THE EFFECTIVENESS OF A GROUP TREATMENT PROGRAM FOR CHILDREN OF ADDICTED PARENTS

By

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Abstract

Titled "Children of Addicted Parents", the purpose of this study was to evaluate the effectiveness of a psycho-educational group intervention for latency age children of alcoholics. The treatment group consisted of eleven children between the ages of eight and twelve, who have lived or who are living with an alcoholic parent or step-parent. Referrals were obtained from elementary school guidance counsellors, Family Service Agencies, Alcohol and Drug Programs and the Ministry of Social Services and Housing. The children and three therapists met one hour a week for nine weeks. The group's dual objectives include educating the children about alcoholism/drug addiction and its effect on the family as well as enhancing the childrens' inherent strengths by teaching strategies to increase self-esteem, problem solving and other coping skills. The program's objectives were carried out through brief lectures, discussion, film, art and therapeutic games. The treatment model has been evaluated using a quasi-experimental design. There was a significant change in the intensity of behaviour problems with a trend for a decrease in the number of problems, as well as a decrease in depression. In addition there was a tendency for an increase in self-esteem.
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DEDICATION

To the children and their parents, who through the intimate act of sharing their pain I have learned so much and in the process a part of myself has been transformed.
PREFACE

LEAVE TAKING

I never thought it would be paradise
I walked a rugged pathway from the start
No ugliness was hidden from my eyes
Nor was life's pain a stranger to my heart
And yet, the earth sprung from beneath my feet
And summer winds were gentle to my hair
I breathed upon the dusk and found it sweet

(Charlott, age 12)
INTRODUCTION

Children of alcoholics have been identified as a vulnerable population, victims of numerous emotional and behavioural problems and at a greater risk of developing alcoholism later in life (Jesse, 1989). Latency age children in particular have been targeted as having difficulties in adjustment. Problems which arise, due to a parent's chemical dependency, create obstacles for these children as they begin to venture outside their family and become part of social groupings (Jesse, 1989). Parental alcoholism creates ongoing difficulties for children making passing through life's developmental stages more problematic. Consequently adolescence may be the culmination of severe conflict that seems to have been brewing since middle-childhood (Jesse, 1989). Research reports that as many as 50% of children of alcoholics become alcoholic themselves, indicating the escalating nature of these children's difficulties (Jesse, 1989).

Most of the literature reports on the research regarding the impact of parental alcoholism on the developing child. Researchers agree that alcoholism within the family appears to shape patterns of interactional behaviour, molding its members in subtle and not so subtle ways. Children become enmeshed in their family's dynamics, unable to separate themselves from their chaotic, unpredictable family system. This distorted family system may lead to problematic parent-child interactions, which may be directly related to continuing the cycle of addiction (O'Gorman & Diaz, 1986).
Although there is a vast amount of literature confirming the deleterious affect of parental alcoholism on the developing child not much is being offered in terms of treatment for latency age children of alcoholics. In addition research supporting the importance of early intervention has been accumulating since the mid 1970's, but still a tremendous gap remains to be filled with respect to providing effective treatment programs for these children. As well empirically based documentation regarding treatment effectiveness is virtually nonexistent.

This project evaluated the effectiveness of a group treatment program for children of addicted parents. Based on the previous research on the impact of parental alcoholism, which identified a number of areas of impairment of functioning for the child, specific areas were targeted in order to improve the child's functioning. These areas were: self-esteem enhancement, teaching coping skills and educating the child about addiction and its affect on the family, thereby reducing anxiety and depression.

According to prior research findings utilizing a group intervention model with this population, (Sunshine & Brown, 1982; Robinson, 1983; Pilat & Jones, 1985) it was expected that the group intervention (independent variable) would have a positive effect on the child's self-esteem and behaviour and decrease the child's level of depression and anxiety (independent variables). In order to
increase the validity of the findings obtained through prior descriptive studies, the treatment intervention was evaluated using a quasi-experimental one-group pretest-posttest design, utilizing self-report measures for children and a child behavioural checklist completed by parents. Outcome measures include: self appraisal, childhood depression and child behaviour inventories, as well as an anxiety scale. The findings obtained from this study will provide the foundation for a more comprehensive study and program implementation for children of addicted parents.
DEFINITION OF THE PROBLEM

The mental health risks of children living with parental alcoholism has been well documented for over thirty years. Beginning with one of the first Canadian studies implemented by Margaret Cork and expanded on by numerous researchers it has been determined that children of alcoholics (COAs) are at a high risk for both hereditary and psychological problems which will continue throughout their lives. While some of these children's problems will be exhibited during childhood, for others problems may not become apparent until adulthood (Arneson, Tripplett, Schweer & Snider, 1983). Nevertheless for the majority of these children long term effects of physiological and psychological damage leads to a profound disruption of family living and a significant decrease in their own productivity and sense of well being (Arneson et al, 1983).

Children raised in families that have alcoholic members are at a greater risk for becoming alcoholic (Robinson, 1989; Bennett, Wolin, Reiss & Teitelbaum, 1987), compulsive eaters, gamblers, spenders, sex and drug addicts (Robinson, 1989). In addition, COAs are at high risk for marrying people who become alcoholic (Naiditch, 1986). It has been suggested that this process of mate selection often sets the stage for a life that revolves around alcoholism (Richards, 1979). Alcoholism then becomes a powerful organizer of family life, altering daily routines and shaping patterns of interactional
behaviour (Steinglass, 1981; Bennett, et al., 1987). While not all COAs grow up to become alcoholic, research indicates that they are also likely to have more physical, mental and emotional problems than children from abstaining families (Woodside, 1988). The difficulties associated with parental alcoholism are then passed down through the generations (Woodside, 1988).

Children of addicted parents often receive little attention and care. In these families attentioned is focused on the addiction and parents lack the time and energy required for child care. Addicted parents are often unable to meet the physical and psychological needs of their children with any semblence of consistency (Black & Mayer, 1980; Jesse, 1989). The greater the degree of alcoholism the more severe the physical abuse or neglect (Woodside, 1983). As well sexual abuse is a common occurrence. Alcohol abuse is generally found among 50% to 80% of homes reporting physical and/or sexual abuse (Black, 1987). Black & Mayer (1980) conducted a study, which was designed to investigate the adequacy of child care in families with an alcohol or opiate addicted parent. They report that, from their sample of 200, 42% physically or sexually abused their children. In addition, these parents were likely to have been abused themselves during childhood. In severely disrupted families children may not be fed, physically cared for and/or medical attention may be neglected, even in serious situations (Black & Mayer, 1980).
The literature reports a number of variables which influence how a child experiences his/her parent's drinking. These include: the age of the child at onset of parental alcoholism, relationship with alcoholic parent; independent of the drinking behaviour, the child's resources outside of the family, availability of the non-alcoholic parent (Brown & Sunshine, 1982; Ackerman, 1986; Morehouse, 1979), severity of alcoholism, duration, degree of marital conflict, sex of alcoholic parent, presence of violence, (Ackerman, 1986; Morehouse, 1979; West & Prinz, 1987), and socioeconomic status (West & Prinz, 1987). Such factors determine the severity of the impact for the child.

The age of the child when parental alcoholism began is significant in terms of the impact on the child. If the child is exposed to a chemically dependent parent at an early age they often have more severe social and emotional problems later in life (Spence & Schmidt, 1989; Richards, Morehouse, Seixas & Kern, 1981). In addition, the impact of maternal alcoholism is viewed as more detrimental to a child than paternal alcoholism for a number of reasons. Traditionally the mother is seen as the primary caretaker of her children. If her functioning is impaired then it is much more likely that the child's basic needs will not be met (Spence & Schmidt, 1989). When mom is the alcoholic the household is usually more chaotic and the children suffer more, especially if the father escapes the situation by overworking (Richards et al., 1981).
Maternal alcoholism creates significant difficulties for her daughter, as she is pushed into a surrogate housekeeper and companion role, giving rise to the problems associated with pseudo-adulthood (Richards et al., 1981). As well, female alcoholics are more likely to abuse their children as compared to male alcoholics (Black & Mayer, 1980). The situation is also compounded by additional stressors such as single parenthood and poverty. Also societal implications are more severe for female alcoholics. For a woman alcoholic her femininity as well as her mothering capabilities are questioned.

Sex of the alcoholic is also indicative of differences in terms of resources available and socioeconomic status. The literature reports that only 1 out of 10 men will stay with an alcoholic wife while 9 out of 10 women will stay with a alcoholic husband (Ackerman, 1986). Consequently female alcoholics are more likely to be single parents with low incomes. Lower financial status and poor living conditions compound the problems and are associated with child abuse and neglect (Black & Mayer, 1980). Financial and social supports appear to be particularly important in preventing child maltreatment in families with an alcohol or opiate addicted parent (Black & Mayer, 1980). If support systems are weak ie. relatives live out of town and/or the nonaddicted spouse is chronically ill or has alcohol or drug problems, then the child is viewed as in a more vulnerable position. Support, both emotional and informational, was
also found to be related to adjustment within alcoholic families. Resources may assist in counteracting the risks associated with living in a disordered family (Clair & Genest, 1986).

Parental violence within the alcoholic family system exacerbates an already strained situation. COAs consistently report greater frequency of family violence than children from abstaining families (Black, Buck & Wilder-Padilla, 1986). One of the strongest predictors of violence between parent and child in Black & Mayer's study was violence between parents. Black (1987) also reports that 95% of her sample (n=409) described greater frequency of both parents being violent in general, and 56% stated that their parents were violent when drinking.

Poor marital relationships were reported more frequently within the alcoholic home as well (Wilson & Orford, 1978). The marital relationship is characterized by critical, hostile and disapproving communication (Edwards, Harvey & Whitehead, 1973). Families of these children tend to be characterized by family disruptions, inconsistent discipline and lack of supervision (Mitchell, Hong & Corman, 1979). COAs report considerably more disruption in their family environments, and they see their family as less cohesive, less organized and more conflict-ridden (Clair & Genest, 1986). In addition, Clair & Genest report that these families are less oriented toward intellectual or cultural pursuits. These children
live in an atmosphere of psychological and physical stress. Consequently they are constantly anxiety ridden (Obuchowska, 1974).

There is consensus among researchers that latency age children of addicted parents comprise a particularly vulnerable group. The effect of parental alcoholism is seen as most disruptive to the pre-pubescent child (Miller & Jang, 1979; Brown & Sunshine, 1982; Richards, Morehouse, Seixas & Kern, 1981). This child has not witnessed a model for normal family life as compared to the adolescent who has already developed his/her coping patterns before the onset of parental alcoholism (Miller & Jang, 1979). There are four areas that the literature points to in terms of the impact of parental alcoholism on the child: characteristics common to these children, impact of psychological abuse, underlying psychological disorders and how these factors impact the child's psychosocial development.

CHARACTERISTICS OF COAs

Various researchers have identified a number of characteristics common to children living in an environment disrupted by alcoholic behaviour. Children feel responsible directly or indirectly for their parents' drinking (Morehouse, 1979; La Pantois, 1986; Richards et al., 1981; Spence & Schmidt, 1989) and conclude that something is wrong with them (Arneson et al., 1983). Parents who are consuming large amounts of alcohol and/or drugs become self absorbed and are
more concerned with their relationship with alcohol/drugs than with their family (Jesse, 1989). Consequently they equate their parents' drinking/drugging with not being loved (Morehouse, 1979; Pilat & Jones, 1985; Ackerman, 1986). Due to the lack of attention and affection, these children feel rejected and hurt (Spence & Schmidt, 1989; Woodside, 1983). In time the children learn that either no one is concerned about how they feel or that they will be punished for expressing feelings. As a result these children learn to deny or displace feelings (Arneson et al., 1983).

COAs react to their situation with a flood of emotions. The most common emotional reaction is anger, with underlying feelings of hurt and sadness (Robinson, 1989). The child feels angry with the nonaddicted parent for not improving the family's situation (Morehouse, 1979), for allowing the loss of some of the carefree aspects of childhood and for not protecting them from the violence and/or verbal abuse (Spence & Schmidt, 1989). Anger is also directed towards the addicted parent for the never ending broken promises (Hecht, 1973). COAs are terrified of their home situation (Richardson, 1989). The chaos and unpredictability of their home life often creates fear and apprehension for these children (Robinson, 1989). The child excessively worries about the addicted parent's well-being (Morehouse, 1979; Black, 1981; Wegescheider-Cruise, 1985). In extreme cases children will want to stay home
from school in order to take care of their parent (Seixas & Youcha, 1985; Cermak, 1986).

Guilt is a prevalent emotion for many children. They feel guilty and responsible for their parent's drinking and they believe they can get them to stop (Robinson, 1989). In situations where the drinking parent is more affectionate and permissive while intoxicated, the child wants the parent to drink, but then feels guilty (Jesse, 1989; Morehouse, 1979). Confusion is a frequent companion for children living within the alcohol/drug addicted family system. Inconsistency, unpredictability and mood swings which are the hallmarks of alcoholism, complicate parental interactions and create constant confusion for the child (Robinson, 1989). Black-outs are especially confusing for these children as they make reality testing difficult (Morehouse, 1979; Richards et al., 1981; Jesse, 1989). Conflict and confusion is created for the child because behaviour during the black-out event is subsequently denied by one or both parents. The child's sense of embarrassment and shame concerning his family's situation prevents him from bringing friends home, consequently limiting his/her ability to form peer relationships and increasing his/her sense of isolation (Brown & Sunshine, 1982; Morehouse, 1979; Fossum & Mason, 1986; Wilson & Orford, 1978; Robinson, 1989).
The COA experiences grief on many levels. He/she will mourn the loss of a "normal" family, lost childhood and the loss of a parent to alcohol/drug addiction (Robinson, 1989). Black (1987) contends that this loss can be so traumatizing that it has been compared to the loss of a loved one. These unresolved emotions when carried throughout childhood and adulthood interfere with fully functioning relationships with friends, spouses and loved ones (Robinson, 1989).

