary client

_____ Group therapy

_____ Individual therapy

_____ Support group

_____ Other, please specify _____

25. _____ How satisfied with the treatment were you?

1. Very dissatisfied

4. Somewhat satisfied

2. Somewhat dissatisfied

5. Very satisfied

3. Neither satisfied nor dissatisfied

26. What factor do you consider most important in the treatment of C.O.A.s?

THANK YOU FOR YOUR TIME

PLEASE FOLD QUESTIONNAIRE AND RETURN IN ENVELOPE PROVIDED.

If you would like a copy of survey results, please send a separate note with your name and address to this address:

The University of Tennessee
College of Social Work
Henson Hall
Knoxville, Tennessee 37996-3333

ATTN: Lisa Bevins

Dear Therapist:

Last month a questionnaire seeking information about treatment modalities was mailed to you. This questionnaire was sent to you from the University of Tennessee College of Social Work.

If you have already completed and returned the form to us, please accept our sincere thanks. If not, please do so today. Because only a certain number of therapists have been contacted to participate, it is extremely important that you take a few minutes to fill out the questionnaire. This will insure our conclusions accurately reflect the treatment modalities used in our area.

If for some reason you did not receive the questionnaire, or it got misplaced, please call me right now at 615-974-3353 and I will mail another immediately.

Sincerely,

Lisa A. Bevins

Lisa A. Bevins

Research Assistant

VITA

Lisa A. Bevins was born in Knoxville, Tennessee. She was educated in the Campbell County schools. After graduation from Campbell County Comprehensive High School, she attended The University of Tennessee, Knoxville, where she obtained the degree of Bachelor of Fine Arts, with a major in graphic arts. After working in the field of advertising for two years, she returned to The University of Tennessee to obtain the degree of Bachelor of Arts, with a major in psychology.

Following graduation, she accepted the position of mental health associate in the adolescent psychiatric unit of Peninsula Hospital, Louisville, Tennessee. She was then accepted into the Graduate School of The University of Tennessee to work toward the degree of Master of Science in Social Work. Upon completion of this degree, she will pursue a career as a family therapist in the field of chemical dependency.