

/Treatment Effectiveness Of A Coping Group  
For College Students With Alcoholic Parents/

by

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## Chapter 1

### Introduction

There is considerable evidence that alcoholism in a biological parent or grandparent is the best predictor of alcoholism in an individual (Goodwin, 1981). Children of alcoholics develop alcoholism four times as often as children of nonalcoholics (Goodwin, 1974). Although children of alcoholics may experience a variety of affective and interpersonal problems, in studies of twins and adoptive children which controlled for environmental and genetic influences results seemed to indicate that the genetic factor was more closely associated with the alcoholism than the environmental factors (Goodwin, 1973; Goodwin, 1974; Schuckit, 1972; Hrubec, 1981).

In addition to this elevated risk for developing alcoholism, children of alcoholics experience many problems more directly related to growing up in malfunctioning families. One common theme in the literature is role confusion. Often in alcoholic families, children take on parental responsibilities, meeting the needs of parents and younger siblings. A second common observation is the difficulty children of alcoholics have in acknowledging any feelings. Claudia Black (1981) talks about three rules in

alcoholic families: "Don't talk," "Don't feel," "Don't trust." She notes that often these children, by the age of nine, protect themselves from fear, anger, and hurt by refusing to acknowledge these feelings. Richards (1980) reported a counterphobia or fearlessness in children of alcoholics combined with an obsession with lack of control. Many of these problems are carried into adulthood. Cermak and Brown (1982) reported in their therapy with adult children of alcoholics the overriding issue was a preoccupation with control. "All feelings are seen as bad, because affect is experienced as lack of control." Janet Woititz (1983), in her book Adult Children of Alcoholics describes 13 common problems of children of alcoholics.

Adult children of alcoholics:

1. Guess at what is "normal".
2. Have difficulty following a project from beginning to end.
3. Lie when it would be just as easy to tell the truth.
4. Judge themselves without mercy.
5. Have difficulty having fun.
6. Take themselves very seriously.
7. Have difficulty with intimate relationships.
8. Overreact to changes over which they have no control.
9. Constantly seek approval and affirmation.
10. Usually feel they are different from other people.

11. Are super responsible or super irresponsible.
12. Are extremely loyal even if evidence is the loyalty is undeserved.
13. Are impulsive, they tend to lock themselves into a course of action without considering alternatives or consequences. Impulsivity leads to confusion, self-loathing, and loss of control over the environment. They spend an excessive amount of time cleaning up the mess.

Despite the evidence that children of alcoholics are at higher risk for developing alcoholism, and tend to develop affective and interpersonal disorders associated with their familial environment, programs to help these high risk people are a rarity. Most children of alcoholics have had two points of contact for learning about alcoholism. The first may be public school prevention programs, which rarely touch on familial drinking. As Janet Woititz (1981) said in a presentation to the National Institute On Alcoholism and Alcohol Abuse.

The alcohol education programs in our schools do a relatively good job of pointing out what will happen to you if you drink irresponsibly. They do no job at all, as far as I can see, in pointing out what will happen to you if your parents drink irresponsibly (Page 188).

The second point of contact occurs if a parent receives treatment. Most treatment programs include a family care component, usually in the form of a family week or family

nights. These programs are effective in helping the family member to cope with alcoholism; however, the focus remains primarily on the alcoholic and they often do not address the issue of prevention with the children of alcoholics. Alateen, a self help group for adolescent children of alcoholics, remains the chief (and sometimes the only) resource for children of alcoholics.

While school prevention programs, and family components of treatment centers provide valuable services there remain enormous gaps in services for children of alcoholics. One problem is services for children of alcoholics are often unavailable until the parent decides to seek help. In addition, there appears to be a need to provide programs that integrate prevention strategies with therapeutic strategies for dealing with the problems associated with growing up in an alcoholic family. Furthermore, there is an absence of data on the effectiveness of therapeutic approaches beyond subjective client perceptions of helpfulness.

Providing these services to children of alcoholics can often be difficult while the child is still living with the alcoholic parent. Parents, particularly those who have not acknowledged their alcoholism, may prevent the child from receiving help. In addition, children of alcoholics tend to be protective of their alcoholic parent; consequently, they may be reluctant in seeking help while they are still living at home. Certainly, the need exists for programs aimed at younger populations; however, in order to avoid these

problems, the focus of this study will be on college undergraduates.

There are several advantages in working with college undergraduates. A publication by NIAAA (1983) on providing services for children of alcoholics reports that many children of alcoholics, who are in college find the typical feeling of positive-regard which may be achieved from new experiences in college are often threatened by feelings of guilt and responsibility for their families. When these students leave their families they often remain socially and emotionally entangled. Upon returning home they find their roles and their rooms filled by siblings, and they feel left out of the family system. Often these young adults build relationships that fit the dysfunctional patterns with which they are familiar. Acting out these dysfunctional patterns inhibits personal and professional relationships, often leading to sudden breakdowns among highly successful professionals who are children of alcoholics (NIAAA, 1981).

Working with college undergraduates provides a uniquely advantageous position for the following reasons:

1. While some children of alcoholics may have already developed problems with alcoholism, most are still early enough in their usage to warrant a preventive approach.

2. For most children of alcoholics, who are college undergraduates, this is their first experience away from home; it may feel safer to seek help when you are not living with an alcoholic parent.

3. Most children of alcoholics feel a need to protect their parents; in seeking help through a coping group on campus, they can more readily protect their parents' anonymity.

4. Most evidence indicates that without intervention the problems of children of alcoholics persist.

#### Statement of the Problem

The purpose of this study was to examine the effects of a short-term group treatment for college undergraduates with alcoholic parents using an intensive analysis of objectively defined client behaviors during therapy, along with both objective and subjective outcome measures. Specifically the study sought to answer the following questions:

1. Did the subjects, as a result of the group experience, have increased knowledge of alcoholism and its impact on the family?
2. Did participation in the group effect subsequent reported drinking behavior?
3. Did subjects find the group helpful in understanding their behavior within their families?
4. Did subjects find the group helpful in forming plans to change their behavior?

#### Hypothesis

1. No differences will be found between pre-test and post-test (alternate forms) scores on a measure of knowledge of alcoholism and the family.

2. No differences will be found across time in reported quantity of alcohol consumed.

3. No differences will be found across time in reported frequency of alcohol consumption.

4. No differences will be found across sessions in frequency of subject verbal behavior in any of the following categories: requests, description, exploration of counselor-client relationship.

5. No differences will be found across sessions in frequency of subject verbal behavior in any of the following categories: experiencing, insight, discussion of plans.

6. No differences will be obtained between pre-test and post-test on a measure of subjects perceived ability to cope with their families.

## Chapter 2

### Review of the Literature

The review of pertinent literature in this study concerns three general areas on children of alcoholics: (a) genetic influences, (b) environmental influences, and (c) therapeutic approaches.

#### Genetic Influences On Alcoholism Predisposition

Studies that have attempted to separate genetic and environmental influences in the intergenerational transmission of alcoholism fall into several categories: twin studies, adoption studies, split sibling studies and half sibling studies. The most often quoted and best known genetic study is the Goodwin et al. (1973) adoption study. This study examined male nonfamily adoptees who had at least one alcoholic biological parent and who had been adopted within the first six weeks of life. These adoptees were compared to two control groups, one with parental psychiatric hospitalization for other disorders, and one with no parental psychiatric hospitalization. The adoptive parents of experimental and control subjects had similar rates of alcoholism and other psychiatric disorders, and were of similar socioeconomic level. Testing for alcoholism among the subjects was done blindly. The rate of alcoholism of the

experimental group was four times that of both control groups. Subsequently, a group of the adoptees who had brothers raised by the alcoholic parent, and a group of controls, were given a blind psychiatric interview. Both groups (adoptees and their brothers) had high rates of alcoholism (17% and 25%) but the difference between these rates was not statistically significant (Goodwin et al., 1974). Number of parental hospitalizations for alcoholism was more closely related to alcoholism in the offspring than was length of exposure to the alcoholic parent. According to the authors, "Simply living with an alcoholic parent appeared to have no relationship to the development of alcoholism."

In a replication of Goodwin's study (Cadoret & Gath, 1978) obtained similar results; alcoholism occurred more frequently among the adoptees with an alcoholic biological parent than among the controls. Age of adoptee, time spent in foster care, age of biological mother at the time of the birth, socioeconomic status of the adoptive home, psychiatric problems other than alcoholism in the biological parents, and psychiatric or behavioral problems in the adoptive families were all unrelated to adult alcoholism.

Kaij (1960) looked at 174 twin pairs in which alcoholism had been diagnosed in one of the twins. Forty-eight of the twin pairs were monozygotic and 126 were dizygotic. The rate of concordance among the monozygotic twins was approximately double that of the dizygotic twins. The finding that

concordance among the monozygotic twins was not perfect, but was significantly higher than among the dizygotic twins might indicate a genetic influence on the development of alcoholism but not a genetic predestination.