Children in chemically dependent families learn behaviours that allow them to function within their family context but which are self-destructive in the outside world (Black, 1981; Wegescheider, 1981). The roles they adopt hide their painful emotions. Black (1979) believes that the majority of COAs escape detection because they adopt one or more of three basic roles which help them manage their lives. The first born or only child may take on the role of the responsible one. These children receive positive reinforcement for the responsibilities they assume which are age-inappropriate. For example, in an alcoholic family it is not unusual for a child of 8 or 9 to be responsible for such tasks as taking care of younger siblings, doing laundry and other household chores. These children develop strong leadership skills and usually have positive self-concepts, although later in life they usually feel deprived of their childhoods. In addition, they try to manage and control others with often disastrous results. Children who assume the placator role develop unusual sensitivity to the hurts of others and have a need
to ease their pain. This is often accomplished at their own expense. Their listening skills and comforting nature is sought by others, while their own emotional needs are generally neglected. In contrast, children who take on the role of the adjuster tend to go with the flow and put their lives into someone else's hands. Being manipulated by others follows the adjustor into adulthood.

Wegescheider (1981), on the other hand, believes children assume four different roles in response to their family dynamics. The family hero, similar to the responsible one, is a child who tends to become perfectionist, always demanding more of themselves and others. They are usually unable to relax and let others care for them. The scapegoat role, often assumed by the second child is viewed as the outlet for parental anger. She/he is groomed to act out the family's dysfunction. Children who act out are readily identifiable and are often labeled problem children or delinquents. The children who assume the lost child role are the most difficult to identify. Like the adjuster she/he hopes to go through life unnoticed. In order to avoid attention and conflict, they constantly adapt. The mascot role is usually reserved for the youngest child. They are seen as a relief from anxiety by their family. Members of the family try to shield the mascot from their troubles and in return the mascot learns to entertain, charm and manipulate others.
Jesse (1989) questions the utility of role assignment of the child's observable behaviour. She contends that the process of child recovery is neither enhanced nor strengthened by seeing the child as a role. She believes that these labels "merely obscure the lost child-self which is screaming for full expression" (p. 186).

PSYCHOLOGICAL ABUSE

The resultant behaviour of a parent's chemical dependency is in and of itself psychologically disruptive to the developing child (Jesse, 1989). It creates a form of psychological maltreatment, which promotes unhealthy patterns of child and family relations (Spence & Schmidt, 1989). The literature delineates those parental interactions which result in the psychological abuse of the children.

Child-rearing is difficult for an alcoholic parent (Udaykamuri, Mohan, Sharrif, Sekar & Chamundi, 1984; Miller & Jang, 1979; Jesse, 1989). Parents who are dependent on alcohol/drugs become lost in their self absorption (Jesse, 1989). In the chemically dependent family system, the addicted parent(s)' alcohol level appears to set the tone for parent child interactions. The alcoholic's behaviour is determined by how much she/he has had to drink and how hung over she/he is. Sudden irrational punishment, or over-reactions followed by over-indulgent behaviour bewilders these children (Woodside, 1983). Woodside (1983) postulates that these children compensate by
experiencing the parent as two discreet personalities, one good, one bad. Negative feelings about the bad parent are often externalized as anger directed at others. Parents studied at the Washington Center for Addiction described addiction as directly and indirectly interfering with the time, energy and emotional responsiveness required for adequate child-rearing (Black & Mayer, 1980; Jesse, 1989). Love consistency and predictability are important parenting tasks. The very nature of alcohol/drug addiction inhibits one's ability to carry out these tasks.

The parenting style of a chemically dependent person is characterized by chaos and unpredictability which presents extreme inconsistencies to the child (Morehouse, 1983; Jesse, 1989; Naiditich, 1987; Wegescheider-Cruse, 1985). Black (1981), Wegescheider (1981) and Woiltz (1983) have suggested that the child's development and identity are stifled by parental inconsistencies, double bind messages, hidden feelings, incomplete information, shame, uncertainty and mistrust. The conflict-ridden alcoholic family causes an incredible amount of psychological stress and strain on its members. Parents cannot protect their children from the marital conflict which accompanies alcoholism. Through her work with latency age children of addicted parents Jesse (1989) found that the child is used to buffer the emotional turmoil of the stressful marital relationship. Two of the most potent roles that a child can take in order to buffer the emotional turmoil of the marital relationships
are those of the scapegoat and the responsible one. In the case of
the scapegoat, the child rebels and/or acts-out thus drawing atten-
tion away from the marital conflict onto himself. The responsible
one, by becoming the confidante and support system for one of the
parents, balances what is missing in the marital relationship. The
addition of each child to the family increases the stress on the
parental relationship and may escalate the addictive behaviour.
When parents are preoccupied with their own frustrations, emotional
upsets and defensiveness, they have difficulty focusing on their
child's needs. Consequently the child suffers interference in self
development. Through the lack of attention, direction and positive
modelling by their parents these children may lack the development
of a coherent positive self-concept.

Emotional availability, although difficult to define, must be
present for a child to feel loved and secure. Alcohol/drug
addiction interferes with a person's ability to be truly empathic,
giving or truly self denying, which is crucial to emotional
availability (Jesse, 1989). There is a pervasive lack of empathy
which characterizes parent-child interactions within the alcoholic
home. The failure to be empathic with one's children affects the
child's ability to maintain self-cohesion — the ability to maintain
integration and balance within. This inability to integrate and
balance daily life experiences may lead to a child acting-out
aggressively or conversely becoming withdrawn and passive. The
parents' inability to be empathically attuned to others and his/her children is due to the chaotic or unstable self of both parents (Jesse, 1989). If the parents' cannot balance and integrate their own daily life experiences and must use alcohol as a stabilizer, how can they model healthy integration for their children?

Jesse (1989) proposes that the parents own lack of self-cohesion interferes with their ability to acknowledge each other or their children as separate autonomous beings. A disordered self is analagous to alcoholism. The nonaddicted parent's co-dependency is far more subtle and more resistant to change, consequently his/her lack of self-cohesion is often less obvious. As long as this parent operates within a controlled external context, the sense of self will appear intact. Any loss of structure threatens the inner self thus making control a major issue. This need for control distorts the parent-child relationship. The purpose of control is always aimed at maintaining the sense of self. Jesse continues to postulate that what underlies the need for control is fear. The major fear in the alcoholic/addicted family system is the fear of loss of self. Fear of loss of self (absorption of another person) may exist because the true self-concept has never been established (Tuna, 1988). Inconsistent, confusing responses from parents can lead to an incomplete sense of self, consequently the adult with an alcoholic family background may have no identity which is strong enough to withstand intimate association with another person (Tuna,
1988). This results in a rigid set of mechanisms for self protection. Some of these mechanisms are denial, repression and dissassocation, all of which interfere with the parents' ability to be empathic, and lead to their inability to interpret the child's cues.

The development of a healthy self begins with what may be called the "caretaking surround" (Jesse, 1989). In order for the child to develop healthy internal coping skills, the caretakers (in most instances the parents) must provide optimal responsiveness to the child's basic needs (Jesse, 1989). The caretaker's approval of the child contributes to the child's inner experiences of being valued, worthwhile and loved (Jesse, 1989). A child is unable to resolve these feelings on his own. Consequently she/he tends to display unrest or agitation, indicating a lack of inner soothing (Jesse, 1989). The capacity for inner coping of a child of an alcoholic is usually grossly disturbed (Jesse, 1989). As well the child's ability to experience his/her feelings are also impaired, for this process can only happen if there is someone who fully supports, accepts and understands him/her (Miller, 1981). The lack of an internalized soothing voice culminates in their lack of sensitivity to their own inner cues, often leading them to follow the patterns set out by their addictive parents (Jesse, 1989).
PSYCHOLOGICAL DISORDERS

The heightened psychological risk for all children with alcoholic parents has been investigated by a number of researchers. A few studies utilizing objective measures have been conducted in order to determine the specific connections between parental alcoholism and psychological disorders. The results from these studies indicate that COAs have lower self-esteem and a more external locus of control implying that their perceptions of rewards and life reinforcements are under control of others (Woodside, 1984). COAs believe that external forces govern their destiny, resulting in an externalization of their responsibilities (Robinson, 1989). Fine (1976) compared COAs with children whose parents had psychiatric disorders and found that COAs were more emotionally detached, dependent and socially aggressive. They were less able to concentrate, more prone to emotional upset, fearful, anxious and more preoccupied.

Research indicates that male children of an alcoholic parent were more likely to exhibit acting out behaviour than female children (Anderson & Quest, 1983). Children whose fathers were alcoholics tended to show greater frequency of conduct disorders whereas children with an alcoholic mother tended to show more emotional problems (Steinhausen, Godel & Nestler, 1984). Children of alcoholic fathers have been reported to show positive emotional functioning when they have experienced a positive relationship with
their mothers (Obuchowska, 1974). If this positive maternal contact is absent the children are negative, resigned or aggressive (Jesse, 1989). In Richard's (1979) work with children of alcoholic mothers he observed a high degree of impairment in reality testing. These children witness not only blackouts, but constant denial of drinking behaviour, often reinforced by their nonaddicted father. Richard's (1979) found that prolonged exposure to such a confusing situation usually results in an intense dependency upon the mother. Since the child can not trust what he or she sees, the mother is needed more, not less, as the child grows.

One of the most comprehensive studies of COAs was completed by Nylander (1960). Nylander compared 229 children of alcoholic fathers in Stockholm with 163 children of nonalcoholic parents. He found that COAs exhibited somatic complaints such as nausea, vomiting and headache. As well they had problems with tics, encopresis, aggression and unsociability. These children also showed mental insufficiencies, mainly anxiety, neurosis and depression. These overall patterns of symptoms are consistent with the findings of another large scale study completed by Haberman (1966). In this study COAs were rated by their mothers for childhood symptoms of emotional problems. These ratings were compared to those of mothers of children from nonalcoholic homes. The COAs had a higher frequency of stuttering or stammering, unreasonable fears, staying alone and rarely playing with other children, frequent
temper tantrums, consisting fighting with other children, bedwetting after age 6, frequent trouble in school because of bad conduct or truancy and often in trouble in the neighbourhood. Miketic (1972) studied 364 COAs between 1968 and 1971 and found similar results. His sample comprised of children from families in which 91% of the fathers were alcoholic. In 4% of the families, the mothers were alcoholic and 5% of both parents were alcoholic. The children displayed neurotic disturbances manifested in bedwetting, fear of the dark, nail biting and stuttering. Underage delinquency was also a consistent finding.

COAs are under a tremendous amount of stress. The naturally calm internal state of latency age does not seem to apply to children from chemically dependent families (Jesse, 1989). Inner coping problems in these children indicated that their inner experience is not a peaceful one (Jesse, 1989). Rather, disruption in self development, such as low self-esteem and delayed verbal skills, which have been occurring throughout childhood renders these latency age children particularly vulnerable to the effect of stress (Jesse, 1989). In Ackerman's (1986) view these children use denial, regression, withdrawal and impulsive acting-out in order to cope with the stress. He defines denial as being functional. It is utilized by the child to alleviate his/her emotional pain or to give him/her a break from thinking about the situation. When the child regresses it is an attempt to return to an earlier more secure
state. Withdrawal can provide relief from his/her stressful circum-
stances by removing the child emotionally or physically from the 
situation. Impulsive acting-out may be a way for children under 
stress to draw attention to themselves instead of focusing on the 
real issues. Jesse (1989) identifies seven defense mechanisms which 
COAs utilize in order to protect their "fragile tentative self". 
Impulsive behaviour is used to relieve the inner tension created by 
the child's situation. Disassociation allows the child to split off 
strong feelings and memories of these feelings from consciousness. 
The defense mechanism disavowal is defined as the repression of the 
emotional component of a painful experience. The painful reality is 
understood but the associated feelings are blocked. Thus, painful 
ideas or feelings whose origins are within the self, are projected 
outwardly and are experienced as though they originate in the 
other. When the child has encountered early trauma, in having his/ 
er her early achievements met by criticism and discounting from the 
parent, he/she experiences depersonalization. Jesse contends as 
adults they then have their accomplishments clouded by a sense of 
unreality. Hypochondriasis and somatization are also characteristic 
defenses used by COAs for self preservation. It is the expression 
through physical symptoms of difficult feeling states.

