1988

Self-Esteem in Adolescent Children of Alcoholic Parents: An Examination of the Problem and Applicable Group Therapies

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SELF-ESTEEM IN ADOLESCENT CHILDREN OF ALCOHOLIC

PARENTS: AN EXAMINATION OF THE PROBLEM AND

APPLICABLE GROUP THERAPIES

by

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A Thesis Submitted to the Faculty of the Graduate School

of Loyola University of Chicago in Partial Fulfillment

of the Requirements for the Degree of

Master of Arts

May

1988

ACKNOWLEDGMENTS

I would like to thank Dr. Manuel Silverman and Dr. William Watts, for their interest in and committment to this thesis.

I would also like to thank the members of the Arrupe House Jesuit Community for their encouragement and support in the completion of this work.

VITA

The author, Daniel T. Reim, S.J., is the son of Richard Nelson Reim and Mary Lou (Gallagher) Reim. He was born May 14, 1962 in Cleveland, Ohio.

His elementary education began first in the catholic schools of Cleveland, Ohio then Girard, Pennsylvania and was completed in the public schools in Fairview, Pa. His secondary education was completed in 1980 at the Cathedral Preparatory School in Erie, Pa.

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In 1986, Mr. Reim, S.J. completed his undergraduate studies at Loyola University of Chicago. He graduated Summa Cum Laude in Psychology and Philosophy. He was awarded the Senior Philosophy Major Award and was elected a member of Alpha Sigma Nu, the National Jesuit Honor Society.

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CHAPTER I

INTRODUCTION

Background of The Problem

The National Institute on Alcohol Abuse and Alcoholism
(NIAAA) reports that there are approximately 9.3 to 10
million alcoholics in the United States. While the
treatment of alcoholics has received considerable attention
in the literature for more than fifty years, the needs and
desires of the children of alcoholic parents has only
recently gained the attention of researchers and health care
professionals. In the past, treatment of the alcoholic
parent alone was believed to be all that was necessary for
the return to normal, healthy family functioning. Margaret
Cork's (1969) study of the "forgotten children" strongly
rebuffed this notion finding that the children of alcoholics
did not report that family life became significantly better
when the drinking stopped. Most recently, Black (1982),
Wegscheider (1981), and Woititz (1985) have, in their works,
popularized the needs of adult children of alcoholics.
Their studies have revealed the fact that if children do not
resolve the problems created by parental alcoholism, they
will carry them the rest of their lives.

Of particular note are those children of alcoholics in
the adolescent stage of development. All children in the
adolescent stage of development, regardless of their

parent's drinking patterns, experience various personal changes which effect their self-esteem. Changes in physiology, cognitive ability, and increased social responsibilities, among others, are factors which tend to lower the individual's self-esteem during this period. Especially for younger adolescents then, when most changes are taking place, self-esteem may be lower than at any other time in the individual's life.

One of the negative consequences for children of alcoholics, particularly adolescents, resulting from their parents' drinking is a sense of personal worthlessness, inadequacy, and in general, lowered self-esteem. The importance of self-esteem in the development and maintenance of healthy ego functioning cannot be underestimated. Carl Rogers (1965) states, "if I were to search for the central core of difficulty in people as I have come to know them, it is that in the great majority of cases they despise themselves, regarding themselves as worthless and unlovable" (p. 1). Hamachek (1977) notes, "the voluminous literature related to the idea of the self and self-concept leaves little doubt but that mental health and personal adjustment depends deeply on each individual's basic feelings of personal adequacy" (p. 95). For children of alcoholics however, feelings of self-esteem are significantly lower than for those children whose parents are not alcoholic. Therefore, children whose parent or parents are alcoholic

suffer developmentally and in mental adjustment as a result of lowered self-esteem. And unless they receive treatment, beyond the treatment of the alcoholic parent alone, children of alcoholics will continue to suffer emotionally into their adult lives.