Schuckit et al. (1972) used as subjects 69 consecutive admissions to the alcohol unit of a state hospital with half siblings, 90 of their relatives were interviewed. The incidence of alcoholism among children with an alcoholic biological parent, who had been raised by a nonalcoholic parent figure, were compared with the incidence in children who did not have an alcoholic parent but who were raised by an alcoholic parent figure. Also, children with and without alcoholic biological parents who shared their childhood home with alcoholic subjects were compared. For each comparison, the genetic factor seemed to be more closely associated with alcoholism than the environmental factor.

Goodwin (1977) looked at daughters of alcoholics. The incidence of alcoholism among both adopted and nonadopted daughters of alcoholics was much lower than that for sons of alcoholics, but the rate of alcoholism among daughters of alcoholics was still four times higher than the rate for women without alcoholic biological parents. Goodwin also found nonadopted daughters of alcoholics had a significantly higher incidence of clinical depression.

Winokur (1974) found that among women raised by their alcoholic parent there was an overlap of alcoholism and

depression. This might lead one to suspect an interactive effect leading to both alcoholism and other affective disorders.

Robins (1966) conducted a follow-up study on 524 children of average intelligence seen in a child psychiatric clinic thirty years earlier. The rate of alcoholism and sociopathy among the subjects was surprisingly similar to the rates of their parents thirty years earlier.

In summary, it would seem children of alcoholics are at higher risk for developing alcoholism than are children of nonalcoholics. They may also be at higher risk for developing affective disorders such as depression when they actively live with an alcoholic parent.

#### Environmental Influences On Psycho-Social Factors

It is far more difficult, in studying the environmental factors, to control for the variety of stresses within the family which may effect the risk for developing alcoholism. There is, however, research which examines the environmental influences on the psychological and emotional dimensions of children of alcoholics.

Nylander (1960) studied children of alcoholics in Stockholm. The experimental group consisted of 229 children age 4-12 who had an alcoholic parent. These were compared with a control group of 163 children with nonalcoholic parents. All subjects were attending an outpatient clinic. Emotional disturbance was significantly more common in the

experimental group than in the controls. The teachers' assessment of children of alcoholics indicated they were significantly more likely to be "problem children" than were the controls.

Aronson and Gilbert (1963) compared personality characteristics derived from teachers' blind ratings of 41 boys of grade school age who had alcoholic fathers and a control group consisting of the three male classmates closest in age to each of the experimental subjects. The experimental subjects were more often described as avoiding unpleasantness and as dependent than were the controls.

MacKay (1961, 1963) looked at adolescent juvenile legal offenders in Massachusetts. He found a very high rate of alcoholism among the fathers of alcohol abusing juvenile offenders.

Kearney and Taylor (1969) studied 40 adolescents seen in a Connecticut psychiatric clinic, 20 from homes with an alcoholic parent and 20 from homes with no parental alcoholism. The children of alcoholics received more serious psychiatric diagnoses, were more likely to act out internal conflicts, to attempt suicide and to experience legal difficulties and institutionalizations than were adolescents from nonalcoholic homes.

Chafetz, Blane, and Hill (1977) compared 100 alcoholic families with 100 nonalcoholic families seen in a child guidance clinic. They found alcoholic families experienced

more marital instability, prolonged separations, and divorce than did the nonalcoholic families. In addition the children of alcoholics reported more serious illness, accidents, school problems, and legal problems than did the children of nonalcoholics. Hindman (1975) reported that children of alcoholics frequently experience neglect, abuse, inconsistent discipline, and a lack of structure in their families.

Booz-Allen and Hamilton (1974) reported "Having an alcoholic parent is an emotionally disturbing experience for children. If children of alcoholics do not resolve the problems created by parental alcoholism they will carry them the rest of their lives." They found that, within their families, children of alcoholics often experience violence, aggression, fighting, spouse abuse, nonfulfillment of parental responsibility, instability, divorce, separation, death, physical abuse, and sexual abuse.

Heccht (1973) reported that communication in alcoholic families was often incongruent, unclear, and led to the isolation of family members. In these families children observed their parents to say one thing and to do another and would not know to which message they should respond. This created "double binds" in that the children could not elicit positive feedback from parents regardless of the behavioral choices they made. These children often expressed a fear that their familial situation would become worse, or that their families would disappear.

Cork (1969) interviewed 115 children of alcoholics to gain insight on their perspective. These children reported their main concerns to be parental fighting, lack of interest of the alcoholic parent, lack of interest of the nonalcoholic parent, and unhappiness of parents. Only six children reported that drunkenness was a main concern. This would seem to imply that, from the perspective of the child, family disorganization which may accompany parental alcoholism is a more serious concern than the alcoholism itself.

Black (1981) reported that in alcoholic families little or no discussion occurs about the distressing aspects of these families. She described three rules in alcoholic families which, although seldom stated, seem to be prevalent. The first rule was "Don't talk." This tends to leave feelings invalidated, and prevents children of alcoholics from seeing others as available for help. The second rule was "Don't trust." This leads children of alcoholics to accept the lack of focused attention they receive in their families and to doubt the motives when they are given focused attention. The third rule was "Don't feel." Children of alcoholics often by the age of nine have developed a denial system about their feelings. They protect themselves from fear, anger, and hurt by refusing to acknowledge that they experience these feelings. Richards (1980) reported a fearlessness or counterphobia among children of alcoholics, combined with an obsession with lack of control.

Black (1979, 1981) has divided the role behavior of children of alcoholics into two categories: (a) the misbehaving obviously troubled child, and (b) the high achieving, behaving child. The behaving children, Black believes, are in the majority. These children tend to learn the rule of not talking well and become self-reliant. They tend to create their own stability by detaching from others and repressing feelings. These adaptive behaviors are often effective in helping the child of the alcoholic cope with life until the midtwenties when long-term life decisions must be made. They then find themselves unable to maintain intimate relationships, and unable to experience the self-esteem that accompanies achievement. Many seek alcoholic spouses thus perpetuating their role behavior patterns, while others develop alcoholism.

Woititz (1984) described 13 common problems of adult children of alcoholics (See Chapter 1). In addition Woititz identified double messages these children receive that follow them as adults. The most important message is "I love you, but don't bother me." As adults, these children of alcoholics are attracted to relationships where they are rejected because they seem to equate love with rejection. A second message is "I'll be there for you, next time." This leads children of alcoholics to expect very little in order to avoid disappointment. Another message is "I need you, you can't do anything right." This leads children of alcoholics

to feel powerless, to distrust their own judgment, and to judge themselves without mercy.

Cermak and Brown (1982) report in their clinical observations that control and conflicts with control were the most pervasive source of anxiety among adult children of alcoholics. One client expressed a fear that if she threw one plate in anger nothing would stop her from throwing another 30. Clients felt that if they could maintain the outward facade of control, things had not gotten too bad. Clients had difficulty trusting others, and trusting the validity of their own feelings and perceptions. Clients saw expressing personal needs as a source of guilt. Cermak and Brown (1982) reported that most clients had experienced a blurring of role boundaries between children and parents with constant confusion and reversal. Often the role of child is abandoned altogether. Adult children of alcoholics in therapy often expressed a desire to be dependent or taken care of by the group.

In conclusion, it would appear that children of alcoholics are at risk for developing alcoholism and that the genetic factor remains the strongest predictor of alcoholism in a person. Children of alcoholics are also at risk for many psycho-social problems which often are carried into adulthood.

#### Therapeutic Approaches

In contrast to the volume of literature on genetic predisposition and on psycho-social problems of children of

alcoholics, literature on remedial strategies is relatively rare. Within this limited literature, objective data on the effects of therapy were noticeably absent. The only process or outcome data reported were attrition rates, and clients subjective evaluation of treatment.

Family therapy has, in the past few years, risen in popularity as a treatment mode for children of alcoholics and their parents. Heccht (1983) suggested working with the spouse of the alcoholic to help him/her provide structure, consistency, and appropriate parent-child role definitions in the family. Black (1981) worked in a California treatment center with children of alcoholics using a group format and art therapy to help these children talk about their feelings to feel less isolated.

The CASPAR program (Dentsch, 1982) combined alcohol education with structured, closed, short term groups for children of alcoholics in a public school system. Students and school staff reported satisfaction with the group and students valued group participation. Outside of this reported satisfaction no evaluation data were reported.

The Children from Alcoholic Families Program (Lawson, 1983) in Lincoln, Nebraska, has attempted to reduce the social and psychological risk factors in children of alcoholics. The program included (a) a parents group focusing on psycho-educational aspects and individual treatment for stress management, (b) a peer group treatment for children of

alcoholics, which included education about alcoholic families, support for the child, and building positive-effect skills to cope with families, (c) a family component consisting of weekly family therapy sessions, and (d) after-care for continuing recovery of the family and referral for family issues requiring further treatment. This was a fairly new program and has not yet published evaluation results.

Cermak and Brown (1982) have treated adult children of alcoholics in an on-going open group to which group members make a nine-month commitment. They reported that most members keep their nine-month commitment; only four out of the 30 left without completing. Many members elected to continue well beyond the nine months.

Brown University (Donovan, 1981) used a short term structured group for students from alcoholic families, this group focused on feelings and response sets learned in the family which may be repeated in other settings. Evaluation was conducted by student self-report of helpfulness. Most students found the group "extremely helpful," or "very helpful."