Anxiety and depression are common reactions to both parental 
drinking and to the ongoing family conflict (Robinson, 1989; Moos & 
Billings, 1982). Fear and anxiety result from a lack of stability
in the home and the consequent lack of inner security in the child (Brown & Sunshine, 1982). Children within the age range of 6-12 years scored higher on the anxiety scales than children from abstaining families (Anderson & Quest, 1983). COAs are more likely to become depressed than children from nonalcoholic homes. They are more likely to describe their childhood as unhappy and unstable, as compared to children from nonaddicted families (Callan & Jackson, 1986). The diagnosis of both major depressive disorder and alcohol disorder are strongly related to unfair discipline or inconsistent discipline (Holmes & Robins, 1988), common occurrences in the alcoholic home. "Depression can result from the depriving nature of the home environment, from the child's low self-esteem and/or from the introjection of harsh devalued parental objects" (p. 69) (Brown & Sunshine, 1982). Their depression, if not treated, may be carried into adulthood, becoming a life long legacy (Black, 1981).

It is apparent that by the time the COA reaches middle childhood he/she may demonstrate impairment in emotional development manifesting in a variety of mental and physical symptoms. The ongoing stress and strain of living in this chaotic environment takes its toll on these children. If there is a positive relationship with the nonaddicted parent, as suggested by Obushowska (1974), the child may be less adversely affected.
IMPACT ON PSYCHOSOCIAL DEVELOPMENT

The experience of living in an alcoholic home generates a daily environment of fear, abandonment and tension (Cermak, 1986; Wilson, 1985; Booze & Allen, 1974). Many clinical reports indicate that the offspring of alcoholics appear to be at an increased risk for psychosocial problems (El-Guebley & Orford, 1977; Jacobs & Leonard, 1986; Chaftez, Blane & Hill, 1971). The literature concurs that the impact and severity of poor parenting due to alcoholism affects the child's self-concept and later adult behaviour in a number of areas. Peer relationships, academic achievement and the ability to parent their own children are adversely effected.

The self-esteem of children who grow up in an alcoholic family is often severely damaged (Robinson, 1989). Social science research reports that overall COAs score lower on virtually all the self-image measures (Robinson, 1989). Self-esteem is a family affair. The child's first experiences in his family leads him to makes decisions on how loveable and likeable she/he is (Naiditch, 1987). Factors such as the nonalcoholic parent who is preoccupied and never seems to have enough time; the alcoholic parent who predictably changes or who promises and never delivers; the child's guilt and self-blame for causing the drinking; the betrayal and hostility that accompanies parental alcoholism; the embarrassment in front of friends and the social stigma attached to alcoholism—all culminate in poor self-worth (Robinson, 1989). When children have been
blamed, humiliated and shamed by the dynamics of the alcoholic family, they become enmeshed in those dynamics. Children then have a difficult time separating themselves from their family situation. Consequently they internalize humiliation and shame and begin to feel unworthy. Shame then becomes part of their self-concept (Robinson, 1989; Fossum & Mason, 1986).

Family patterns of relating set the stage for the kinds of relationships children will have with others outside the home. In the chemically addicted family positive role models are generally missing. Furthermore, sibling relationships are often conflict-ridden (Robinson, 1989). This less than ideal home environment affects the developing child's ability to relate to others in mutually enhancing ways (Morehouse & Richards, 1982). For many of these children the "need for control" leads to difficulty in maintaining meaningful relationships (Black, 1981). During the middle childhood years when socialization and peer relationships are particularly important these children are often prevented from making normal friendships. They may withdraw inward or may turn their frustration and anger outward in aggressive anti-social behaviour (Jesse, 1989). Consequently, they tend to have fewer peer relationships and a greater tendency to have adjustment problems as adolescents (Spence & Schmidt, 1989; Robinson, 1989).
In the alcoholic home, with its skewed communications and confused roles, the child has to make sense of what is often an irrational situation (Hecht, 1977). Trapped in this distorted family system it is difficult for these children to master life's developmental tasks. They have trouble developing trust in verbal communication due to the parents' broken promises and unpredictable behaviour (Hecht, 1977; Richards et al., 1981). They become cue-oriented, that is, dependent on environmental feedback to determine how they should act (Hecht, 1977; Jesse, 1989). Distrust of parents is often generalized to other adults, authority figures and peers (Robinson, 1989). The real tragedy occurs when as adults themselves, they find it difficult to form intimate relationships, which are necessarily based on trust (Subby, 1987; Richards et al., 1981; Robinson, 1989).

It is apparent from the literature that the chemically addicted family environment is often plagued with tense, bitter interactions that cause anxiety and stress for all family members. The child's anxiety may be so high that it interferes with his/her ability to process and store information, thus creating difficulties in short and long-term memory storage (Jesse, 1989). Their academic success is hindered by difficulties created in behaviour and relationships. Some behavioural difficulties are lack of concentration (Spence & Schmidt, 1989; Brown & Sunshine, 1982), low attention span (Robinson, 1989) and fidgety, restless behaviour (Jesse, 1989; Brown
Learned helplessness (Brown & Sunshine, 1982), fear of teachers, fear of failure and fear that other students will dislike them (Brown & Sunshine, 1982; Robinson, 1989), increase these children's already heightened anxiety and stress level thus making academic success difficult (Robinson, 1989).

Robinson (1989) points to several additional factors that increase our understanding of why these children do poorly in school. Parents are consumed by their problems and are unable to be a support to their children. If the child does do well in school it is generally without parental assistance. It is difficult for children to study or keep their mind on homework in a home where chaos is the norm. The unpredictability and inconsistency of alcoholic households have a direct bearing on poor academic performance. Constant upheaval at home makes completing homework assignments impossible. Coping with the effects of alcoholism on the family often drains 90% of a child's energy, leaving the child with very little left for school.

Alcoholic parents model poor mastery of adult skills including parenting. O'Gorman & Diaz (1986) in their work with parents who were raised by alcoholic/drug addicted parents found that the dysfunctional parent-child interactions are directly related to continuing the cycle of addiction. They contend that alcoholism anesthetizes emotions and prevents the alcoholic from being able to
identify his emotions, thus making it difficult for him/her to handle his/her child's emotions. Such parents often react negatively or respond in ways which attempt to stop the child's emotional expression in order to lower the parent's own anxiety. As a result the children learn to hide their feelings to avoid displeasing their parents. This repeats the cycle of denial that most alcoholics went through as children. It breeds resentment, erodes self-esteem and sets the stage for the next generation of alcoholics.

DEVELOPMENT OF INTERVENTION APPROACHES

Despite the literature confirming the impact of parent alcoholism, until recently little effort has been devoted to creating suitable treatment alternatives for these children. In the past it was seen as sufficient to work with only the parents, with sobriety of the parent being viewed as the only solution needed to solve the child's problems.

Clinical evidence supporting the importance of early intervention gradually began to accumulate in the mid 1970s. Researchers and theorists generally agree that early education and intervention is needed in order to effect long-term behavioural changes in COAs (El-Guebaly & Orford, 1977; Richards, 1979; Homonoff & Stephen, 1979; Morehouse, 1983; Brown & Sunshine, 1982; Typpo & Hastings, 1984; Spence & Schmidt, 1989; Pilat & Jones, 1985; La Pantois, 1987; Jesse, 1989). The bulk of the literature are descriptions of group
treatment interventions using clinical observations to determine treatment success. Although to date there is little documentation regarding empirical evidence as to the method that would be most beneficial for this population, beginning work in this area would now suggest that group treatment at an early age maybe an effective way to intervene (Typpo & Hastings, 1984; Pilat & Jones, 1985; Brown & Sunshine, 1982).

One of the primary tasks of treatment is to help the child deal with the frightening and shameful secret of alcoholism by talking about it (Brown & Sunshine, 1982; La Pantois, 1987; Pilat & Jones, 1985; Morehouse, 1983). This process is immediately relieving for the child. Sharing secrets reduces shame, isolation and guilt and allows the exchange of ideas for coping with common problems (Cable, Noel & Swanson, 1985; La Pantois, 1987). Theory suggests that as the child gains a greater understanding of alcohol, alcoholism and the recovery process, painful feelings of guilt and responsibility will decrease reducing the child's anxiety and depression (Brown & Sunshine, 1982; Robinson, 1989). There are a number of reasons as to why group treatment might be an effective way to intervene with these children. COAs often have deficits in the area of social development and lack successful experiences in relating to peers. Thus a group treatment model would seem to provide those skills necessary for social interaction. However there seems to be some controversy in terms of the effectiveness of individual treatment versus group treatment.
Werner (1986) states that "intervention for children of alcoholics may be conceived as an attempt to restore balance, either by decreasing their exposure to the risk of parental alcoholism and associated problems or by increasing the number of protective factors, i.e. competencies, sources of support that children can draw upon in themselves and their care-giving environment" (p. 39). Practitioners generally agree on the common goals of a treatment group. A psycho-educational group should focus on assessing the children's needs and situation (Cable et al., 1985; Morehouse, 1983; Jesse, 1989); providing support and education regarding alcohol, alcohol abuse and alcoholism (Cable et al., 1985; Brown & Sunshine, 1982; Typpo & Hastings, 1984; Robinson, 1989); teaching coping strategies and problem solving (Homonoff & Stephen, 1979; Typpo & Hastings, 1984; Brown & Sunshine, 1982; Naiditch, 1986; Spence & Schmidt, 1989); enhancing self-esteem and modeling the identification and expression of feelings (Cable et al., 1985; Morehouse, 1983; Pilat & Jones, 1985; La Pantois, 1987; Typpo & Hastings, 1984). These objectives are carried out through brief lectures, discussions, role plays, film and art activities.

Jesse (1989) has integrated previous work and taken it a step further in her development of the "Parent as Co-Therapist Child Recovery Model (PACT)". She believes that group treatment can be used in addition to individual child centered therapy. She states that a group treatment model will not significantly alter a child's
developmental deficits. She believes group treatment is not the most beneficial treatment model for a number of reasons. Children have difficulty forming a cohesive sense of self, thus making group cohesion very difficult. In addition these children's problems in verbal skills and difficulties with inner coping interfere with the therapeutic effect of group treatment.

The PACT child recovery model is based on the assumption that the most therapeutic agent for the child will be the parents and that the family is most conducive to supporting lasting change. She views the child's treatment and parents' treatment as simultaneous. While developing the empathic potential of the parent, she is continually facilitating the development of a more adequate and responsive care-taking environment for the child.

Jesse (1989) states that intrapsychic change comes about slowly. The child's sense of self which was derived from the chaotic period of drinking is extremely resistant to change. This is due to the internalization process that takes place unquestioned by the child. This is particularly evident for the child who is born into the alcoholic family system, the dynamics of which become part of his identity formation. Consequently she sees one year as a minimum for successful treatment. In her model individual child centered therapy focuses on facilitating cohesion of the child's inner world and encouragement of the full expression of the child's inner self.
Soothing interactions with the therapist promotes ego strengthening and increases the child's ability to use the therapist as a source of calm and strength.

Jesse's (1989) major intervention with the parent during this time is based on a supportive/observational model. Supporting the parents through early phase recovery work, the therapist acts as a role model of empathic responsiveness. This process comprises the first 10-15 minutes of a child's session. Later in a session with the parents, the therapists speaks about her observations and gives feedback regarding misconceptions about their child and parenting.

Jesse (1989) believes that the real healing for the child comes from healing the troubled parent-child relationship. The child's healing is going to require slow, steady, ongoing recovery with lots of love. Although Jesse recognizes that engaging the parents as co-therapist is not always possible, she believes the parent is the best person to provide that care and healing.

GROUP TREATMENT EFFECTIVENESS

Documentation regarding the effectiveness of children of addicted parents groups are few in number. Five studies were found in the literature and of those five only one was empirically based, utilizing an experimental design involving 81 children (Roosa, Gensheimer, Ayers & Shell, 1989). In the remaining four studies,
research design methods were not mentioned, sample sizes were small and clinical observations were used to assess treatment success (Homonoff & Stephen, 1979; La Pantois, 1986; Pilat & Jones, 1985; Robinson, 1983). In two of the studies, parent-child questionnaires were administered to measure improvement in the child's functioning (Homonoff & Stephen, 1979; Robinson, 1983).

Recruitment procedures, sample sizes, selection criteria, group size and duration of the group intervention varied among the studies. Of those studies that mentioned recruitment, procedures consisted of self-referral (Homonoff & Stephen, 1979; La Pantois, 1986; Robinson, 1983); self-selection; active recruitment within the elementary school system (Roosa et al., 1989); and encouragement of clients from alcohol and drug treatment programs to enroll their children (Brown & Sunshine, 1982; Pilat & Jones, 1985). Of those studies that reported sample size, numbers ranged from 25 (La Pantois, 1986) to 81 in the Roosa et al. (1989) study.

Criteria for entry into a particular program differed as well. In the Roosa et al. (1989) study, children in the 4th, 5th and 6th grades were shown a film called "Kids Like Us" which depicted 10 and 12 year old COAs experiencing a number of crises, percpititated by their parent's alcoholism. The film portrays an alcoholic family realistically from the child's perspective. Children who were interested in dicussing the film and a related program being offered
in the school were invited to a second meeting scheduled for later that day. Children who attended the second meeting were given parental permission slips. Those children who received parental permission were then randomly assigned to an intervention or control group. Those assigned to the intervention group met in groups of 8 to 10 for one hour a week for eight weeks. Each session was led by a graduate student and teacher or social worker from the host school. Brown & Sunshine's (1982) study was heterogeneous with regard to age, sex and socioeconomic class. The child's parents were required to have a diagnosis of alcoholism and be in treatment. The group met during the school year for an hour each week and the children remained members for an average of two years. The group size was limited to eight children. The remaining studies did not mention sampling criteria.