As previously mentioned, children of alcoholics experience more feelings of low self-esteem than their peers. For adolescents already experiencing feelings of low self-esteem as part of the normal developmental process, the further diminishing of the self-esteem as a result of the parental alcoholism and its effects on the family dynamics, may result in the development of dysfunctional coping mechanisms and, in general, an emotionally disturbed personality.

Of the 28 to 34 million children of alcoholics (Booz-Allen and Hamilton, 1974) only 5 to 10 percent of this group receive treatment of any sort (Deutsch, 1982). Three processes of group treatment will be reviewed: Alateen; other group programs including Peitler's (1980) group counseling, the Cambridge and Sommerville Program for Alcohol Rehabilitation (CASPAR), and Hawley and Brown's (1981) group treatment model; and the Children from Alcoholic Families program, a group treatment program involving family therapy.

The predominant method of treatment at present for children of alcoholics is Alateen. Alateen is a worldwide

organization of teenagers who have or have had an alcoholic parent. The group process is based upon the twelve-step process created by Alcoholics Anonymous. Alateen is available to teenagers regardless of parental knowledge and/or approval.

The Cambridge and Sommerville Program for Alcohol Rehabilitation (CASPAR) treatment program is a school-based group method provided for the education and treatment of children of alcoholics. This program, like Alateen, does not require the permission of the parents for participation. Unlike Alateen, the CASPAR program does not have a consistent record of success.

The most successful form of group treatment for children of alcoholics is family therapy. Presupposing the alcoholic is receiving treatment, family therapy enables the adolescent to understand and break from the rigid roles acted out in the family system. Unfortunately, only a small minority of all children of alcoholics are able to receive this form of treatment.

Purpose and Significance of This Study

The task of this study is to review and synthesize the literature related to self-esteem in adolescent children of alcoholics and the prevailing group methods of treating this population. This study differs from all others in its focus on the psychological construct of self-esteem, which is greatly diminished in children of alcoholics. As well, this

study will examine the literature regarding the particular difficulty of children of alcoholics in the adolescent period of development. This study will provide a review of the literature on prevailing group methods for treating this population, examining their benefits and limitations. Finally, some conclusions and recommendations will be made for the purpose of future research and application for health care professionals.

Methodology

The review of the literature was derived from several sources: two computer searches, sources obtained through the Comprehensive Bibliography of Alcohol and the Family, and sources obtained from Psychological Abstracts. These materials were obtained from the libraries of Loyola University of Chicago. Information on Alateen was provided by the Chicago chapter of Alateen.

Limitations of This Study

This study is limited by several factors. This thesis is limited to the research available on adolescent children of alcoholics. Generalizations, therefore, cannot be made to younger children or to adults. As well, the thesis is restricted to the review of the literature on the psychological construct self-esteem for this population. Secondly, this thesis was prepared in the '87-'88 academic year. More time for research would have resulted in a more complete and concise review of the literature. Finally,

this study was limited by the resources available at the Loyola University of Chicago libraries.

Definition of Terms

Alateen- a group of adolescent children of alcoholics who meet one a week under the supervision of an adult Al Anon member for the purpose of discussing ways of coping with living with an alcoholic parent either sober or still drinking.

Alcoholic- Definitions of alcoholics range from very broad descriptions to restrictive characteristics. For the purpose of this paper the definition of an alcoholic will be derived from the President's Commission on Mental Health (1978). The term alcoholic, then, "refers to individuals with serious drinking problems, whose drinking impairs their life adjustment in terms of health, personal relationships, and/or occupational functioning."

Children of alcoholics- any individual whose parent or parents are, or have been, alcoholic as defined above.

Self-esteem- Self-esteem is the evaluation which an individual makes and customarily maintains with regard to him/herself. A further delineation of self-esteem and its related constructs will be given in Chapter 2.