In summary, clients and therapists appear to consensually agree that treatment in a group modality is very helpful. In all of the group approaches cited, clients reported positive affective outcomes. No data was given on the behavioral impact of therapy.

## Chapter 3

### Methods

Methods in this study employ an intensive system of evaluating client change by using client in-session verbal behavior as an objective, measureable indicant of client change over time in group counseling. The study incorporates both subjective and objective data and both process and outcome measures.

#### Subjects

Subjects for this study were volunteers presently enrolled in undergraduate study at Kansas State University. All subjects had at least one parent with alcoholism. Parental alcoholism was defined as a persistent pattern of alcohol consumption perceived by the subject as causing problems to the parent and/or the family. There were three females and one male in the group.

#### Treatment

Subjects participated in a structured eight-week therapy group aimed at addressing subjects risk level for alcoholism, and aimed at exploring the psycho-social problems related to familial alcoholism. Each session consisted of two parts, first a structured educational component which lasted approximately 30 minutes per session, followed by a group

therapy session. Counselors for the group were, the writer who is presently a masters student in counseling, and a PhD counselor from the University Counseling Center. The counseling approach was generally insight-oriented and fostered a warm and supportive atmosphere. Material covered in group therapy was generally introduced by the clients while material in the structured portion of the sessions was introduced by the writer. For a more thorough outline of group goals, objectives, and activities see Appendix A.

#### Data Collection

Data collection consisted of two major types, process measures and outcome measures. Process measures were aimed at identifying across session changes in client verbal behavior, while outcome measures were aimed at identifying pre-treatment--post-treatment changes. To aid in clarity the two types of data will be described separately.

#### Outcome Measures

Before participating in the group all subjects were given a 20-item multiple-choice objective test of knowledge of alcoholism and the family, a written self-report of quantity and frequency of alcohol consumption for the three weeks prior to the initial group session, and a likert-type scale of attitudes towards alcoholism and the family. During the eight-week group subjects continued recording daily quantity of alcohol consumption. At the conclusion of the eighth session the record of alcohol consumption was

collected, subjects were given a second form of the 20-item multiple-choice objective test of knowledge of alcoholism and the family, and likert-type scale of attitudes toward alcoholism and the family. In addition, subjects were asked to complete a subjective evaluation of satisfaction with therapy.

The likert-scale instrument, designed by the author, consists of three scales of parallel items aimed at identifying perceived change over time of attitudes towards alcoholism and the family. Parallel items on the three scales differed in time orientation. In scale one all items are worded to reflect present attitude, "I often get angry with my parents." In scale two all items are worded to reflect perceived change from the past until now, "I used to get angry with my parents more often than I do now." In scale three all items are worded to reflect perceived change in the future, "In the future, I will probably get angry with my parents more often."

Items for the pre and post tests of knowledge on alcoholism and the family were reviewed by three professionals in the field. Each one was evaluated for relevancy and clarity. In addition the revised full tests were reviewed to establish that each test adequately sampled the domain.

Given the experimental nature of the knowledge tests and the attitude scale combined with the low number of subjects

no conclusions can be drawn from these instruments. However, data from these will be reported graphically. Copies of these instruments are contained in Appendix B.

At the conclusion of session eight all subjects completed a subjective evaluation of the group. In this instrument subjects were asked to identify the "most helpful session," and the "least helpful session." Information from these questions was used conjointly with the process data to identify differences in client and counselor verbal behavior categories in best versus worst sessions. For a copy of this instrument see Appendix B.

#### Process Measures

Five of the eight sessions were audio taped. From this audio tape a transcript was made of three 5 minute segments of each session. The first transcribed section began 5 minutes into the session and ended 10 minutes into the session. The second transcribed section began 45 minutes into the session and ended 50 minutes into the session. The third transcribed section began 80 minutes into the session and ended 85 minutes into the session. Session 8 varied from this as it lasted only 1 hour instead of 1 1/2 hours. The transcription however did sample 5-10 minutes into the session, 30-35 minutes into the session and 50-55 minutes into the session. Sessions not taped were sessions one, which consisted of orientation and testing, and session six and seven during which the audio tape equipment failed.

Transcripts were analyzed using the Client Verbal Response Category System (Hill, C.; Greenwald, C.; Reed, K.; Charles, D.; O'Farrell, M.; & Carter, J.; 1981). The Client Verbal Response Category System consists of nine nominal, mutually exclusive categories for identifying client response types:

1. Simple responses
2. Requests
3. Description
4. Experiencing
5. Exploration of counselor-client relationship
6. Insight
7. Discussion of plans
8. Silence
9. Other

For a more complete description of the Client Verbal Response categories see Appendix C.

Transcripts of the sessions were divided into response units which are essentially grammatical sentences. Rules for unitizing were specified in Hill, et al. (1981). After the transcripts were unitized, three trained raters independently categorized the units of client verbal responses. Agreement between raters was determined by using a Kappa Statistic. This is percent agreement corrected by chance agreement. The Kappa Statistic was recommended for use with Hill's system (Hill, et al., 1981). For a more extensive discussion of the Kappa Statistic see Tinsley & Weiss (1975, p. 369-371).

## Chapter 4

### Results

In this chapter data and a discussion of the findings will be presented. Data will be presented in sections corresponding to the hypothesis which they were intended to test.

#### Hypothesis 1

No differences will be found between pre-test and post-test scores on a measure of knowledge of alcoholism and the family.

Table 1 depicts the pre-test and post-test scores for each of the four subjects.

Table 1

Knowledge Test Of Alcoholism And The Family

<u>Subject</u>	<u>Test Score</u>	
	<u>Pre</u>	<u>Post</u>
1	10	14
2	7	9
3	10	16
4	12	14

While scores for all four subjects increased from pre-test to post-test, hypothesis one is retained. The small number of subjects prevents drawing conclusions from this data.

Hypothesis 2 and 3

2. No differences will be found across time in reported quantity of alcohol consumed.

3. No differences will be found across time in reported frequency of alcohol consumption.

Table 2 illustrates the average weekly quantity of alcohol consumption for each subject for the three weeks prior to the treatment, and for the last three weeks of the treatment.

Table 2

## Average Number Of Drinks Weekly

<u>Subject</u>	<u>Pre</u>	<u>Post</u>
1	2.33	3.33
2	2.0	2.67
3	2.33	4.67
4	3.33	5.67

Table 3 illustrates the average weekly frequency of alcohol consumption for each week for the three weeks prior to the group, and for the last three weeks of the group.

Table 3

## Average Number Of Days Weekly Drinking Occurred

<u>Subject</u>	<u>Pre</u>	<u>Post</u>
1	1.33	2.67
2	1.33	1.67
3	2.0	1.0
4	1.33	1.33

Average quantity of alcohol consumption increased from pre-group to post-group for all four subjects.

Average frequency of alcohol consumption increased for two subjects, decreased for one subject, and remained unchanged for one subject.

The t-test showed no significant change in frequency of alcohol consumption.

#### Hypotheses 4 and 5

4. No differences will be found across session in frequency of subject verbal behavior in any of the following categories: requests, description, exploration of counselor-client relationship.

5. No differences will be found across sessions in frequency of subject verbal behavior in any of the following categories: experiencing, insight, and discussion of plans.

Fifteen, 5 minute segments of five sessions were analyzed. This included 525 client verbal response units. Response units analyzed in each session ranged from 85-114. Kappas for independent judgements for all pairs of the three judges on the client verbal response category system were .77, .82, and .79

Table 4 illustrates the proportions of client responses in each verbal response category for each session.

Chi square tests of goodness of fit for percentages were performed for categories 1 (simple response), 3 (description), 4 (experiencing), and 6 (insight).

Table 4

## Client Verbal Response Category

<u>Session</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>
2	.09	.02	.73	.12	0	.03	.01	0	0
3	.12	.02	.68	.13	0	.04	0	.01	.01
4	.09	.01	.49	.07	.02	.20	0	0	.13
5	.06	0	.62	.18	0	.14	0	0	0
8	.14	.06	.43	.14	0	.16	.08	0	0

Verbal responses across sessions in category 1 did not change significantly. The obtained  $X^2 (4)=3.8$  (with four degrees of freedom) value of 3.8 was not significant at the .05 level. Verbal responses in category 3 across sessions yielded a  $X^2$  value of 10.882, significant at the .05 level. Verbal responses in category 4 yielded a  $X^2$  value of 4.91 which was nonsignificant. Category 4 responses did not appear to change across sessions. Verbal responses in category 6 yielded a  $X^2$  value of 19.93 which was significant at the .001 level.

Verbal responses in categories 2, 5, 7, 8, and 9 occurred inconsistently and infrequently across sessions. This prevented any statistical analyses of these response categories.

On the basis of analyses of verbal response categories, the null hypotheses are retained for categories 2, 4, 5, and 7. The null hypotheses are rejected for categories 3 and 6. Visual scan of Table 4 illustrates a tendency of verbal

responses in category 3 to decrease across sessions, and a tendency for verbal responses in category 6 to increase across sessions.