La Pantois (1986) conducted an open-ended group with children of alcohol and cocaine-addicted parents. The children were from lower middle class families. Most of their parents were in treatment. Although there were a total of 25 children who registered in the program, only 8 consistently attended the group each week. The children met once a week for 1 1/2 house in an outpatient drug and alcohol clinic.

Pilat & Jones (1985) developed a treatment program for COAs through a large family alcoholism treatment center. Parents that
were involved with the center were encouraged to bring their children aged 5 to 19 years to the children's group. Their three phase program met for a total of twenty weeks. Before the first phase children attend a series of educational lectures with the entire program population twice a week for four weeks. The purpose of Phase I is to begin to educate the children about alcoholism and its affect on the family. During this phase the children are encouraged to be open and honest with their feelings. The children were divided into age appropriate groupings and met for 1 1/2 hours a week for four weeks. Phase II is based on a support group model. The structure is similar to Phase I. Children attend Phase II for 1 1/2 hours once a week for twelve weeks. Important issues that are dealt with in this phase include: coping mechanisms, self-esteem and mastery, generational boundaries and self-identity. Phase III involves regular attendance at Alateen or pre-Alateen meetings in the community. These meetings allow ongoing support and provide a solid program for recovery from family alcoholism. Description of the sample was not mentioned in this study or the Robinson (1983) study. The Robinson study required children to maintain a minimum active membership of six months. The children met once a week for 2 to 5 hours for a ten week module.

The intervention in all these studies was a group treatment model that educated the children about the addictive process and how it affects family members. Goals of treatment were overcoming
feelings of isolation, shame or guilt related to parent's addictions. As well the children were taught skill development regarding problem solving and coping; how to identify and express emotions; self-esteem enhancement and how to seek support from outside resources. Two of the studies (Brown & Sunshine, 1982; Homonoff & Stephen, 1979) attempted to repair the family relationships that had been damaged by alcoholism, although they did not describe how this was done.

The objectives of the group were implemented by a range of intervention techniques including play therapy, art activities, structured homework, role playing and films. Roosa et al. (1989) used video taped modelling, didactic presentations and behavioural rehearsal as teaching aides. Reports regarding implementation difficulties were minimal. Homonoff & Stephen (1979) reported difficulties in recruitment, noting that word of mouth by satisfied clients proved to be the most successful method. In La Pantois (1986) study one of the criteria for determining therapeutic success was the development of group cohesion. This might imply that group cohesion was difficult.

Outcome measures were utilized in only one study (Roosa et al., 1989). The measures used were designed to serve three objectives: to identify children who have an alcohol abusing parent, to evaluate the impact of the mediator variables manipulated by the intervention
(self-esteem, coping and their impact on mental health outcomes regarding depression and school adjustment), and to collect information on the intervention process for the purpose of guiding curriculum revision and future program implementation. Outcome measures were: Harter's (1985) Self-Perception Profile for Children (SPPC), which was used to assess global self-concept and self evaluation in specific domains (cognitive competence, social competence and global self-worth); Will's (1985) Coping Strategies Inventory (modified version); Kovac's (1985) Children's Depression Inventory (CDI) and the AML Behaviour Rating Scale (1973). Process measures were used to evaluate participants' participation and satisfaction with the program. At post-test all children were given a 16 item questionnaire requesting their opinions on various aspects of the program. In addition, group leaders completed a brief evaluation form after each session. Evaluation was done in terms of completing goals, level of group participation and level of tension in the group. Researchers found that the intervention group children showed a significant increase in the use of positive coping strategies, while the control group showed no change. There was a trend (p<.06) for an improvement in support-seeking behaviour and significant changes in the use of both problem-focused and emotion-focused coping. In addition to the self reported changes in coping scores, there was a trend (p<.06) for teacher reports of children's moodiness to be more positive. There was a trend (p<.07) for group participants to experience a drop in depression. However, there was no improvement
on the self-concept measures. Due to the small sample size the researchers state that the results should be treated with caution.

Although no formal evaluations have been done in terms of the following programs, clinical observations of children of addicted parents who participate in a psycho-educational group report similar results. Pilat & Jones (1985) in their three phase program noted that after the intervention the children had a greater understanding of alcohol and its affect on the family, as well as improved communications with family members. Other studies have reported an increase in coping strategies within the system, improved problem solving (Pilat & Jones, 1985; Homonoff & Stephen, 1979), less intense feelings of anger, fear and confusion, with an increase in ability to disclose these feelings to others (La Pantois, 1987; Pilat & Jones, 1985) and more assertive, self-confident behaviour (Pilat & Jones, 1985; Homonoff & Stephen, 1979; Robinson, 1983).

Common limitations to the current research lies in two major areas: an empirical base is lacking and sample sizes are limited and poorly described. Given that the literature delineates a number of variables that influence the level of impairment for these children future research would benefit from full descriptions of the sample. Such data will aid in the assessment of intervention methods for children who have varying levels of dysfunction.
CHAPTER II

METHODS

Between January and April 1990, eleven children from eight families attended Family Services, North Burnaby Alcohol and Drug Programs' Children of Addicted Parents Group. The children ranged in age from eight to twelve and were living or had lived with an alcohol or drug addicted parent/step-parent. Referrals were made by guidance counsellors, family service agencies, addiction programs and child protection agencies. Two children did not complete the program. A 12 year old girl felt that the program was too immature for her. Furthermore, her mother was not committed to bringing her to the sessions every week. The other child, a 9 year old girl who was extremely withdrawn, attended three sessions and then continued treatment with a therapist on an individual basis.

Criteria for inclusion in the study were: the child must be of latency age, living or have lived with an alcohol/drug addicted parent/step-parent, have informed parental consent, and agreement to participate in pre- and post-testing. Participation in the study was entirely voluntary. Children were not forced to attend. If the child was reluctant about his/her enrollment in the group we contracted with the child to attend three sessions. At that time he/she could decide whether or not to continue. No Alcohol or Drug Services or Family Services were contingent upon willingness to participate in the research.
PROCEDURE

Information letters were sent to a variety of social service agencies i.e. Family Services, Alcohol and Drug Programs (ADP), Women's Resource Centers, Ministry of Social Services and Housing (MSSH) and Transition Houses, requesting referrals. In addition a presentation was given by the writer to local elementary school guidance counsellors. Advertisements were taken out in the local newspaper advising the public of a children's group geared towards addressing the needs of COAs. The potential participants were referred by the following sources: three from MSSH, four from ADP, three were referred by elementary school guidance counsellors and one was self-referred.

The parents and/or guardians of the referred clients met with the writer at her office at ADP. At this time the program's objectives, goals and philosophy were explained. Background information regarding family history with respect to substance abuse, as well as information concerning specific problems that the child may be experiencing was discussed. If sexual abuse was identified as an issue, back up support was enlisted.
SUBJECTS

The mean age for the four boys and seven girls was 9.8 years. The average age of the child at onset of parent alcoholism was 2.6 years. Six of the children were from single parent families and over half the sample were living with maternal alcoholism. Four of the children were from homes where violence was an issue. One of the mothers of two boys in the group suffered from mental illness and was refusing treatment. Seven of the addicted parents were in early recovery from alcohol/drug addiction and three were still actively abusing. Five of the children were involved with MSSH concerning abuse and/or neglect issues. Seven of the children's mothers had completed high school, one was a high school graduate and two of the moms had university degrees. Six of the children's fathers had completed high school, two graduated and the information on the remaining fathers was unavailable. Five of the mothers were at home with their children on a full-time basis. Two worked outside the home as unskilled workers, one as a skilled worker and one women was employed in a professional position. Six of the fathers were employed as unskilled workers, two were skilled workers, two were in professional positions and the information on the remaining men was unavailable. More than half the sample (6) reported familial substance abuse. Two of the children aged 11 and 12
Table 1

DEMOGRAPHIC DATA

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(siblings) reported experimenting with alcohol and drugs. In terms of treatment, eight of the addicted parents were in attendance at various Alcohol and Drug Programs and/or A.A. With respect to the nonaddicted parents two were in treatment, four were not and for the remaining five this was not applicable or the information was unavailable. Most of the children attended the sessions on a regular basis.

DESIGN

A one group pretest-posttest quasi-experimental design was utilized. Participants were interviewed approximately 1 1/2 weeks prior to the group. The writer met with the child and parent/guardian to explain to the child the group and research process, establish a relationship with the child and explain and administer the measures. Measures were completed individually in the writer's office at ADP, 1 1/2 weeks prior to the group (Time 1) and 10 to 12 weeks later (Time 2). The questions were read aloud and the child was asked to respond as best he/she could. The child was assured that there was no right or wrong answers and that this was not a test. If the child was unsure of how to respond he/she was asked to reply with the first answer that came to mind. During this time the parent/guardian was in the waiting room signing consent forms and completing a demographic questionnaire which also described familial substance abuse, child's behavioural problems and current marital situations.
The intervention was conducted over a nine week period. The group met weekly, every Tuesday from 3:30 pm to 4:30 pm. The group was led by three therapists: myself, a MSW student with experience in family violence and the ADP program director with experience in addictions and sexual abuse. All leaders were knowledgeable about the addictive process and its affect on the child and family.

Each session addresses issues relevent to children of addicted parents. The major issues are those dealing with control, mistrust, avoidance of emotions, inability to define boundaries and over-responsibility. During every session each child was treated with acceptance, consistency and understanding. Rather than strictly adhering to program scheduling leaders respected each child and their family's individuality with their own timing of understanding and integrating the program content. The leaders focused on the child's strengths as well as helped facilitate healing the parent-child relationship.

The intervention targets three major goals;

1. To educate the children regarding alcoholism/drug addiction, substance abuse use and its impact on the family.

2. To enhance the child's inherent strengths by teaching problem solving, coping strategies and increasing networking skills with community resources.

3. To increase the child's self-esteem.
SESSION CONTENT

Session 1 - The group content, objectives and purpose were introduced to the children. The concept of confidentiality was discussed at length. The children and group leaders spoke about the rules of the group. Children introduced themselves to each other through a group exercise.

Session 2 - The concept of commitment was discussed and the links of the commitment chain were made by each child (art activity). The check-in ritual was introduced. During this ritual each child briefly describes who his/her week went or brings up and problem or issue he/she may want to discuss. This ritual starts every group meeting. The alcohol/drug education component was introduced, through a film and brief lecture.

Session 3 - This session focused on problem-solving skills. Children were encouraged to discuss problems they were facing, and problem-solve with the help of the other children. Generating alternatives and making a plan helps reduce the child's sense of powerlessness. The children also viewed a film titled "Facing Your Fears", which was the basis of a discussion that followed.

Session 4 - Identifying and expressing emotions were the topics of this session. A film on body language was shown. The children were encouraged to talk about what their body language was trying to say.
Session 5 - Trapped feelings and defenses were discussed. Each child drew his body and coloured areas where his/her feelings were trapped.

Session 6 - Through family sculpting, the child's perception of his family was explained to the group. Each child had a turn at this exercise and discussion was encouraged.

Session 7 - The children were taught the technique of "brain-storming" as a means to develop a resource list. This is a list of names and agencies in the community that the child can call if he/she needs help.

Session 8 - The children were taught progressive relaxation and creative visualization techniques.

Session 9 - Part of this session focused on exploring the children's feelings regarding the completion of the group and saying good-bye to the group members. The remainder of this session was spent playing games and having a party.

MEASURES

To standardize test administration the interview schedule was read to all participants. The measures were chosen for their relevance, ease of administration and availability.
1. Children of Alcoholics Screening Test (CAST) (Jones, 1983).

Children were asked to complete the CAST, which is a 30-item inventory designed to identify COAs, as well as determine the child's perception and concerns regarding his/her family situation. Research has shown that the CAST can withstand scientific scrutiny and will yield impressive reliability and validity (Pilat & Jones, 1985). A reliability co-efficient of .98 is reported for this instrument using a Spearman-Brown split-half procedure (Jones, 1982). Validity was determined by chi-square analysis and it showed that all 30 items significantly discriminated COAs from control group children.


This self-report inventory is used as an indicator of self-concept. It was developed to evaluate programs designed to improve the learner's self-esteem and its use is encouraged within an educational setting.

The test consists of items relating to the child's subjective feelings about peers, family, school and general self-concept (a comprehensive estimate) (Harrison, 1984). As well it offers a global score which is a composite of all subscales. The instrument is divided into three levels: grades k-3 with 36 items, 4-6 with 77
items and a high school level with 66 items. A high score is indicative of effective adjustment (Frith & Narakawa, 1972). Using this system test-retest reliability for the measures has shown to be .73 for the primary level, .88 for the intermediate level and .87 for the high school level. (Frith & Narakawa, 1972).

3. Kovacs Childhood Depression Inventory (CDI) (Kovacs, 1985).

This self rated depression inventory was designed to quantify the severity of the depressive syndrome (Kovacs, 1985). It has been used to assess treatment outcome, test research hypotheses, as well as to select research subjects (Kovacs, 1985). The CDI is a 27 item self report symptom oriented scale that was designed for school-aged children and adolescents. Its readability is at the first grade level (Kazdin & Petti, 1982). The instrument assesses affective, cognitive and behavioural symptoms of childhood depression (e.g. sleep disorders, sadness) (Roosa et al., 1989).