Procedure of Thesis

Chapter 2 will provide a review of the literature on self-esteem and adolescence. This material is provided for the purpose of establishing a background for the review of

the literature in Chapter 3 on the nature and problems of
children of alcoholics. Also in Chapter 3, some conclusions
will be drawn regarding the self-esteem in adolescent
children of alcoholics from the literature defining the
development of self-esteem and the home environment of
children of alcoholics. Chapter 4 will provide a review of
the literature on the group methods available for the
treatment of these children. Three major forms of treatment
for this population will be examined, Alateen, CASPAR, and
family therapy. Finally, Chapter 5 will provide a summary
and conclusion of the literature review on self-esteem in
adolescent children of alcoholics. Recommendations will be
made for the direction of future research for both academic
researchers as well as for health care professionals.

CHAPTER II

SELF-ESTEEM AND ADOLESCENCE

Chapter 1 provided the background, purpose, and
procedure for this study. Chapter 2 will present the
background literature necessary for the discussion of self-
esteem in adolescent children of alcoholics. The first two
sections of this chapter are devoted to the psychological
construct self-esteem, its definition and distinction from
related constructs, and its development. The third and
fourth sections will focus on the developmental stage of
adolescence, the developmental issues particular to this
period of growth, and their effect on the individual's self-
esteem. The final section of this chapter outlines the
parenting tasks which are crucial to the positive
development of self-esteem in children and adolescents.
This final section is given separate attention for the later
purpose of contrasting the parenting styles of alcoholic
parents and their purported influence upon the self-esteem
of their adolescent children.

Definition of Self-esteem

The psychological constructs self-concept and self-
esteem have been used interchangeably in the literature
(Shavelson, Hubner, & Stanton, 1976; Stanwyck, 1983; Beane &
Lipka, 1980). Although the concepts are closely related, it
is important to differentiate the two. Greater confusion in

the literature has resulted from other related concepts being interchanged with these two constructs as well. Self-image, self-picture, self-view, are constructs often associated with self-concept. While self-worth, self-regard, and self-evaluation are terms often interchanged with self-esteem. With such a vast number of constructs being interchanged with each other, it is important to establish clear, differentiated definitions for the originating constructs.

Blyth and Traeger (1983) make the following distinction between the two constructs. "Those aspects of the self-image which are considered to be basically descriptive and non-judgmental are one's self-concept or self-picture. Those aspects or attitudes which can be classified as evaluations of the self or the degree of satisfaction with the self make up one's self-esteem" (p. 91). Beane and Lipka (1980) make the same distinction yet include the evaluations as descriptive or evaluative in terms of the roles one plays as well as personal attributes. Beane and Lipka (1980) further delineate the two constructs by distinguishing the terminology used to describe them. Self-concept is either clear or confused, complete or incomplete, general or specific, but is inappropriately described as strong or weak, positive or negative. Such value-related judgmental terminology belongs to the construct self-esteem.

The self-concept can be defined as the sum total of the

view which an individual has of himself. It includes one's
picture of what he or she is, one's "extant self," what one
would like to be, "desired self," and what one wants others
to think he or she is, "presenting self" (Felker, 1974;
Rosenberg, 1979).

The most widely recognized definition of self-esteem
within the literature is that of Stanley Coopersmith's
(1967). "Self-esteem is the evaluation which an individual
makes and customarily maintains with regard to himself; it
expresses an attitude of approval or disproval (sic), and
indicates the extent to which the individual believes
himself to be capable, significant, successful, and worthy"
(p. 4-5). Coopersmith's definition focuses on the
relatively enduring estimate of general self-esteem rather
than upon the more fluctuating changes in day to day self-
esteem evaluation.

Several authors have broken the construct of self-
esteem into several components. Felker (1974) defines three
components: belonging, competence, and worth. Belonging
involves participation in a group and "being accepted and
valued by the other members of the group" (p. 25). Feeling
competent involves how effective one accomplishes what one
has set out to do (p. 26). The third component, feeling
worthwhile, arises, or fails to arise, out of one's
perception of himself as worthwhile alone or in the
estimation of others (p. 29).