#### Hypothesis 6

No differences will be obtained between pre-test and post-test on a measure of subjects perceived ability to cope with their families.

Table 5 illustrates the pre-test and post-test scores for each subject on the likert-scale instrument.

Table 5

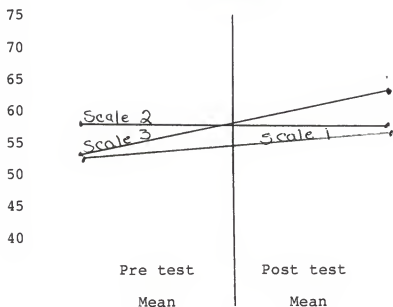
#### Likert Scale Scores

Subject	Pre-test Scales			Post-Test Scales		
	<u>1</u>	<u>2</u>	<u>3</u>	<u>1</u>	<u>2</u>	<u>3</u>
1	39	61	65	51	71	69
2	67	60	54	66	65	66
3	69	70	56	62	50	68
4	36	46	40	43	50	46

Figure 1 illustrates the mean pre-test and post-test scores in graph form.

While scores on scales 1 and 2 remained unchanged, scores on Scale 3 increased from pre-test to post-test. The t-test for related samples was performed on Scale 3; the t-test value, with three degrees of freedom, 4.13 was significant at the .025 alpha level. This level, .025, was selected as the critical value over .05 to compensate for the inflation in alpha that may result from the low N. Interpretation of this shall be cautious as information on

Figure 1



the stability of scores on the instrument is absent. Given this, judgement as to the null hypothesis was suspended until further research explores this issue.

#### Research of Subjective Evaluation of the Group

Table 6 contains items from the group evaluation along with Modal response for each item.

Table 6

#### Subjective Group Evaluation and Modal Response

Item	Modal Response
I feel that I got:	
1. relief from the tension I was under. . . . .	2
2. better insight and self-understanding. . . . .	1 + 2
3. reassurance and encouragement about how I'm doing. . . . .	1 + 2
4. better ability to feel my feelings, to be what I really am. . . . .	1 + 2 + 3

Table 6 (continued)

Item	Modal Response
5. ideas for new or better ways of dealing with people.. . . . .	1
6. a sense of having close person-to-person relationships with group members. . . . .	1 + 2
7. help in being able to talk about what was really troubling to me and really important	1
8. a better ability to tell which of the things I felt and thought were real and which were mostly in my own mind. . . . .	2
9. better self-control over my moods and actions. . . . .	3

## Response options

1--very much

2--moderately

3--slightly or not at all

Item 5 was most often rated "very much" (three of four respondents). Items 1, 2, 3, 6, and 7 were rated "very much" or "moderately" by all four subjects. Item 9 was the only item rated "slightly or not at all" by more than one subject.

Responses on the four open ended questions were quite diverse. All four subjects identified a different session as most helpful. Three of the four subjects reported that what made their identified session significant was experiencing some personal insight. Only one of the four subjects identified a session as "least helpful."

## Chapter 5

### Summary, Discussion, and Implications

#### Summary

The purpose of this study was to examine the effects of a short-term group treatment for college undergraduates with alcoholic parents. The group was studied using process and outcome measures, and both subjective and objective data.

The research was concerned with whether treatment would cause change in any of the following areas: subjects knowledge of alcoholism and the family, subjects reported quantity and frequency of alcohol consumption, and subjects understanding of their behavior within their families.

Relevant research in the area of children of alcoholics as adults indicated that children of alcoholics are at risk for a number of psycho-social problems. In addition, this population is at high-risk for developing alcoholism themselves. Genetic studies seem to indicate that increased risk for developing alcoholism seems somewhat independent of environmental factors. Furthermore, children of alcoholics are at higher risk for psycho-social problems when they actively live with their alcoholic parent. In conclusion, research has indicated that many adults raised in alcoholic families carry these psycho-social problems into their adult lives.

In contrast to the literature on problems of children of alcoholics, little has been written on effective intervention strategies for adult populations.

A process of treatment was developed for this study, that combined an educational component, which focused on information about alcoholism, families, and prevention, and a group therapy component, which focused on subjects gaining personal insight into their behavior within and outside of their alcoholic families.

Data collection included a pre-test and a post-test of knowledge of alcoholism and the family, a pre-test and post-test likert scale of subjects attitudes towards their alcoholic families, daily record of alcohol consumption, subjective evaluation of group therapy, and analysis of tape-scripts of five of the eight sessions using the Client Verbal Response Category System.

The results of the analysis of the data indicated that there was an increase in reported quantity of alcohol consumption across time, and no difference in reported frequency of alcohol consumption. On the knowledge test of alcoholism and the family all four subjects' scores increased from pre-test to post-test; however, no conclusions can be drawn because of the small N and lack of reliability and validity of data. The likert scale, given as a pre-test and post-test, rendered a significant gain on scale 3. This should be viewed cautiously given the absence of reliability

and validity data and the small N. In analyzing Client Verbal Response categories it was determined that responses in category 3, description, declined across sessions. Client verbal responses in category 6, in-sight, increased across sessions. On the subjective evaluation of the group, subjects identified several helpful aspects of the group.

### Discussion

Because of the relatively higher risk children of alcoholics have of developing alcoholism, reduction in alcohol consumption was selected as a dependent variable. As noted, quantity of alcohol consumption increased over time. Change was in the opposite direction of what was expected. There were, however, mitigating circumstances. The pre-group measure included three weeks early in the semester, while the post-group measure included the second weekend of spring break and three weeks after this. Quantity and frequency of drinking was highest during the week of spring break. In addition, three of the four subjects while drinking more total quantity over more total days, tended to drink within low risk guidelines (no more than two or three drinks per day). The fourth subject requested extra time with the writer to discuss a problem with drinking, and elected to seek further help for this drinking problem. The client expressed that no help had been sought for this problem previously, and no recognition of this problem had been made previously. While this is a very positive outcome in counseling, it tends

to prove true the adage concerning counseling research, "If you can't count it, it doesn't count; if you can count it, that ain't it (Kiesler, 1973).

Given the small N in this research, no conclusions can be made from the knowledge test. Although all four scores increased, the source of the increase can not be determined. Possibilities include chance, differences in difficulty of the two tests, or an increase in knowledge as a result of the group.

The analysis of counseling process through the use of the Client Verbal Response Category System was aimed at objectively identifying clients change across sessions. Two categories showed significant change. Description, defined as, "Discussing history, events, or incidents in a story-telling or narrative style," decreased across sessions. This is change in the desired direction. The second category showing significant change across sessions was Insight, defined as, "Indicators that a client understands or is able to see themes, patterns, or casual relationships in his/her behavior or personality, or in another's behavior or personality." This category of verbal behavior also changed in the desired direction. These findings indicate that as counseling progressed clients spent less time relating stories about themselves and their families, and spent more time identifying themes and patterns in the behavior of themselves and their families. One might conclude from this

that clients, as a result of the group, appeared to have a better understanding of themselves and their families.

Corroborating these findings are clients' comments on the subjective evaluation of the group: "It helped me see myself a little differently, especially that I seemed to be a hero or enabler, taking care of others but not myself." "The session was significant to me because I became aware that I keep my feelings under my skin when it would be better to let others know how I feel." "This session made me recognize the types of roles I play in my everyday life." All of these comments seem to indicate that what proved significant from the perspective of clients was gaining personal insight.

Discussion of plans, category 7 of the Client Verbal Response Category System, occurred almost exclusively in the final session. This would tend to indicate that counseling may have been too brief. Perhaps with more sessions clients may have had more opportunity to convert personal insights into specific plans for change.

In developing the likert-type attitude scale, the writer intended to attempt to avoid the common problem of using self-concept scales with short-term treatment. It is unreasonable to expect a significant change in self-concept as a result of short-term counseling. Scale 2 of the likert-type scale most closely resembled a measure of self-concept. No change occurred in scores on this scale from pre-test to post-test. Scale 3 of the likert-type scale was

intended to measure the construct "Instillation of hope". Instillation of hope is defined as seeing one self as growing, changing and more in control over ones life. All items on scale 3 paralleled the items on scale 2 except that they were oriented towards seeing oneself as improving in the future. Scores on scale 3 were significantly higher on the post-test than on the pre-test. While these findings are encouraging, there remain problems with drawing any conclusions from this instrument at this time. First, the instrument was used on a very small sample and therefore is subject to a great deal of chance variation. Secondly, there is, at this time, no information on the stability of scale 3 scores on untreated groups.

#### Implications

It is difficult to evaluate a structured group therapy program on the basis of statistical analyses. Many of the benefits derived by participants are beyond the scope of statistical testing. Yet use of the Client Verbal Response System tended to transform the elusiveness of client change in therapy, to a more objective and quantifiable construct.

The group approach used in this study seemed to be appropriate for all participants. Structuring the group to be time limited, and focused in topic, seemed beneficial as there were no drop-outs and little absenteeism. Subjects seemed committed and involved in the group.