Each item consists of three possible responses keyed from 0-3 in the direction of increasing severity. The total score can range from 0-54. Reported internal consistency reliabilities have ranged from .70 to .94 (Kovacs, 1985; Saylor, Finch, Bennett & Spirito, 1984). Validity studies indicate that the CDI can distinguish children with general emotional distress from normal school children (Saylor et al., 1984). However differences between CDI scores of
depressed (by symptom check list, DSM III) and non-depressed children were not significantly different (Saylor et al., 1984). The authors' data suggests that the CDI measures a multidimensional construct that overlaps with other childhood anxiety. As well they report that although the CDI may be the best researched instrument available to measure depression from the child's point of view, more work is needed before it can be interpreted with confidence in clinical research settings.


This instrument was utilized to measure changes in anxiety levels of the participants. The scale consists of 28 anxiety items and nine lie items. The reading level is suitable for primary grade children. The scale has shown to be a reliable measure of anxiety in children by Reynolds & Richmond (1979). Reliability estimates have ranged from .83 to .88 (Reynolds & Richmond, 1979). As well there is considerable support for the construct validity of this scale as a measure of childhood anxiety (Reynolds, 1980; Reynolds & Richmond, 1979). It is seen as a valuable tool in determining anxiety levels when used in a pre-post design.
5. Eyberg Child Behaviour Inventory (Eyberg, 1980).

This scale was designed to measure parental perception of behaviour problems in their children. The measure is appropriate for children between the ages of 2 and 16. Total problem scores and problem intensity scores are computed. Test-retest reliability (.86) for the intensity score and (.88) for the problem score was found (Robinson, Eyberg & Ross, 1980). The mean split-half reliability for intensity is .95 and the mean split-half reliability for the problem score is .94 (Robinson et al., 1980). Item analysis showed that each of the minimum standards for item reliability were met. The external validity of this instrument was reported in previous research (Eyberg & Ross, 1978).

6. Observations

At the end of each session the leaders discussed each child's progress. Information was gathered on each child with regards to physical appearance, behavioural and emotional changes, participation level and interactions with other children and leaders. Additional information was gathered on an informal basis from parents, social workers and guidance counsellors, if appropriate. These observations were important in order to improve the reliability and validity of these conclusions.
CHAPTER III

RESULTS

The findings will be presented in two sections. The first section will be comprised of the outcome measures; Children of Alcoholics Screening Test, Eyberg Childhood Behaviour Inventory and The Frith and Narawaka Self-Appraisal Inventory. The second section presents individual evaluations.

CHILDREN OF ALCOHOLICS SCREEN TEST

________________________________________________________________________

Insert Table 2 about here

________________________________________________________________________

This tool was utilized for identification purposes only. Nine children yeielded scores which are indicative of children of alcoholics. Two of the children's scores indicate children of problem drinkers (see Table 2).
Table 2

CHILDREN OF ALCOHOLICS SCREENING TEST

<table>
<thead>
<tr>
<th>CASE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>5</td>
<td>04</td>
</tr>
<tr>
<td>6</td>
<td>04</td>
</tr>
<tr>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>11</td>
<td>10</td>
</tr>
</tbody>
</table>

A score of:  
0 to 1 indicates children from non-alcoholic homes  
2 to 5 indicates children of problem drinkers  
6 or more indicative of children of alcoholics
Results of the intensity of problem scale indicates a significant difference between time 1 and time 2. Intensity refers to the frequency of occurrence of the behaviour (see Table 3). Paired t-tests found that parents' perception of intensity of child behaviour problems decreased between time 1 ($\bar{x}=138$, $SD=37.0$) and time 2 ($\bar{x}=119$, $SD=11.6$, $p<.05$). In terms of number of problems, neither paired t-tests or Wilcoxon Matched-Pairs Ranked-Sign tests revealed significant changes between time 1 and time 2. However, an examination of mean scores does reveal a tendency for a decrease in number of problems between time 1 ($\bar{x}=18.2$, $SD=7.0$) and time 2 ($\bar{x}=14.0$, $SD=7.1$).
Table 3

MEAN SCORES OF ALL PARTICIPANTS ON CHILD BEHAVIOUR SCALE

<table>
<thead>
<tr>
<th>Variable</th>
<th>Time 1</th>
<th></th>
<th></th>
<th>Time 2</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N=9</td>
<td>X</td>
<td>SD</td>
<td></td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Intensity</td>
<td>138</td>
<td>37.0</td>
<td></td>
<td>119*</td>
<td>11.6</td>
<td></td>
</tr>
<tr>
<td># of Problems</td>
<td>18.2</td>
<td>7.0</td>
<td></td>
<td>14.0</td>
<td>7.1</td>
<td></td>
</tr>
</tbody>
</table>

*p<.05
Paired t-tests and Wilcoxon Matched-Pairs Ranked-Sign tests did not reveal any significant change between time 1 and time 2 (see Table 4). However, the change in total mean scores does show a decrease in depression. Time 1 mean scores yield 13.7 (\( \bar{x} = 13.7 \), SD=5.7) and time 2 yields 10.4 (\( \bar{x} = 10.4 \), SD=5.0) indicating movement in the anticipated direction.
Table 4

MEAN SCORES OF ALL PARTICIPANTS ON CHILDHOOD DEPRESSION INVENTORY

<table>
<thead>
<tr>
<th>Variable</th>
<th>N=9</th>
<th>Time 1</th>
<th></th>
<th>Time 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>x</td>
<td>SD</td>
<td>x</td>
<td>SD</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td>13.7</td>
<td>5.7</td>
<td>10.4</td>
<td>5.0</td>
</tr>
</tbody>
</table>

*p<.05
Self-Appraisal Inventory

Neither paired t-tests, nor Wilcoxon Matched-Pairs Ranked-Sign tests yield any significant change between time 1 and time 2 (see Table 5). The change in total mean scores reveals that there is a trend for an increase in affective adjustment between time 1 ($\bar{x}=60.2, SD=16.8$) and time 2 ($\bar{x}=63.4, SD=5.9$). When looking at the subscales family relations, again there is a tendency for improvement. Time 1 mean scores yield $61.1 (x=61.1, SD=14.1)$ and time 2 yielded a score of $68.5 (\bar{x}=68.5, SD=13)$. The general subscale yielded scores of time 1 ($\bar{x}=60.3, SD=28.6$) and time 2 ($\bar{x}=72.4, SD=15.2$) also indicating movement in the anticipated direction. Mean scores in the subscales peer relations and school, as well as in the anxiety measure yielded lower scores in time 2 (see Table 6). Individual evaluations which will be presented in the next section may explain these results by describing each child's family situation and his/her progress in the group.

Insert Table 6 about here
Table 5

MEAN SCORES OF ALL PARTICIPANTS

ON SELF-ESTEEM MEASURE

<table>
<thead>
<tr>
<th>Variable</th>
<th>N=9</th>
<th>Time 1</th>
<th></th>
<th></th>
<th>Time 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$\bar{x}$</td>
<td>SD</td>
<td></td>
<td>$\bar{x}$</td>
<td>SD</td>
</tr>
<tr>
<td>Total</td>
<td>60.7</td>
<td>16.8</td>
<td></td>
<td></td>
<td>63.4</td>
<td>5.9</td>
</tr>
<tr>
<td>General</td>
<td>60.3</td>
<td>28.8</td>
<td></td>
<td></td>
<td>72.4</td>
<td>15.2</td>
</tr>
<tr>
<td>Family Relations</td>
<td>61.0</td>
<td>14.1</td>
<td></td>
<td></td>
<td>68.5</td>
<td>13.0</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>64.0</td>
<td>17.8</td>
<td></td>
<td></td>
<td>63.8</td>
<td>14.2</td>
</tr>
<tr>
<td>School</td>
<td>51.4</td>
<td>27.7</td>
<td></td>
<td></td>
<td>46.6</td>
<td>21.3</td>
</tr>
</tbody>
</table>

*p<.05
Table 6

MEAN SCORES OF ALL PARTICIPANTS ON CHILDHOOD ANXIETY

<table>
<thead>
<tr>
<th>Variable</th>
<th>N=9</th>
<th>( \bar{x} )</th>
<th>SD</th>
<th>( \bar{x} )</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>16.4</td>
<td>5.7</td>
<td></td>
<td>16.7</td>
<td>6.2</td>
</tr>
<tr>
<td>Lie</td>
<td>2.2</td>
<td>2.3</td>
<td></td>
<td>2.1</td>
<td>2.3</td>
</tr>
</tbody>
</table>

*p<.05
INDIVIDUAL EVALUATIONS

In the descriptions that follow names and ages have been altered in order to maintain confidentiality.

Insert Table 7 about here

Case 1

Beverly is an eleven year old girl who lives with her alcoholic mother and two older siblings. Her mother recently separated from a physically abusive relationship. However, during the duration of this relationship, Beverly and her siblings were witnesses to violence on a regular basis. Also due to certain age-inappropriate behaviours exhibited by the children, sexual abuse was suspected. Although Beverly's attendance was consistent she initially did not participate in any of the group activities. Midway through the program she was able to begin to disclose her feelings, participating in activities and actually take a leadership role (when her sibling was absent) in the group. It was noticeable that by the end of the group Beverly was now wearing almost no make-up and looking more like an eleven year old. She shows improvement on most of the measures except for perception of self in relation to school. Beverly had significant school difficulties during the time of the group that might account for the lower scale (see Table 7).
Table 7

MEAN SCORES ON ALL MEASURES

FOR CASE #1

<table>
<thead>
<tr>
<th>Scale</th>
<th>Before</th>
<th>After</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Esteem Total</td>
<td>48</td>
<td>61</td>
<td>+13</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>74</td>
<td>84</td>
<td>+10</td>
</tr>
<tr>
<td>Family Relations</td>
<td>42</td>
<td>57</td>
<td>+05</td>
</tr>
<tr>
<td>School</td>
<td>53</td>
<td>84</td>
<td>-05</td>
</tr>
<tr>
<td>General</td>
<td>53</td>
<td>84</td>
<td>+31</td>
</tr>
<tr>
<td>Depression</td>
<td>17</td>
<td>15</td>
<td>-02</td>
</tr>
<tr>
<td>Anxiety</td>
<td>17</td>
<td>10</td>
<td>-07</td>
</tr>
<tr>
<td>Lie</td>
<td>0</td>
<td>01</td>
<td>+01</td>
</tr>
<tr>
<td>Intensity of Problem</td>
<td>105</td>
<td>93</td>
<td>-12</td>
</tr>
<tr>
<td>Number of Problems</td>
<td>28</td>
<td>12</td>
<td>-16</td>
</tr>
</tbody>
</table>

*p < .05
Abby, a year older than Beverly, presents similar to her sister in terms of appearance and age-inappropriate behaviour. Abby spoke frequently about her dates with her 17 year old boyfriend. She took on a powerful position in her family, the caretaker role. Abby's progress in the group was similar to her sister with respect to participation in group activities and to the changes in her physical appearance. As well Abby recognized that her parental role in her family was a heavy burden for her to bear and it appeared that she was making an effort to relinquish this position. Abby's mom was also making progress in her treatment. Consequently she was becoming more effective in her parenting. Although this change appeared to create anxiety for Abby, it might also account for the higher score in the family relations subscales, a decrease in depression and number of behaviour problems as well (see Table 8).
Table 8
MEAN SCORES ON ALL MEASURES
FOR CASE #2

<table>
<thead>
<tr>
<th>Scale</th>
<th>Before</th>
<th>After</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Esteem Total</td>
<td>58</td>
<td>66</td>
<td>+08</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>44</td>
<td>62</td>
<td>+18</td>
</tr>
<tr>
<td>Family Relations</td>
<td>44</td>
<td>81</td>
<td>+37</td>
</tr>
<tr>
<td>School</td>
<td>29</td>
<td>25</td>
<td>-04</td>
</tr>
<tr>
<td>General</td>
<td>50</td>
<td>81</td>
<td>+31</td>
</tr>
<tr>
<td>Depression</td>
<td>12</td>
<td>10</td>
<td>-02</td>
</tr>
<tr>
<td>Anxiety</td>
<td>09</td>
<td>10</td>
<td>+01</td>
</tr>
<tr>
<td>Lie</td>
<td>01</td>
<td>01</td>
<td>0</td>
</tr>
<tr>
<td>Intensity of Problem</td>
<td>84</td>
<td>84</td>
<td>0</td>
</tr>
<tr>
<td>Number of Problems</td>
<td>14</td>
<td>06</td>
<td>-08</td>
</tr>
</tbody>
</table>

*p<.05
Matthew is a nine and a half year old boy whose sibling is in the group as well. There is a parental history of mental health problems and alcohol abuse. His parents have been separated many times due to his mom's refusal to take her medication or remain in treatment. Matthew presents as a severely physically and emotionally neglected child in need of protection. Matthew's participation in the group enabled him to disclose the painful feelings he had trapped inside him. Although his test results reveal a decline in adjustment, clinical observations indicate he no longer is in denial regarding his family situation and it appears that he is not repressing his pain. His poor scoring on the measures might be indicative of an attempt by the child to deal with his painful emotions (see Table 9).
Table 9

MEAN SCORES ON ALL MEASURES

FOR CASE #3

<table>
<thead>
<tr>
<th>Scale</th>
<th>Before</th>
<th>After</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Esteem Total</td>
<td>61</td>
<td>58</td>
<td>-0.03</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>67</td>
<td>55</td>
<td>-1.2</td>
</tr>
<tr>
<td>Family Relations</td>
<td>56</td>
<td>55</td>
<td>-0.01</td>
</tr>
<tr>
<td>School</td>
<td>44</td>
<td>55</td>
<td>+1.1</td>
</tr>
<tr>
<td>General</td>
<td>78</td>
<td>66</td>
<td>-1.2</td>
</tr>
<tr>
<td>Depression</td>
<td>15</td>
<td>18</td>
<td>-0.03</td>
</tr>
<tr>
<td>Anxiety</td>
<td>25</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Lie</td>
<td>01</td>
<td>0</td>
<td>-0.01</td>
</tr>
<tr>
<td>Intensity of Problem</td>
<td>157</td>
<td>163</td>
<td>+0.06</td>
</tr>
<tr>
<td>Number of Problems</td>
<td>22</td>
<td>23</td>
<td>+0.01</td>
</tr>
</tbody>
</table>

*p < .05
Carlton, Matthew's brother, suffers from learning problems. Although their family situation is similar, their test scores are very different. Carlton was experiencing problems in school, related to his learning problems and his disruptive acting-out behaviour. Consequently the school identified him as having difficulty and enrolled him in extra group and individual counselling. The divergent test scores might be accounted for by Carlton's attendance in additional therapeutic groups. Although Carlton improved on all measures, his anxiety level is still high (see Table 10).
### Table 10

**MEAN SCORES ON ALL MEASURES**

**FOR CASE #4**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Before</th>
<th>After</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Esteem Total</td>
<td>28</td>
<td>58</td>
<td>+30</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>33</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td>Family Relations</td>
<td>56</td>
<td>88</td>
<td>+77</td>
</tr>
<tr>
<td>School</td>
<td>11</td>
<td>22</td>
<td>+11</td>
</tr>
<tr>
<td>General</td>
<td>11</td>
<td>88</td>
<td>+77</td>
</tr>
<tr>
<td>Depression</td>
<td>20</td>
<td>06</td>
<td>-14</td>
</tr>
<tr>
<td>Anxiety</td>
<td>23</td>
<td>20</td>
<td>-03</td>
</tr>
<tr>
<td>Lie</td>
<td>04</td>
<td>03</td>
<td>-01</td>
</tr>
<tr>
<td>Intensity of Problem</td>
<td>172</td>
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<td>-22</td>
</tr>
<tr>
<td>Number of Problems</td>
<td>26</td>
<td>19</td>
<td>-07</td>
</tr>
</tbody>
</table>

*p < .05*
Case 5

Insert Table 11 about here

Susie is a nine year old girl living with her mother. Susie's parents are separated due to her father's alcoholism and violence. Susie visits her dad frequently and regularly. Susie disclosed in the group that she does not enjoy these visits because her dad is either sleeping or yelling at her. Susie presented as a "happy go lucky" little girl and initially scored relatively high on all the subscales of the self-esteem measure. However, during her participation in the group, she was able to verbalize her feelings of anger towards both her mother and father. Her lower scales in terms of perception of self in relation to peers, family and school as well as the increase in the number of behavioural problems was seen as consistent with her particular situation (see Table 11). Susie's mom reported that although Susie seemed angry a good deal of the time and was harder to handle, she felt this was positive in the sense that her daughter was finally able to articulate her repressed feelings. This may account for the decrease in depression.
Table 11

MEAN SCORES ON ALL MEASURES

FOR CASE #5

<table>
<thead>
<tr>
<th>Scale</th>
<th>Before</th>
<th>After</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Esteem Total</td>
<td>69</td>
<td>66</td>
<td>-03</td>
</tr>
<tr>
<td>Peer Relations</td>
<td>74</td>
<td>64</td>
<td>-10</td>
</tr>
<tr>
<td>Family Relations</td>
<td>84</td>
<td>64</td>
<td>-20</td>
</tr>
<tr>
<td>School</td>
<td>80</td>
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</tr>
<tr>
<td>General</td>
<td>42</td>
<td>68</td>
<td>+26</td>
</tr>
<tr>
<td>Depression</td>
<td>12</td>
<td>09</td>
<td>-03</td>
</tr>
<tr>
<td>Anxiety</td>
<td>16</td>
<td>26</td>
<td>+10</td>
</tr>
<tr>
<td>Lie</td>
<td>07</td>
<td>04</td>
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<tr>
<td>Intensity of Problem</td>
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<td>107</td>
<td>-14</td>
</tr>
<tr>
<td>Number of Problems</td>
<td>08</td>
<td>10</td>
<td>+02</td>
</tr>
</tbody>
</table>

*p<.05
Case 6

Charles is a nine year old boy living with his younger siblings and alcoholic parent. His parent's are separated and Charles has liberal access to the noncostodial parent. Charle's participation in the group activities was inhibited by the constant fighting with his sibling, who was also in the group. Although Charles' parent reported that his behaviour improved at home, his scores were slightly lower on the peer, school and general subscales of self-esteem. There was a larger decrease in terms of perception of self in relation to family (see Table 12). This change might be attributed to Charles' costodial parent being absent from the family for several weeks. Charles was unable to discuss this situation, although it was clear from his acting-out behaviour that he was distressed about the absence. This might account for the increase in depression and anxiety (see Table 12).
Table 12

MEAN SCORES ON ALL MEASURES

FOR CASE #6

<table>
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<th>Scale</th>
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<tr>
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<td>General</td>
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<td>20</td>
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*p<.05
Case 7

Bryan is Charles' ten year old brother. Bryan did not do very well in the group. The group leaders spent most of their time managing Bryan's aggressive behaviour. His participation in every activity was inhibited by this acting-out behaviour. The leaders believed that Bryan would benefit from individual counselling and the appropriate referral was made.

Case 8

Charlotte is an eleven year old girl who lived away from her family at the time she entered the group. At mid-point she returned to her parent who is recovering from drug addiction. Charlotte improved in all areas except in terms of her perception of self in relation to family (see Table 14). This may well be related to her change in her living situation. Her decrease in depression is viewed as a positive indicator.
Table 13

MEAN SCORES ON ALL MEASURES

FOR CASE #7

<table>
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<td>+01</td>
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*p<.05
Table 14

MEAN SCORES ON ALL MEASURES

FOR CASE #8

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<td>-01</td>
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<tr>
<td>Lie</td>
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<td>Number of Problems</td>
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<td>04</td>
<td>-06</td>
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</table>

*p < .05
Case 9

Alice is a nine year old girl who lives with her mom and dad. Alice's alcoholic parent refuses treatment and is still actively drinking. Initially Alice was very withdrawn and would not participate in any of the activities or discussions. She would stay after each session was over and complete the exercise with me in private. Alice would like to spend time with one of the leaders on her own and speak about her fears and her family situation. Towards the fifth session Alice started to participate in the group exercises. She did particularly well in the family sculpting exercise. This enabled Alice to see what role she played in her family and how she could keep herself safe when her parent was drunk. Although Alice improved minimally in terms of the subscales peer and school relations, her guidance counsellor reported a noticeable change in her. She appeared happy and was able to concentrate on her work. Her mother as well reported an improvement in the frequency of behavioural problems. Although there was a slight increase in anxiety there was an increase in her perception of self in relation to her family, and a decrease in depression (see Table 15).
Table 15
MEAN SCORES ON ALL MEASURES
FOR CASE #9

<table>
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<th>After</th>
<th>Change</th>
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<td>Family Relations</td>
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<td>84</td>
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<tr>
<td>School</td>
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<tr>
<td>General</td>
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<tr>
<td>Depression</td>
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<td>01</td>
<td>-02</td>
</tr>
<tr>
<td>Anxiety</td>
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<td>12</td>
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*p<.05
CHAPTER IV
DISCUSSION

Data from the interviews have given strong support for the study's hypothesis, that the group intervention would have a positive effect on the child's self esteem and behaviour and decrease the child's level of depression and anxiety. One measure was statistically significant, and with one exception results on the nonsignificant results were in the expected direction.

Findings regarding the subjects are consistent with those reported in the literature. These children tend to feel guilty and responsible for the parental drinking. The household revolves around the alcoholic parent, leaving the children feeling angry and unloved. Their lack of self-cohesion, which may manifest itself in acting-out aggressive behaviour or alternatively passive withdrawn behaviour, often made group cohesion difficult. Low self-esteem, depression and anxiety were found again in this study. Due to their anxiety children were often unable to concentrate and were restless and fidgety, which inhibited their ability to participate in group activities.

In this particular sample more than half the children had alcoholic mothers. As well parental alcoholism began when the children were young. Again in accordance with the literature these children were more likely to be abused and neglected, often with
basic needs not being met. This was true for a number of the participants in this study. Two of the children reported physical abuse and observations by leaders and referral sources indicated that a number of the children were physically and emotionally neglected. In addition early childhood age at onset of parental alcoholism is associated with more problematic functioning for the child. The average age of the child when parental alcoholism began was 2.6 years. These children have not witnessed a role model for "normal" family functioning, nor have they developed nondestructive coping strategies. Also some of the characteristics of alcoholism such as chaos, inconsistency and unpredictability become entrenched in the child's identity and continue to direct his or her behaviour.

Overall results suggest that attendance at the children's group is associated with changes in how participants see themselves. As the children gained a better understanding of the process of addiction and its impact on the family they were able to relinquish feelings of responsibility and guilt. Through this education and the various therapeutic games the children were able to view their situation as out of their control and realized that they could only be responsible for themselves. Thus, they were more able to disengage from their family's dynamics.

The group provided a safe and consistent environment for these children to begin to form trusting relationships. The leaders
modelled consistent emotional responsiveness, as well as open and honest communication. They encouraged this type of interaction among the children enabling positive experiences related to social situations. The secret that surrounds alcoholism was shared and the children began to feel supported, thus reducing their alienation and isolation. This process and their increase in self-esteem may account for the decrease in depression for the children.

Most of the parents in this sample were in treatment for co-dependency and/or alcoholism. Although this may have confounded the results, it appeared to have a positive impact in terms of the parents' perception of child behaviour. The parents were feeling better about themselves, consequently they were able to view their child in a more positive light. The significant change in frequency of behavioural problems and a tendency for a decrease in the number of problems might indicate that both parent and child were working in co-operation. As well, the group provided a place where the child could alleviate some of his/her pain, and use the therapist as a source of calm which helped facilitate self-cohesion. This might have helped reduce the child's acting-out behaviour, thus making parent-child interactions more positive.

When the occurrence of multiple stressors is taken into account, these additional factors may explain why some of the children did not do as well as compared to others in the group. For example the
literature reports that the impact on the child of parental alcoholism is more severe when violence, mental illness, poverty, etc. are present, which compounds the already problematic situation for the child. These family situations were present for a number of the children.

An additional factor that might account for lower results in time 2 was the children's rigid defense mechanisms. At the beginning of the group the child's denial regarding the family situation, repression of uncomfortable feelings, or people pleasing manner were operating without the child's awareness. The lower results in time 2 might be explained by the occurrence of the intervention. It was designed to help the child identify when and why she/he was using a particular defense mechanism and to assist the child in making a conscious choice as to whether or not to use it. Having triggered those defense mechanisms its conceivable that the child became more aware of his/her situation and pain. Thus initially the intervention could have exacerbated the child's situation due to the impact on the child's denial system.

CLINICAL IMPLICATIONS

The children's group appears to be effective in preparing the participants for self-change as described above. Given that change comes about slowly, a continuation of the group would be most beneficial to these children. Attendance in the children's group
appears to be associated with improvements in perceptions of frequency of behavioural problems, as well as nonsignificant trends towards improved self-esteem, decrease in depression and number of behavioural problems.

However, anxiety levels increased. The general nature of the group process as well as the content appears to have increased the child's anxiety level. Although stress reduction exercises were taught, it was apparent that the children were unable to implement these techniques on their own on any regular basis. Factors that might contribute to this problem are the child's lack of self-cohesion, which made exercises that produced uncomfortable feelings impossible to complete. As well, a nine week program did not seem to be enough time to relieve these children of their anxiety. For some of these children, their family situation was such that they were going home to a place that was actually deteriorating instead of improving.

This study's findings is consistent with Jesse's (1989) work which suggests that the child's lack of self-cohesion creates difficulties in group cohesion. She states that group treatment will not significantly alter a child's developmental deficits. The leaders noticed that at times the children were unable to sit still, incapable of coping with their inner turmoil, which led to a constant struggle for the leader's attention. Jesse (1989) contends that
group treatment which focuses on education about substance abuse, reducing feelings of alienation and improving peer functioning, may be used along with individual treatment. Although it was not feasible during this study to incorporate individual work with these children, in future ADP could provide individual work before group treatment begins. The individual sessions would give the leader the time necessary to assess the severity of the trauma for the child, as well as determine where the child is developmentally.

Individual sessions would help the child trust the therapist and use him/her as a source of comfort. The child would get the individual attention he/she so desperately needs, which could help reduce his/her painful feelings. He/she could then internalize the therapist's soothing voice and begin to develop his/her own. This process will begin to prepare him/her for the group process which inevitably produces anxiety.

This does not imply that change will come easily or quickly for these children, given the scope of the problems these children and their families face. The group process did produce positive changes for these children, but the stressors in their lives still remain. For example, parents who are engaged in early recovery have a long road ahead of them. In two of the cases the addicted parent was still actively drinking. The children and their parents would benefit from more than one level of treatment available to them.
Although this group seems to be a viable one, to date a childrens' group is not part of ADP programming. ADP rarely considers the child's recovery as important. Individual work for children in this field is virtually non-existent.