Problems encountered in the study included restrictions in interpretation of some instruments because of the low N,

and lack of reliability and validity data on the knowledge tests and likert-type scale. About five hours were spent training each rater on the Client Verbal Response Category System. Levels of agreement between the raters were comparatively low indicating the need for more training of the raters. In addition it may improve level of interrater agreement if all raters had a strong counseling background.

A prohibitive factor in using the Client Verbal Response Category System was the time-consuming process of transcribing audio tapes, unitizing the tape scripts, and scoring the tape scripts. The writer found that there were two hours of transcribing invested in each 5 minute segment of tape.

Future research on adult children of alcoholics might include larger samples compared to a control group. Therapy might be extended from 2 hours per session to 2 1/2 to better accomodate the educational function of the group. Total number of sessions should probably be extended from eight to ten to allow clients more time to practice new behaviors and formulate plans for change.

In gathering subjective data on group effectiveness it may be more useful to include a short instrument at the end of each session instead of one assessment at the conclusion of therapy. This would provide more information session by session which might be used with the data from the Client Verbal Response Category System, to help in further understanding the process of client change.

Finally, teaching clients low-risk guidelines for drinking should occur early in therapy, and assessment of drinking might be more useful if dichotomously scored as within low-risk guidelines or beyond low-risk guidelines.

## References

- Aronson, H., & Gilbert, A. (1963). Preadolescent sons of male alcoholics. Archives of General Psychology, 8, 235-241.
- Black, C. (1979). Children of alcoholics. Alcohol, Health and Research World, 4, 23-37.
- Black, C. (1981). It will never happen to me. Hollywood, FL: Health Communications, Inc.
- Booz-Allen & Hamilton, Inc. (1974). An assessment of the needs and resources for children of alcoholic parents. Springfield, VA: National Technical Information Service.
- Cadore, T., & Gath, A. (1978). Inheritance of alcoholism in adoptees. British Journal of Psychiatry, 252-258.
- Cermak, T., & Brown, S. (1982). Interactional group therapy with the adult children of alcoholics. International Journal of Group Psychotherapy, 32(3), 375-389.
- Chafetz, M., Blane, H., & Hill, M. (1971). Children of alcoholics: Observations in a child guidance clinic. Quarterly Journal of Studies on Alcohol, 32, 687-698.
- Cork, M. (1969). The forgotten children. Don Mills, Canada: Paperjacks General.
- Daugherty R., Neuman, D., & O'Bryan, T. (1983). Talking with your kids about alcohol. Lexington, KY: Prevention Research Institute.

- Deutsch, C. Broken bottles, broken dreams: Understanding and helping the children of alcoholics.
- Donovan, B. (1981). A collegiate group for the sons and daughters of alcoholics. Journal of the American College Health Association, 30, 83-86.
- Goodwin, D., Schulsinger F., Hermansen, L., et al. (1973). Alcoholism in adoptees raised apart from alcoholic biological parents. Archives of General Psychiatry, 28, 238-243.
- Goodwin, D., Schulsinger, F., Moller, N., et al. (1974). Drinking problems in adopted and nonadopted sons of alcoholics. Archives of General Psychiatry, 31, 164-169.
- Goodwin, D., Schulsinger, F., Knop, J., et al. (1977). Psychopathology in adopted and nonadopted daughters of alcoholics. Archives of General Psychiatry, 34, 1005-1009.
- Goodwin, D. (1981). Alcoholism: The facts. Oxford, England: Oxford University Press.
- Heccht, M. (1973). Children of alcoholics are children at risk. American Journal of Nursing, 73, 1764-1767.
- Hill, C., Greenwald, C., Reed, K., Charles, D., O'Farrell, M., & Carter, J. (1981). Counselor and Client Verbal Response Category System. Columbus, OH: Marathon Consulting and Press.
- Hindman, M. (1975-76, Winter). Children of alcoholic parents. Alcohol, Health and Research World, 2-6.

- Hinbec, S., & Gilbert, S. (1981). Evidence of genetic predisposition to alcoholic cirrhosis and psychosis: Twin concordance for alcoholism and its biological endpoints by zygosity and male veterans. Alcoholism: Clinical and Experimental Research, 5, 207-215.
- Kaij, L. (1968). Alcoholism in twins. Stockholm, Almqvist & Wiksell.
- Kearney, T., & Taylor, C. (1969). Emotionally disturbed adolescents with alcoholic parents. Acta Paedopsychiatr (Basel), 36, 215-221.
- Kiesler, D. J. (1973). The Process of Psychotherapy. Chicago, IL: Aldine.
- Lawson, G., Peterson, J., & Lawson, A. (1983). Alcoholism and the family: A guide to treatment and prevention. Denver, CO: Aspen Systems Corporation.
- McCauliffe, R., & McCauliffe, M. (1975). The essentials of chemical dependency. Minneapolis, MN: American Chemical Dependency Society.
- MacKay, J. (1961). Clinical observations on adolescent problem drinkers. Quarterly Journal of Studies on Alcohol, 22, 124-134.
- MacKay, J. (1963). Problem drinking among juvenile delinquents. Crime and Delinquency, 9, 29-38.
- National Institute and Alcohol Abuse and Alcoholism. (1981). Services for children of alcoholics (Research Monograph No. 4). DHHS pub. no. (ADM). Washington, DC: Superintendent of Doc.: US Government Printing Office.

- Nylander, I. (1960). Children of alcoholic fathers. Acta Paedopsychiatr, 49, 1-134. Stockholm.
- Richards, T. (1979). Working with disturbed children of alcoholic mothers. New York, NY: Grune and Stratton, Inc., Academic Press.
- Robins, L. (1966). Deviant children grown up. Baltimore, MD: Williams and Wilkens, Co.
- Schuckit, M., Goodwin, D., & Winokur, G. (1972). A study of alcoholism in half-siblings. American Journal of Psychiatry, 128, 122-126.
- Tinsley, H. E., & Weiss, D. (1975). Interrater reliability and agreement of subjective judgements. Journal of Counseling Psychology, 22, 358-376.
- Winokur, G. (1974). The division of depressive illness into depression spectrum disease and pure depressive disease. International Pharmopsychiatry, 9, 5-13.
- Woititz, J. (1981). The educational aspects of servicing the children of alcoholics (NIAAA Research Monograph No. 4).
- Woititz, J. (1983). Adult Children of Alcoholics. Hollywood, FL: Health Communications, Inc.

APPENDIX A

## The Structure of the Group

### Physical Setting

The group was held in a comfortable room with comfortable chairs arranged in a circle. Unnecessary objects (books, radios, T.V.'s, etc.) were minimized.

### Membership

Group members were college undergraduates including three women and one man.

### Selection Procedures

Screening of potential subjects consisted of an initial interview with the writer. Anyone deemed inappropriate because of psychological problems beyond the scope of this group were eliminated from the sample.

### Session 1

Goal 1: Clients will examine the structure, interaction patterns, and survival roles in their alcoholic families and the impact these factors had on them as they were growing up.

Objectives:

1. Clients will begin to get to know each other and begin to feel more comfortable in the group.
2. Clients will describe their families, family functioning patterns, and identity feelings they have about their families.

3. Clients will discover how the other members' families function.

Warm Up:

Each client will introduce herself or himself and tell one thing they hope to gain from the group. Next, the leader will review the rules, goals, and any other details necessary.

Lecture:

What is alcoholism and chemical dependency?

Group Activity:

"Family Dinner"

Materials:

Large sheets of newsprints.

Colored magic markers.

Instructions:

With the newsprint and the magic markers each of you are to draw a picture of your family having dinner. Try to tell us as much as possible about your family by varying the size and shape of the table, where people sit, who they sit with, who they talk to, what color you make them, what size you make them, etc. Include anyone who seems important in the family picture. Try to include one thing that best represents that family member to you (a football, a book, a fist, etc.). When you have finished you will introduce your family to the rest of us using your picture.

Process:

After all members have finished drawing (10-15 minutes), begin introducing families. The leader should go first. The leader and group members may ask each other questions or make comments.

Closure: Things to think about:

What similarities did you see among your family and the families of other group members? What differences? Did you discover any feelings you have about your family that you weren't aware of before? What feelings did you have listening to other people describing their families?

Assignment: Write a short paragraph on each of these questions.

1. How did you feel sharing your "family dinner" with the group.
2. What did you find helpful in this session? or not so helpful?
3. What do you hope to accomplish in the next seven weeks?

Session 2

Goal 1: Clients will examine the structure, interaction patterns, and survival roles in their alcoholic families and the impact these factors had on them as they were growing up.

Goal 2: Clients will identify aspects of survival roles and self-defeating behaviors which they continue to exhibit now.

### Objectives:

Participate in sculpture--actively.

Describe role played and feelings of that person.

Describe behavior someone in that survival role might play.

Identify survival roles you see in your own families.

Identify role or roles you see yourself playing.

Talk about feelings in and around these roles.

### Lecture:

Film: "Children of Denial."

### Introduction:

Together, we all share the experience and the pain of growing up with an alcoholic. An alcoholic family is very confusing, and sometimes it's hard to sort out what's really happening.