A nine week program can plant the seeds for recovery for these children. It provides the children with another view of life removed from their chaotic, inconsistent and unpredictable environment. However, brief intervention will not be sufficient to assist these children. Unless the child's recovery is considered as important as the addicted parents' recovery, the cycle of addiction will continue.

LIMITATIONS OF THE RESEARCH

There are a number of limitations to this study. First, the validity of the data is effected by the small sample size. Consequently, caution must be exercised when interpreting trends and drawing conclusions. Secondly, there were extraneous variables that might confound the results. For example, the high incidence of maternal alcoholism, the presence of mental illness and violence and the children's participation in other therapeutic groups, may have threatened the validity of the data.

Measurement issues may also confound the results. The measures did not account for a range of defense mechanisms that are common
among children of addicted parents. The child's denial and people pleasing manner may have biased the childrens' responses. As well it was not feasible in this study to take into account the child's developmental level. Consequently, some of the children experienced some distress related to their not understanding certain questions or words used in the interview schedule. Measuring the child's developmental level might enhance the validity of the findings.

RECOMMENDATIONS FOR FURTHER RESEARCH

A controlled study with a larger sample would be required in order to fully test the success of the intervention. As well the utility of different intervention modes could be effectively examined using multiple group comparison. For example, group treatment with prior individual work vs. group treatment without prior individual work might increase our understanding of program effectiveness. In addition, standardized measures which take into consideration the issues common to children of addicted parents need to be designed and pre-tested to determine their utility with this population.
REFERENCES


APPENDIX A
Dear Parent/Guardian

I would like to invite your child to participate in a project to study the effectiveness of a children's group whose goal is to help children learn to cope with the problems of living in a home with alcoholism or other drug addictions. This research will help us understand the impact of parental alcoholism on children as well as help us develop future programs for these children.

I would like to explain more about this program that your child will be involved in, should you agree to his/her participation.

Program

Through role play, films, discussions and structured activities, the children will learn about alcoholism and its effects on the family. As well they will learn how not to get caught up in the cycle of alcohol/drug dependence and co-dependence. The group will focus on stress management, problem solving, assertiveness training; including discussion of their personal rights, how to take care of themselves in an emergency situation and briefly on how to say no to inappropriate touching. This group will run for 12 weeks, every Tuesday from 3:30 to 4:30.

Evaluation Process

Before the group begins you will be asked to attend with your child an interview with myself or a co-worker. At this time we will discuss the children's group in more detail and get to know your child. You will be asked to fill out an information sheet regarding your family's alcohol/drug problem. Separately your child will be given a series of tests that will help us understand how he is coping with his/her situation, how much control he/she feels he has over his/her life and how good he feels about him/herself. This appointment will take approximately 1 1/2 hours. In addition, while your child is participating in the group as well as after its completion your child will again be tested with the same series of tests. Testing after the group's completion will require approximately 1 hour.
While we hope that the group experience will be interesting and enjoyable for your child, we also know that uncomfortable feelings may arise during particular sessions. If this should happen we will help your child deal with his feelings by being supportive and nurturing as well as using stress management techniques. In addition, we realize that some children become anxious during tests. If this happens we will help your child deal with his discomfort, again with stress management techniques, and if necessary make arrangements to administer the tests at another time.

Should you decide to allow your child to participate in this study, we will require written consent. Confidentiality will be maintained by having individual responses coded so that you child's forms will not be matched with his/her name. The forms will be destroyed no later than August 1990. At any point during your child's involvement in this program you will be able to contact me with any questions or concerns. As well you may withdraw your child from the study without prejudice. Withdrawing your child from this study will in no way effect his/her treatment with Alcohol and Drug Programs or Family Services, now or in the future.

I believe that the information we learn from this study will help make future programs for children more helpful. Please let me know if you have any questions about this project now or in the future.

______________________________  _______________________
DATE WITNESS

SIGNATURE

PARENTAL/GUARDIAN CONSENT

I ____________________________ Hereby consent to my child/ren attending the Children of Addicted Parent's Group Study at Family Services North Burnaby Alcohol and Drug Programs. I have had an explanation of the content of the group and the evaluation process and fully understand that my child/ren's involvement and my consent to their involvement is completely voluntary. Should I disagree with the manner in which the group is conducted, I know that I can withdraw my child/ren at any time; otherwise I commit myself to their attendance at all sessions of the group. I understand that I have a right to a full explanation of the workings of the group as it affects my child/ren.

I understand that this consent in no way obligates me to further involvement with Alcohol and Drug Programs or Family Services. I also understand that as per legal and ethical requirements we will respond to current physical, sexual or extreme emotional abuse. Where possible or appropriate the parent will be given the opportunity to contact their local Ministry of Social Services and Housing. Failing this we will be obligated to contact the above agency. This would be discussed prior to such contact being made, if appropriate.
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**************************************************
To Whom It May Concern:

Re: Children of Addicted Parent's Group
(8-12 years old)

I am currently a graduate student attending the UBC School of Social Work. My thesis is concerned with the effects of parental alcoholism on children who are between the ages of 8-12 years old, and the effectiveness of an educational/therapeutic group intervention. I am conducting this group through Family Services, North Burnaby Alcohol and Drug Program and welcome referrals from interested parent's and agencies.

This group will run for 12 weeks, every Tuesday from 3:30 to 4:30. The goal of the group is to teach children how to cope with the problems of living in a home with alcoholism or other drug addictions. This group will focus on stress management, assertiveness, self-esteem enhancement and an understanding of addicted families. Through role plays, films, discussion and structured activities, children will learn how to identify and express feelings and how to prevent themselves from getting caught up in the cycle of alcohol/drug dependence and co-dependence.

In order to determine the effectiveness of the group, each child will be given a series of tests before, during and after the group's completion. These tests will measure self-esteem, stress, helplessness and the child's perception of his/her environment. An assessment interview will be set up with each parent and child, at which time information about the group will be given in detail and with parental permission the tests will administered by me or my co-worker Myrna Driol. Parent's have the right to withdraw their child from the study at any point, without jeopardizing present or future treatment with Family Services or Alcohol and Drug Programs.

Interested parents should contact North Burnaby Alcohol and Drug Programs at . For further information please feel free to contact me at this clinic.

Thank you,

Marcelle Mason, BSW, RSW
TO THE PARENT(S): Please complete the following information on your child.

---

Child's Full Name
Birthdate

---

Please list all members of the child's immediate family and provide the information indicated:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relation to Child</th>
<th>How Person Gets Along With Child</th>
</tr>
</thead>
</table>

---

Which parent is alcoholic? Mother ( ) Father ( ) Both ( )

If applicable -- Length of sobriety of the alcoholic parent(s)
Mother _____ Father _____

Age of child when parental alcoholism developed _____.

If the alcoholic parent is not the child's natural (biological) parent at what age did the child come to live with the step-parent? _____

If the child has not always lived in the same home, please list all the moves.

<table>
<thead>
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<th>Area</th>
<th>Age Moved Away</th>
<th>Length of Stay</th>
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</thead>
</table>

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Are parent's currently living together: Together ( ) Separated ( )

If separated please briefly explain:
For example due to alcohol/drug abuse?
Violent behaviour?
Length of separation?
Education level of mother ____________________.

Education level of father ____________________.

Mother's occupation ________________________.

Father's occupation ________________________

Describe briefly family history of alcoholism.

Mother's

Father's

If you or your partner are still actively using alcohol or drugs, please describe briefly the nature of your involvement/partner's involvement.
Have you had any reports from the school regarding poor academic performance or behavioural problems in the classroom concerning your child?  Yes ( )  No ( )

If yes, when? ________________ If yes, please explain in detail.

Briefly describe what you consider your child's major problems now.

Name of person completing form _______________________________________
Relationship to child _________________________________________________
Date: _____________________________________________________________
APPENDIX B

Measures of Self-Concept

Grades K-3

4-6

7-12
SELF-APPRAISAL INVENTORY

Grades K - 3    Subject #

NAME: _______________________
SEX: _______________________
GRADE: _______________________

1. Are you easy to like?
2. Do you often get in trouble at home?
3. Can you give a good talk in front of your class?
4. Do you wish you were younger?
5. Are you an important person in your family?
6. Do you often feel you are doing badly in school?
7. Do you like being just what you are?
8. Do you have enough friends?
9. Does your family want too much of you?
10. Do you wish you were someone else?
11. Can you wait your turn easily?
12. Do your friends usually do what you say?
13. Is it easy for your to do good in school?
14. Do you often break your promises?
15. Do most children have fewer friends than you?
16. Are you smart?
17. Are most children better liked than you?
18. Are you one of the last to be chosen for games?
19. Are the things you do at school easy for you?
20. Do you know a lot?
21. Can you get good grades if you want to?
22. Do you forget most of what you learn?

23. Do you feel lonely very often?

24. If you have something to say do you usually say it?

25. Do you get upset easily at home?

26. Do you often feel ashamed of yourself?

27. Do you like the teacher to ask you questions in front of the other children?

28. Do the other children in class think you are a good worker?

29. Are you hard to be friends with?

30. Do you find it hard to talk in your class?

31. Are most children able to finish their school work more quickly than you?

32. Do members of your family pick on you?

33. Are you any trouble to your family?

34. Is your family proud of you?

35. Can you talk to your family when you have a problem?

36. Do your parents like you even if you've done something bad?
SELF-APPRAISAL INVENTORY

Grades 4 - 6 Subject #

NAME:

SEX:

GRADE:

YES NO

1. Other children are interested in me?
2. Schoolwork is fairly easy for me.
3. I am satisfied to be just what I am.
4. I should get along better with other children than I do.
5. I often get into trouble at home.
6. My teachers usually like me.
7. I am a cheerful person.
8. Other children are often mean to me.
9. I do my share of work at home.
10. I often feel upset in school.
11. I'm not very smart.
12. No one pays much attention to me at home.
13. I can get good grades if I want to.
14. I can be trusted.
15. I am popular with kids my own age.
16. My family isn't very proud of me.
17. I forget most of what I learn.
18. I am easy to like.
19. Girls seem to like me.
20. My family is glad when I do things with them.
21. I often volunteer to do things in class.

22. I'm not a very happy person.

23. I am lonely very often.

24. The members of my family don't usually like my ideas.

25. I am a good student.

26. I can't seem to do things right.

27. Older kids like me.

28. I behave badly at home.

29. I often get discouraged in school.

30. I wish I were younger.

31. I am friendly toward other people.

32. I usually get along with my family as well as I should.

33. My teacher makes me feel I'm not good enough.

34. I like being the way I am.

35. Most people are much better liked than I am.

36. I cause trouble to my family.

37. I am slow finishing my school work.

38. I am often unhappy.

39. Boys seem to like me.

40. I live up to what is expected of me.

41. I can give a good report in front of the class.

42. I am not as nice looking as most people.

43. I have many friends.
<p>| | | |</p>
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<thead>
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<tbody>
<tr>
<td>44.</td>
<td>My parents don't seem interested in the things I do</td>
<td>NO</td>
</tr>
<tr>
<td>45.</td>
<td>I am proud of my school work.</td>
<td></td>
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<tr>
<td>46.</td>
<td>If I have something to say, I usually say it.</td>
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<tr>
<td>47.</td>
<td>I am among the last to be chosen for teams.</td>
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<tr>
<td>48.</td>
<td>I feel that my family usually doesn't trust me.</td>
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<tr>
<td>49.</td>
<td>I am a good reader.</td>
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<tr>
<td>50.</td>
<td>I can usually figure out difficult things.</td>
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<tr>
<td>51.</td>
<td>It is hard for me to make friends.</td>
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<tr>
<td>52.</td>
<td>My family would help me in any kind of trouble.</td>
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<tr>
<td>53.</td>
<td>I am not doing as well in school as I would like.</td>
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<tr>
<td>54.</td>
<td>I have a lot of self-control.</td>
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<tr>
<td>55.</td>
<td>Friends usually follow my ideas.</td>
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<tr>
<td>56.</td>
<td>My family understands me.</td>
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<tr>
<td>57.</td>
<td>I find it hard to talk in front of the class.</td>
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<tr>
<td>58.</td>
<td>I often feel ashamed of myself.</td>
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<tr>
<td>59.</td>
<td>I wish I had more close friends.</td>
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<tr>
<td>60.</td>
<td>My family often expects too much of me.</td>
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<tr>
<td>61.</td>
<td>I am good in my school work.</td>
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<tr>
<td>62.</td>
<td>I am a good person.</td>
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<tr>
<td>63.</td>
<td>Others find me hard to be friendly with.</td>
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<tr>
<td>64.</td>
<td>I get upset easily at home.</td>
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<tr>
<td>65.</td>
<td>I don't like to be called on in class.</td>
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<tr>
<td>66.</td>
<td>I wish I were someone else.</td>
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<tr>
<td>67.</td>
<td>Other children think I'm fun to be with.</td>
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</tbody>
</table>
68. I am an important person in my family.
69. My classmates think I am a poor student.
70. I often feel uneasy.
71. Other children often don't like to be with me.
72. My family and I have a lot of fun together.
73. I would like to drop out of school.
74. Not too many people really trust me.
75. My family usually considers my feelings.
76. I can do hard homework assignments.
77. I can't be depended on.
SELF-APPRAISAL INVENTORY

Grades 7 - 12

NAME: _______________________
SEX: _________________________
GRADE: _______________________  YES  NO

1. School work is fairly easy for me.
2. I am satisfied to be just what I am.
3. I ought to get along better with other people.
4. My family thinks I don't act as I should.
5. People often pick on me.
6. I don't usually do my share of work at home.
7. I sometimes feel upset when I'm at school.
8. I often let other people have their way.
9. I have as many friends as most people.
10. Usually no one pays much attention to me at home.
11. Getting good grades is pretty important to me.
12. I can be trusted as much as anyone.
13. I am well liked by kids my own age.
14. There are time when I would like to leave home.
15. I forget most of what I learn.
16. My family is surprised if I do things with them.
17. I am often not a happy person.
18. I am not lonely very often.
19. My family respects my ideas.
20. I am not a very good student.
21. I often do things that I'm sorry for later.