While all families are different, there are some similarities, today I'd like to present a model of alcoholic families that generally describes the roles we in alcoholic families play in order to survive.

I think you'll find this a very valuable exercise. It will require your active participation. You will each be given a survival role to play in a living sculpture of an alcoholic family. As you do this I would like you to think about the role you are playing--try to identify some of the feelings someone in that role may have, think about the kinds of things someone in that role might do.

The real purpose of this exercise is to give us a new way to look at our own families and our own roles within our families. As we do the sculpture and particularly as we talk about it afterwards try to identify what roles or aspects of roles you see in your family, and try to identify which survival role you most often play.

The Sculpture:

Chair: Alcohol

Alcoholic: (on chair--standing on one foot)

Alcohol supports him/her, firmly believes that being on top of the chair is safer, despite being unstable. Needs someone to support him.

Enabler: (on knees and hands, alcoholic stepping on back)

Scared of leaving--"he'll fall."

Feels needed and important versus feeling used and humiliated.

Needs to be encouraged, needs to be recognized.

Hero: (one hand on alcohol and one hand on enabler)

Smiles no matter how tired arms get.

Tries to make the family O.K. by accomplishing--it never works--feels inadequate, desperate, feels like a failure--can't fix these people.

Scapegoat: (slightly away from family but facing them,  
fists clenched, the face tense)

Causes trouble--distracts family from other problems.

Labeled--"the Problem."

Feels lonely--not a part of the rest of the family.

Feels angry.

Feels scared--"If I stop playing the family will break up."

Lost Child: (sitting, away from family, back to them, one ear towards them)

Seems not to be a part of what's happening.

Appears unaffected but keeper of the family secrets--others confide in her/him.

Feels overwhelmed, helpless, isolated.

Mascot: (skipping around the group, making faces, always smiling and laughing)

Appears to be happy.

Distracts the family by being cute, lovable, happy.

Process:

Survival roles:

How did you feel in your role?

What part of your body got tired?

What feelings did you have towards the others? Did you notice them--were you so into your role that they didn't exist?

What roles do you think people in your family play?

What role do you play? How do you play it?

How do you play your role with other people and in other situations?

What are the payoffs? What are the costs?

#### Closure:

Typically this exercise is pretty heavy stuff, but I think it's really valuable in helping us to learn about ourselves. What I'd like you to do this week is notice how you interact with other people, notice what choices you make--do you see yourself playing any of these survival roles? Which ones? When? How? Write them down. (Roles adopted from Wegsneider, 1981)

#### Session 3-5

Goal 2: (See Session 2).

Goal 3: Clients will identify more effective behaviors and develop plans for practicing these.

#### Objectives:

1. Each client will identify a few personal objectives and share these with the group.
2. Each client will develop some strategies for achieving his or her objectives.
3. Each client will try out new strategies, evaluate the results, and make any adjustments.

#### Methodology:

Session 3 would begin with reviewing assignment from Session 2. Material for group is highly flexible, depending upon the needs of the members. Sessions 3-5 may use role playing, feedback, assignments, etc. to help clients achieve their objective.

Lecture topics: Chosen to reflect client objectives.

Getting and giving confrontation and feedback.

Alanon.

Common problems of children of alcoholics as adults.

A.A.

### Session 6

Goal 4: Clients will determine their personal risk level for alcoholism or chemical dependency and evaluate the risk level of their present drinking behavior.

Objectives:

1. Clients will be able to identify social, psychological, and genetic risk factors.
2. Clients will be able to determine the risk level of reported situations.
3. Clients will evaluate the risk level of their present drinking behavior.

Lecture:

Facing my own risk for alcoholism.

Risk factors for chemical dependency.

Genetic.

Psychological.

Social.

Risk levels of abuse--evaluating daily choices.

Activity:

Given a set of descriptions of situations determine the risk level of the behavior described for the individual

described. Break into groups of three and come up with a consensual agreement about the risk levels.

Closure:

Tabulate answers. Talk about the process you used. How did you determine the risk level? Can you identify how your own values about drinking affected your decisions? What are your values about drinking? What is your risk level?

Assignment:

Complete exercise: "What are my drinking choices?"  
(adapted from T.W.Y.K.A.A., 1983)

Session 7

Goal 5: Clients will make a contract for low risk alcohol and chemical use.

Objectives:

1. Client will identify present relationship with drugs and alcohol.
2. Client will determine a personal use level that minimize risk and yet is feasible to maintain.
3. Client will write a contract for low risk use (determined by the above).
4. Client will sign contract along with counselor, contract will be shared with the group.

Group Activity:

Cover last week's assignment. What are your drinking choices? List some low risk limits for you that you think you can live with. Share these with the group.

\*Note: Feedback is very important in this.

Assignment:

Write a contract you can live with for low-risk usage.

Lecture:

Where do I go from here?

Options for continuing personal growth.

Session 8

Goal 6: Client will develop an after care plan to continue the growth developed in the coping group.

Objective:

Client will determine specific plans for continuing growth after the coping group.

Group:

How have I grown in coping group? How have I seen others grow? What areas in me still need work? Describe my after-care plans with the group. How do I feel about leaving?

## APPENDIX B

## INFORMED CONSENT FORM

You are invited to participate in a coping group for students with alcoholic parents. Because this group is also a research effort exploring problems common to children of alcoholics, data will be collected. The anonymity of all participants will be closely guarded. The information concerning each participant will be recorded by a code number instead of by name.

The coping group will consist of eight sessions, each one week apart, for two hours each week. There are no attendant discomforts or risks. The main benefits are learning to understand and to cope with alcoholic families, and to recognize and avoid further problems related to growing up in an alcoholic home.

Although completion of the eight sessions is encouraged, you may withdraw from the group at any time without explanation. You may, also, withdraw your consent to be used as a subject for research if you so choose. At any time any participant may inquire as to the procedures used in the program.

I have read the above statements and have been fully advised to the procedures to be used in this project. I understand the potential risks involved and I hereby assume them voluntarily.

Date\_\_\_\_\_Subject\_\_\_\_\_

Last 4 digits of your social security number\_\_\_\_\_.

Knowledge test on prevention, alcoholism, and the family.

Directions: This test has 20 multiple-choice items. Please mark your answers to all questions on the line to the left of the question. Make the best guess you can on each question. Please answer all questions.

- \_\_\_\_\_ 1) The strongest predictor of alcoholism in someone is:
  - a) low socio-economic status
  - b) inconsistent discipline in the home
  - c) alcoholism in a biological parent or grandparent
  - d) low problem solving ability
- \_\_\_\_\_ 2) The phrase "Alcoholism is a family illness" probably means
  - a) If one person in a family gets it the others probably will too.
  - b) Problems in the family cause alcoholism.
  - c) If one family member has alcoholism, the others tend to be adversely affected.
- \_\_\_\_\_ 3) Research shows that most children of alcoholics
  - a) have a strong aversion for alcohol
  - b) have unusual biological responses to alcohol
  - c) have difficulty with blood sugar levels after drinking
  - d) show no significant differences in their reaction to alcohol
- \_\_\_\_\_ 4) Which set of psychological factors are more closely associated with higher risk for developing alcoholism?
  - a) depression, external locus of control, low self-esteem
  - b) loneliness, tension, low self-control
  - c) gregariousness, impulsiveness, and rebelliousness
  - d) there are no psychological factors associated with higher risk for alcoholism
- \_\_\_\_\_ 5) What proportion of drinkers develop alcoholism?
  - a) 1 in 8
  - b) 1 in 12
  - c) 1 in 15
  - d) 1 in 20
- \_\_\_\_\_ 6) Compared to people with no alcoholism in their parents, children of alcoholics
  - a) are no more likely to develop alcoholism
  - b) develop alcoholism 4 times as often
  - c) develop alcoholism 10 times as often
  - d) develop alcoholism one-half as often

- \_\_\_\_\_ 7) As a whole, untreated daughters of alcoholics are
  - a) more likely to marry alcoholics than are other women.
  - b) less likely to marry alcoholics than are other women.
  - c) no more or less likely to marry alcoholics than are other women.
  
- \_\_\_\_\_ 8) Which of the following is not a common characteristic of children of alcoholics?
  - a) Children of alcoholics have difficulty talking about their family situation.
  - b) Children of alcoholics have difficulty trusting adults or seeing others as available for help.
  - c) Children of alcoholics have difficulty acknowledging and expressing strong emotion.
  - d) Children of alcoholics have difficulty coping with authority figures.
  
- \_\_\_\_\_ 9) Most psychological problems associated with growing up in a family with an alcoholic parent
  - a) Tend to persist through adulthood unless treated.
  - b) Tend to resolve themselves in early adulthood.
  - c) Tend to intensify in adulthood leading to severe psychological disorders.
  
- \_\_\_\_\_ 10) Alcoholism might best be described as
  - a) a physical allergy to alcohol
  - b) an unhealthy reaction to one's inability to cope with life
  - c) a symptom of underlying psychological disorders
  - d) a chronic, progressive life-style related illness
  
- \_\_\_\_\_ 11) Children of alcoholic's risk for developing alcoholism has been shown to be at least partially influenced by
  - a) poor decision making ability
  - b) low self concept
  - c) poor communication skills
  - d) genetic predisposition
  
- \_\_\_\_\_ 12) The distinguishing feature between alcoholics and nonalcoholics is
  - a) All alcoholics have a personal commitment or love relationship with the alcohol or drug high.
  - b) All alcoholics have a history of personal and

- legal problems in which alcohol was involved.
- c) All alcoholics have signs of organic damage, such as fatty deposits on the liver.
  - d) All alcoholics have difficulty maintaining jobs.
- \_\_\_\_ 13) What is meant by the phrase "alcoholism is a progressive disease"?
- a) It only occurs in progressive, industrialized societies.
  - b) It is characterized by a progressive loss of abstract reasoning.
  - c) Over time, the personal involvement with alcohol and the personal consequences of drinking tend to worsen.
  - d) There is predictable progression of deterioration of the liver and muscle tissue.
- \_\_\_\_ 14) As a whole, children of alcoholics
- a) Usually become alcoholics or addicts.
  - b) Tend to take on survival roles which help them cope but mask their true feelings.
  - c) Tend to be under achieving problem children with more juvenile delinquency than other children.
  - d) Tend to be high achieving motivated children.
- \_\_\_\_ 15) When an alcoholic receives treatment and stops drinking, the problems of the children
- a) Tend to resolve themselves.
  - b) Usually go away if the alcoholic and his/her spouse get marital therapy.
  - c) Usually worsen severely.
  - d) Tend to persist until each member receives help.
- \_\_\_\_ 16) Research indicates that the most common factors in someone developing alcoholism are
- a) Genetic predestination and availability of alcohol.
  - b) Genetic factors and psycho-social influences on drinking choices.
  - c) Environmental influence of parents, low self-concept and poor communication skills.
  - d) Environmental influence of parents, and peer pressure to drink abusively.

Read the following situations in questions 17-20. Given the risk factors and drinking behaviors involved, determine whether each person is making a) high risk drinking choices, b) responsible-moderate drinking choices, c) low risk

drinking choices, or d) not enough information is given to determine the risk level.

- \_\_\_\_\_ 17) Jane is a sophomore in college, she has no family history of alcoholism. She comes home every evening and has one or two margaritas. She never drinks more than this but rarely misses a day.
- \_\_\_\_\_ 18) Fred is a junior in college. He has an alcoholic father, but no other alcoholism in his family. He likes to go out on weekends and have 5 or 6 beers with his friends.
- \_\_\_\_\_ 19) Gerry is a freshman in college. Both of his parents have alcoholism, along with 2 of his grandparents. He enjoys 1 or 2 drinks with pizza, no more than once or twice per week.
- \_\_\_\_\_ 20) Lisa is a senior in college. She has an alcoholic grandfather. Lisa very rarely drinks, but once in a while she likes to go out and really celebrate and get drunk. This happens only 5 or 6 times per year. She always has someone drive her home in these situations.

Last 4 digits of your social security number\_\_\_\_\_.

Knowledge test on prevention, alcoholism, and the family.

Directions. This test has 20 multiple-choice items. Please mark your answers to all questions on the line to the left of the question. Make the best guess you can on each question. Please answer all questions.

- \_\_\_\_\_ 1) If one family member has alcoholism, how are other family members usually affected?
- a) They are not usually affected.
  - b) The spouse may have problems, but usually not the children.
  - c) All family members usually are adversely affected.
  - d) Most family members will develop problems with drinking.
- \_\_\_\_\_ 2) How does the rate of alcoholism among children of alcoholics compare with rates of alcoholism for others?
- a) Children of alcoholics have lower rates of alcoholism than do others.
  - b) Children of alcoholics have higher rates of alcoholism than do others.
  - c) Children of alcoholics have the same rate of alcoholism as others.
- \_\_\_\_\_ 3) Most people develop alcoholism because
- a) They can not cope with their personal problems, and so use alcohol to avoid painful feelings and events.
  - b) They don't really care about themselves or others and so they choose to drink.
  - c) They can not avoid it, it is part of their biological make-up.
  - d) The combination of biological risk factors and high-risk drinking choices triggers alcoholism.
- \_\_\_\_\_ 4) Research indicates that children of alcoholics' risk for developing alcoholism is most affected by
- a) The model of inappropriate drinking they see from their parents.
  - b) The inconsistent discipline often given by alcoholic parents.
  - c) The increased genetic risk they inherit from their parents.
  - d) The amount of abuse in the alcoholic family.

- 5) Which of the following best describes children of alcoholics?
- Most are very high achieving people with no adverse affects from the alcoholism in their families.
  - Most are low achieving people prone to anti-social behavior.
  - Most have adapted survival roles that inhibit emotional and social development.
  - Most develop serious psychological problems requiring extensive psycho-therapy and hospitalization.
- 6) How do rates of alcoholism between men and women compare?
- Men have higher rates of alcoholism than women.
  - Women have higher rates of alcoholism than men.
  - Women and men have the same rates of alcoholism.
  - Rates of alcoholism are the same, but women develop alcoholism at later ages.
- 7) Which of the following are common early symptoms of alcoholism recognized by others.
- Discoloration of skin, redness of nose and yellow blotchy skin tone.
  - Increased problems at home, work, or with the legal system related to drinking.
  - Daily drinking accompanied by nervous shaking and occasional hallucinations.
  - Increased incidence of violence and disregard for others personal safety while drinking.
- 8) What psychological characteristics were most common among young people who later developed alcoholism?
- Gregariousness, impulsiveness, and rebelliousness.
  - Low self-concept, dependency, and depression.
  - Passivity, indecisiveness, and depression.
  - Sociopathy, paranoia, impulsiveness
- 9) Which of the following statements are generally true of children of alcoholics' biological reactions to alcohol.
- After drinking they often have more of the chemical which causes damage in the liver and heart than other people do.
  - They often have different brain wave patterns after drinking than other people do.
  - They often have higher peak blood alcohol concentrations from similar amounts of alcohol compared to other people.
- Only I
  - Both I and II
  - Both II and III
  - I, II and III



- a) I only
- b) I and II

- c) III only
- d) II and III

Read the following situations in questions 16-20. Given the risk factors and drinking behaviors involved, determine whether each person is making a) high risk drinking choices, b) responsible-moderate drinking choices, c) low risk.

- \_\_\_\_\_16) Martha has an alcoholic mother. She enjoys going out with friends for long leisurely evenings and having 2 or 3 drinks. She does this 3-4 nights per week.
- \_\_\_\_\_17) Mike is a sophomore in college; he has an alcoholic father and grandfather. Mike really enjoys a couple of beers after class. He drinks 2 everyday and never misses a day.
- \_\_\_\_\_18) Roger is a good student, well respected by his teachers and peers. Roger drinks very rarely (once or twice per month). When he does drink he likes to have 6-8 drinks. He always has a friend drive him home on these occasions.
- \_\_\_\_\_19) Arnold drinks 4 or 5 drinks 5 or 6 times per month. He usually does this a couple nights before a big test to help him relax.
- \_\_\_\_\_20) Linda has a strong family history of alcoholism. She has had problems with depression in the past few years and has found that medication helps. She drinks rarely, once or twice per month, and generally has no more than 2 or 3 drinks.

Last 4 digits of your student number\_\_\_\_\_.

Directions: Each of the statements in this questionnaire expresses a feeling, belief, or experience you may have had. Please answer according to how it applies to you now. Circle Definitely True (DT), Somewhat True (ST), Unsure (U), Somewhat False (SF), or Definitely False (DF) for each question.

- |   |    |    |   |    |    |
|---|----|----|---|----|----|
| 1. I often worry about my family.   | DT | ST | U | SF | DF |
| 2. I am more protective now of my siblings than I used to be.                                 | DT | ST | U | SF | DF |
| 3. My family will probably have less control over me in the future.                           | DT | ST | U | SF | DF |
| 4. I will probably be less attracted to people with personal problems in the future.          | DT | ST | U | SF | DF |
| 5. I find it easy to make friends.  | DT | ST | U | SF | DF |
| 6. I find it easy to share my feelings with others.   | DT | ST | U | SF | DF |
| 7. I worry less now than I used to about my friends' drinking.                                | DT | ST | U | SF | DF |
| 8. I am very protective of my siblings.   | DT | ST | U | SF | DF |
| 9. I will probably feel less angry in the future about my parent's drinking.                  | DT | ST | U | SF | DF |
| 10. My parent's alcoholism affects me less now than it used to.                               | DT | ST | U | SF | DF |
| 11. I will probably be better able to change and improve aspects of myself in the future.     | DT | ST | U | SF | DF |
| 12. I am easily upset at home.  | DT | ST | U | SF | DF |
| 13. I will probably be less likely in the future to say something that might upset my family. | DT | ST | U | SF | DF |