22. Other kids seem to like me.

23. I sometimes behave badly at home.

24. I often get discouraged in school.

25. I often wish I were younger.

26. I am usually friendly toward other people.

27. I don't usually treat my family as well as I should.

28. My teacher makes me feel I'm not good enough.

29. I always like being the way I am.

30. I am just as well liked as most people.

31. I cause trouble to my family.

32. I am slow finishing my school work.

33. I often am not as happy as I would like to be.

34. I am not as nice looking as most people.

35. I don't have many friends.

36. I feel free to argue with my family.

37. Even if I have something to say, I often don't say it.

38. Sometimes I am among the last to be chosen for team.

39. I feel that my family always trusts me.

40. I am a good reader.

41. It is hard for me to make friends.

42. My family would help help me in any kind of trouble.
<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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<tr>
<td>43. I am not doing as well in school as I would like.</td>
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<td>44. I find it hard to talk in front of the class.</td>
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<td>48. I'm not very good in my school work.</td>
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<tr>
<td>49. I'm not as good a person as I would like to be.</td>
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<tr>
<td>50. Sometimes I am hard to make friends with.</td>
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<td>51. I wish I were someone else.</td>
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<tr>
<td>52. People don't usually have much fun when they are with me.</td>
<td></td>
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<td>53. I am an important person to my family.</td>
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<td>55. I am not very sure of myself.</td>
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</tr>
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<td>56. Often I don't like to be with other kids.</td>
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<tr>
<td>57. My family and I have lots of fun together.</td>
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<tr>
<td>58. There are times when I feel like dropping out of school.</td>
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<tr>
<td>59. I can always take care of myself.</td>
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<tr>
<td>60. Many times I would like to be with kids younger than me.</td>
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<tr>
<td>61. My family usually doesn't consider my feelings.</td>
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<tr>
<td>62. I can't be depended on.</td>
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Children of Alcoholics Screening Test
C.A.S.T.

Please check ( ) the answer below that best describes your feelings, behaviour and experiences related to a parent's alcohol use. Take your time. Answer all 30 questions be checking either yes or no.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>QUESTIONS</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>1. Have you ever thought that your parent's had a drinking problem?</td>
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<td>2. Have you ever lost sleep because of your parent's drinking?</td>
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<td>3. Did you ever encourage one of your parent's to quit drinking?</td>
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<td>4. Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?</td>
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<td>5. Did you ever argue or fight with a parent when he or she was drinking?</td>
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<td>6. Did you ever threaten to run away from home because of a parent's drinking.</td>
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<td>7. Has a parent yelled at or hit you or other family members when drinking?</td>
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<td>8. Have you ever heard your parent's fight when one of them was drunk?</td>
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<td></td>
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<td>9. Did you ever protect another family member from a parent who was drinking?</td>
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<td></td>
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<td>10. Did you ever feel like hiding or emptying a parent's bottle of liquor?</td>
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<td>11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his/her drinking?</td>
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<td></td>
<td></td>
<td>12. Did you ever wish that a parent would stop drinking?</td>
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<td></td>
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<td>13. Did you ever feel responsible for and guilty about a parent's drinking?</td>
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<td></td>
<td></td>
<td>14. Did you ever fear that your parent's would get divorced due to alcohol misuse?</td>
</tr>
</tbody>
</table>
QUESTIONS

15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking?

16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?

17. Did you ever feel that you made a parent drink alcohol.

18. Have you ever felt that a problem drinking parent did not really love you?

19. Did you ever resent a parent's drinking?

20. Have you ever worried about a parent's health because of his or her drinking?

21. Have you ever been blamed for a parent's drinking?

22. Did you ever think your father was an alcoholic?

23. Did you ever wish that your home could be more like the homes of your friends who did not have a parent with a drinking problem?

24. Did a parent ever make promises to you that he/she did not keep because of drinking?

25. Did you ever think your mother was an alcoholic?

26. Did you ever wish that you could talk to someone who would understand and help the alcohol-related problems in your family?

27. Did you ever fight with your brothers and sisters about a parent's drinking?

28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?

29. Have you ever felt sick, cried or had a knot in your stomach after worrying about a parent's drinking?

30. Did you ever take over any chores and duties at home that were usually done by a parent before he/she developed a drinking problem?
KOVAC'S CHILD DEPRESSION INVENTORY
FEELINGS QUESTIONNAIRE

KIDS SOMETIMES HAVE DIFFERENT FEELINGS AND IDEAS.

THIS FORM LISTS THE FEELINGS AND IDEAS IN GROUPS. FROM EACH GROUP, PICK ONE SENTENCE THAT DESCRIBES YOU BEST FOR THE PAST TWO WEEKS. AFTER YOU PICK A SENTENCE FROM THE FIRST GROUP, GO ON TO THE NEXT GROUP.

THERE IS NO RIGHT ANSWER OR WRONG ANSWER. JUST PICK THE SENTENCE THAT BEST DESCRIBES THE WAY YOU HAVE BEEN RECENTLY. PUT A MARK LIKE THIS NEXT TO YOUR ANSWER. PUT THE MARK IN THE BOX NEXT TO THE SENTENCE THAT YOU PICK.

HERE IS AN EXAMPLE OF HOW THIS FORM WORKS. TRY IT. PUT A MARK NEXT TO THE SENTENCE THAT DESCRIBES YOU BEST.

EXAMPLE:

☐ I READ BOOKS ALL THE TIME.

☐ I READ BOOKS ONCE IN A WHILE.

☐ I NEVER READ BOOKS.
REMEMBER, PICK OUT THE SENTENCES THAT DESCRIBE YOUR FEELINGS AND IDEAS IN THE PAST TWO WEEKS.

1. □ I AM SAD ONCE IN A WHILE.
   □ I AM SAD MANY TIMES.
   □ I AM SAD ALL THE TIME.

2. □ NOTHING WILL EVER WORK OUT FOR ME.
   □ I AM NOT SURE IF THINGS WILL WORK OUT FOR ME.
   □ THINGS WILL WORK OUT FOR ME O.K.

3. □ I DO MOST THINGS O.K.
   □ I DO MANY THINGS WRONG.
   □ I DO EVERYTHING WRONG.

4. □ I HAVE FUN IN MANY THINGS.
   □ I HAVE FUN IN SOME THINGS.
   □ NOTHING IS FUN AT ALL.

5. □ I AM BAD ALL THE TIME.
   □ I AM BAD MANY TIMES.
   □ I AM BAD ONCE IN A WHILE.

6. □ I THINK ABOUT BAD THINGS HAPPENING TO ME ONCE IN A WHILE.
   □ I WORRY THAT BAD THINGS WILL HAPPEN TO ME.
   □ I AM SURE THAT TERRIBLE THINGS WILL HAPPEN TO ME.

7. □ I HATE MYSELF.
   □ I DO NOT LIKE MYSELF.
   □ I LIKE MYSELF.
8. ALL BAD THINGS ARE MY FAULT.
   MANY BAD THINGS ARE MY FAULT.
   BAD THINGS ARE NOT USUALLY MY FAULT.

9. I DO NOT THINK ABOUT KILLING MYSELF.
   I THINK ABOUT KILLING MYSELF BUT I WOULD NOT DO IT.
   I WANT TO KILL MYSELF.

10. I FEEL LIKE CRYING EVERY DAY.
    I FEEL LIKE CRYING MANY DAYS.
    I FEEL LIKE CRYING ONCE IN A WHILE.

11. THINGS BOTHER ME ALL THE TIME.
    THINGS BOTHER ME MANY TIMES.
    THINGS BOTHER ME ONCE IN A WHILE.

12. I LIKE BEING WITH PEOPLE.
    I DO NOT LIKE BEING WITH PEOPLE MANY TIMES.
    I DO NOT WANT TO BE WITH PEOPLE AT ALL.

13. I CANNOT MAKE UP MY MIND ABOUT THINGS.
    IT IS HARD TO MAKE UP MY MIND ABOUT MANY THINGS.
    I MAKE UP MY MIND ABOUT THINGS EASILY.

14. I LOOK O.K.
    THERE ARE SOME BAD THINGS ABOUT MY LOOKS.
    I LOOK UGLY.

15. I HAVE TO PUSH MYSELF ALL THE TIME TO DO MY SCHOOLWORK
    I HAVE TO PUSH MYSELF MANY TIMES TO DO MY SCHOOLWORK
    DOING SCHOOLWORK IS NOT A BIG PROBLEM.
<p>| | | |</p>
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</table>
| 16. | I HAVE TROUBLE SLEEPING EVERY NIGHT.  
I HAVE TROUBLE SLEEPING MANY NIGHTS.  
I SLEEP PRETTY WELL. |   |   |
| 17. | I AM TIRED ONCE IN A WHILE.  
I AM TIRED MANY DAYS.  
I AM TIRED ALL THE TIME. |   |   |
| 18. | MOST DAYS I DO NOT FEEL LIKE EATING.  
MANY DAYS I DO NOT FEEL LIKE EATING.  
I EAT PRETTY WELL. |   |   |
| 19. | I DO NOT WORRY ABOUT ACHES AND PAINS.  
I WORRY ABOUT ACHES AND PAINS MANY TIMES.  
I WORRY ABOUT ACHES AND PAINS ALL THE TIME. |   |   |
| 20. | I DO NOT FEEL ALONE.  
I FEEL ALONE MANY TIMES.  
I FEEL ALONE ALL THE TIME. |   |   |
| 21. | I NEVER HAVE FUN AT SCHOOL.  
I HAVE FUN AT SCHOOL ONLY ONCE IN A WHILE.  
I HAVE FUN AT SCHOOL MANY TIMES. |   |   |
| 22. | I HAVE PLENTY OF FRIENDS.  
I HAVE SOME FRIENDS BUT I WISH I HAD MORE.  
I DO NOT HAVE ANY FRIENDS. |   |   |
| 23. | MY SCHOOLWORK IS ALRIGHT  
MY SCHOOLWORK IS NOT AS GOOD AS BEFORE.  
I DO VERY BADLY IN SUBJECTS I USED TO BE GOOD IN. |   |   |
24. I CAN NEVER BE AS GOOD AS OTHER KIDS.
   I CAN BE AS GOOD AS OTHER KIDS IF I WANT TO.
   I AM JUST AS GOOD AS OTHER KIDS.

25. NOBODY REALLY LOVES ME.
   I AM NOT SURE IF ANYBODY LOVES ME.
   I AM SURE THAT SOMEBODY LOVES ME.

26. I USUALLY DO WHAT I AM TOLD.
   I DO NOT DO WHAT I AM TOLD MOST TIMES.
   I NEVER DO WHAT I AM TOLD.

27. I GET ALONG WITH PEOPLE.
   I GET INTO FIGHTS MANY TIMES.
   I GET INTO FIGHTS ALL THE TIME.

The End

THANK YOU FOR FILLING OUT THIS FORM
What I Think and Feel Questionnaire.

NAME: __________________________ AGE: ___ SEX: ___

1. I have trouble making up my mind. Y N
2. I get nervous when things do not go the right way for me Y N
3. Others seem to do things easier than I can. Y N
4. I like everyone I know. Y N
5. Often I have trouble getting my breath. Y N
6. I worry a lot of the time. Y N
7. I am afraid of a lot of things. Y N
8. I am always kind. Y N
9. I get mad easily. Y N
10. I worry about what my parents will say to me. Y N
11. I feel that others do not like the way I do things. Y N
12. I always have good manners. Y N
13. It is hard for me to get to sleep at night. Y N
14. I worry about what other people think of me. Y N
15. I feel alone even when there are people with me. Y N
16. I am always good. Y N
17. Often I feel sick to my stomach. Y N
18. My feelings get hurt easily. Y N
19. My hands feel sweaty. Y N
20. I am always nice to everyone. Y N
21. I am tired a lot. Y N
22. I worry about what is going to happen. Y N
23. Other children are happier than I. Y N
24. I tell the truth every single time.  Y N
25. I have bad dreams.  Y N
26. My feelings get hurt really when I am fussed at.  Y N
27. I feel someone will tell me to do things the wrong way.  Y N
28. I never get angry.  Y N
29. I wake up scared some of the time.  Y N
30. I worry when I go to bed at night.  Y N
31. It is hard for me to keep my mind on my schoolwork.  Y N
32. I never say things I shouldn't.  Y N
33. I wiggle in my seat a lot.  Y N
34. I am nervous.  Y N
35. A lot of people are against me.  Y N
36. I never lie.  Y N
37. I often worry about something bad happening to me.  Y N