14.	Relaxing and having fun will probably be easier in the future.	DT	ST	U	SF	DF
15.	I am more comfortable now being with my family than I used to be.	DT	ST	U	SF	DF
16.	I am less likely to get caught up in family arguments than I used to be.	DT	ST	U	SF	DF
17.	I find it difficult to talk about my family.	DT	ST	U	SF	DF
18.	I will probably feel less different from other people in the future.	DT	ST	U	SF	DF
19.	I am more likeable than I used to be.	DT	ST	U	SF	DF
20.	I worry more about my family now than I used to.	DT	ST	U	SF	DF
21.	I get caught up in family arguments.	DT	ST	U	SF	DF
22.	I will probably be more easily upset at home in the future.	DT	ST	U	SF	DF
23.	My parent's alcoholism strongly affects me.	DT	ST	U	SF	DF
24.	I feel less angry now about my parent's drinking than I used to.	DT	ST	U	SF	DF
25.	I avoid saying anything that might upset my family.	DT	ST	U	SF	DF
26.	Being with my family will be more comfortable in the future.	DT	ST	U	SF	DF
27.	Relaxing and having fun is less difficult than it used to be.	DT	ST	U	SF	DF
28.	My family has less control over me than it used to.	DT	ST	U	SF	DF

- |     |   |    |    |   |    |    |
|-----|---|----|----|---|----|----|
| 29. | I will probably find it more difficult to talk about my family in the future.       | DT | ST | U | SF | DF |
| 30. | I am often attracted to people with many personal problems.                         | DT | ST | U | SF | DF |
| 31. | I find it easier to make friends than I used to.                                    | DT | ST | U | SF | DF |
| 32. | I feel less different from other people than I used to.                             | DT | ST | U | SF | DF |
| 33. | It will probably be harder to share my feelings with others in the future.          | DT | ST | U | SF | DF |
| 34. | I am likeable.  | DT | ST | U | SF | DF |
| 35. | It used to be harder to share my feelings with others than it is now.               | DT | ST | U | SF | DF |
| 36. | I will probably worry less about my friends' drinking in the future.                | DT | ST | U | SF | DF |
| 37. | I can change and improve aspects of myself.   | DT | ST | U | SF | DF |
| 38. | I am easily upset at home more often than I used to.                                | DT | ST | U | SF | DF |
| 39. | My parent's alcoholism will probably affect me less in the future than it does now. | DT | ST | U | SF | DF |
| 40. | I will probably be more protective of my siblings in the future.                    | DT | ST | U | SF | DF |
| 41. | I often feel angry about my parent's drinking.                                      | DT | ST | U | SF | DF |
| 42. | I am less likely now to say something that might upset my family than I used to be. | DT | ST | U | SF | DF |
| 43. | I am comfortable being with my family.  | DT | ST | U | SF | DF |

44.	I am becoming more likeable each day.	DT	ST	U	SF	DF
45.	I am better able to change aspects of myself than I used to be.	DT	ST	U	SF	DF
46.	I often worry about my friends' drinking.	DT	ST	U	SF	DF
47.	I will probably worry less about my family in the future.	DT	ST	U	SF	DF
48.	I will probably be less likely to get caught up in family arguments in the future.	DT	ST	U	SF	DF
49.	I often find it difficult to relax and have fun.	DT	ST	U	SF	DF
50.	My family has a great deal of control over me.	DT	ST	U	SF	DF
51.	I find it more difficult to talk about my family now than I used to.	DT	ST	U	SF	DF
52.	I often feel different from other people.	DT	ST	U	SF	DF
53.	I will probably find it easier to make friends in the future.	DT	ST	U	SF	DF
54.	I am less attracted to people with personal problems than I used to be.	DT	ST	U	SF	DF

## RECORD OF DRINKING BEHAVIOR

Last 4 digits of your student number \_\_\_\_\_

Please estimate the number of drinks you consumed in each day over the past 3 weeks. For purposes of this study a drink is defined as 1 can of beer, 6 ounces or more, or 1 ounce of distilled spirits.

Sample:

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
<u>Week 1</u>	2	0	0	0	1	0	3
<u>Week 2</u>	0	0	0	2	1	2	2
<u>Week 3</u>	0	0	0	0	0	5	3

If you do not know the exact number of drinks you consumed on a day just give your best guess.

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
<u>Week 1</u>							
<u>Week 2</u>							
<u>Week 3</u>							

Over the next 8 weeks please record the number of drinks you consume in each day.

	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
<u>Week 1</u>							
<u>Week 2</u>							
<u>Week 3</u>							
<u>Week 4</u>							
<u>Week 5</u>							
<u>Week 6</u>							
<u>Week 7</u>							
<u>Week 8</u>							

Last four digits of your social security number

GROUP EVALUATION

1. Which of the 7 sessions we have had was most significant for you? Describe the session.
  
  
  
  
  
  
  
  
  
  
2. What made this session significant for you?
  
  
  
  
  
  
  
  
  
  
3. Which of the 7 sessions was least helpful to you? Describe this session.
  
  
  
  
  
  
  
  
  
  
4. Why was this session not helpful? What feelings did you have during this session?

5. What do you feel that you got out of participating in this group? (For each item circle one of the following:  
1--very much  
2--moderately  
3--slightly or not at all

I feel that I got

- 1 2 3 relief from the tension I was under.  
1 2 3 better insight and self-understanding.  
1 2 3 reassurance and encouragement about how I'm doing.  
1 2 3 better ability to feel my feelings, to be what I really am.  
1 2 3 ideas for new or better ways of dealing with people.  
1 2 3 a sense of having close person-to-person relationships with group members.  
1 2 3 help in being able to talk about what was really troubling to me and really important.  
1 2 3 a better ability to tell which of the things I felt and thought were real and which were mostly in my own mind.  
1 2 3 better self-control over my moods and actions.

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

APPENDIX C

Client Verbal Response Category System  
Definitions and Examples

1. Simple Responses: brief limited phrase indicating agreement, disagreement, or a short informational response to a counselor's questions.  
Examples: "Yea sure."  
              "I don't know."  
              "No, not really."
2. Requests: Attempts to obtain information or advise or to place the burden of responsibility for solution of the problem on the counselor.  
Examples: "What should I do?"  
              "Who can I call to find out about that?"
3. Description: Discusses history, events, or incidents related to the problem in a story-telling style.  
Example: "My boyfriend got mad at me last night and called me names, afterwards he stomped out of the room and drove off."
4. Experiencing: Affectively explores feelings, behaviors or reactions about self or problems, does not convey an understanding of causality.  
Example: "I'm mad at myself cause I wish I hadn't done that."
5. Exploration of Client-Counselor Relationship: Indicates feelings, reactions, attitudes or behaviors related to the counselor or the counseling situation.  
Example: "I was afraid to come back to counseling this week because I didn't like what you said last week."
6. Insight: Indicates that a client understands or is able to see theme patterns, or causal relationships in own or others personality or behavior.  
Example: "I think I stay so busy because I'm afraid of having free time."
7. Discussion of Plans: Refers to action-oriented plans, decisions, future goals, and possible outcomes of plans.  
Example: "Next time I feel angry with my roommate I'm going to tell him how I feel."
8. Silence: A pause of five seconds or more.
9. Other: Small talk, statements unrelated to counseling, comments that do not fit elsewhere.

TREATMENT EFFECTIVENESS OF A COPING GROUP  
FOR COLLEGE STUDENTS WITH ALCOHOLIC PARENTS

by

SHERYL A. BENTON

B. S., University of Nebraska/Lincoln, 1978

AN ABSTRACT OF A MASTER'S THESIS

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1985

## ABSTRACT

Recent studies indicate that children of alcoholics have an elevated risk for alcoholism. This increased risk for alcoholism appears to be more closely associated with a genetic factor than with environmental factors. In addition children of alcoholics are at risk for many psycho-social problems which often are carried into adulthood.

The purpose of this study was to examine the effects of a short-term group treatment for college undergraduates with alcoholic parents. The research was concerned with whether treatment would cause change in subjects knowledge of alcoholism and the family, subjects reported quantity and frequency of alcohol consumption, and subjects understanding of their behavior within their families. The treatment process developed for this consisted of eight sessions, two hours in length. Each session had an educational component, and an insight-oriented group therapy component. Subjects were four undergraduates at Kansas State University. Three of the subjects were female, one was male.

Data collection included a pre-test and post-test of knowledge of alcoholism and the family, a likert-type attitude scale, daily records of alcohol consumption, subjective evaluation of group therapy, and analysis of tape scripts of five of the eight sessions using the Client Verbal Response Category System.

Results indicated that subjects quantity of alcohol consumption increased over time, while subjects frequency of alcohol consumption remained unchanged. Subjects reported positive gains from participation in the group on the subjective evaluation of group therapy. Analysis of tape scripts revealed significant changes across sessions (significant at greater than the .05 level) on two verbal response categories. Subjects' descriptive behavior decreased across sessions, while subjects' insight related verbal behavior increased across sessions. Finally, subjects scores on the likert-scale showed no change on a scale of self-concept, but an increase on a scale of instillation of hope.

These findings indicate that subjects increased in understanding of their behavior in their families. Indicators of this include changes in frequency of verbal responses in insight and descriptive categories, increases in scale 3 scores of the likert scale, and subjective reports of subjects. No change was evidenced in subjects drinking behavior, or in subjects knowledge of alcoholism and the family.