Norem-Hebeisen's (1976) analysis of the literature produced four dimensions of self-esteem. The first dimension, basic acceptance, is "a preverbal emotional acceptance or rejection that is developed before an individual has developed a conceptualization of self" (p. 559). Conditional acceptance, the second dimension, involves the self-esteem derived from meeting the standards of one's self and others. Real-ideal self congruence is the match between perceptions of what one is and what one thinks one ought to be, i.e., the match between one's "extant self" and "desired self." The fourth dimension revealed through Norem-Hebeisen's analysis of the literature was self-evaluation, the individual's judgment of how he or she compares with others. Norem-Hebeisen concludes that an appropriate measure of self-esteem must include these four dimensions.

Much of the literature on self-esteem differentiates high self-esteem from low self-esteem. Rosenberg (1965) describes the typical individual with high self-esteem as one who "respects himself, considers himself worthy; he does not necessarily consider himself better than others, but he definitely does not consider himself worse; he does not feel that he is the ultimate in perfection but, on the contrary, recognizes his limitations and expects to grow and improve" (p. 31).

Unlike the individual with high self-esteem, the low

self-esteem individual is likely to experience feelings of self-rejection, self-dissatisfaction, self-contempt, and lack of self-respect. Coopersmith reports that clinicians have observed that low self-esteem individuals can neither give nor receive love, apparently fearing that the exposure that comes with intimacy will reveal their inadequacies and cause them to be rejected.

Two competing theories regarding self-esteem exist in the literature. The first, self-consistency theory postulates that "relations between evaluations of the self and others are mediated by a tendency toward self-consistency" (Jones, 1973, p. 186). Therefore, those individuals with high self-esteem will react more favorably towards approval than disapproval while individuals with low self-esteem will react more favorably towards disapproval than approval since it is consistent with their self-concept. Self-consistency theorists believe that changing one's self-esteem is very difficult since "they are generally unwilling to accept evidence that they are better or worse than they themselves have decided, and generally resolve any dissonance between evidence and their judgment in favor of their customary judgment" (Coopersmith, 1967, p. 5). Nowicki and Strickland (1973) refer to Festinger's (1957) theory of cognitive dissonance to support the self-consistency theory. Cognitive dissonance is "the feeling that occurs when we encounter data that contradict our

locus-of-control attitude, our existing self-concept (including self-esteem), and our existing assumptions about other people" (p. 168). Data suggesting that one is more competent, significant, and powerful than he presently believes himself to be, for example, will often be dismissed since it contradicts the prevailing self-concept. More positively, the principle of cognitive dissonance in explaining the consistency theory of self-esteem suggests that the individual with a positive level of self-esteem will interpret events in such a way that maintains one's self-esteem.

The self-esteem theory, according to Samuels (1977), postulates that "individuals have a need to enhance their self-evaluation and to increase, maintain, or confirm their feelings of worth, effectiveness and self-satisfaction" (p. 65). Unlike the self-consistency theory, then, an individual will react favorably only to approval, regardless of his/her level of self-esteem.

Development of Self-Esteem

Several authors have attempted to describe the development of self-esteem. In each description, self-esteem arises from two sources, those factors outside the self and internal factors. However, how the outside factors affect self-esteem depends upon their interpretation as determined by the internal factors. Stanwyck (1983) cites three critical elements of experience that pertain to

the development of self-esteem. A significant other, the
first critical element, is defined as a social entity, an
individual or group, "that takes on special importance for
the development of self-esteem during a particular life
stage" (p. 14). Stanley Coopersmith (1967) believed years
earlier that the amount of respectful, accepting, and
concerned treatment that an individual receives from
significant others greatly influences one's self-esteem. We
value ourselves according to how significant others value
us. "The esteem of significant others," writes Cotton
(1983), "creates the positive emotional milieu in which
self-love develops, and provides specific information about
what is worthwhile and lovable about the person" (p. 124).
Therefore, the role of parents, according to Coopersmith, is
crucial to the healthy development of self-esteem in their
children. He lists four parental characteristics that are
essential to the healthy development of self-esteem in their
children. These are: acceptance, limits, respect, and high
self-esteem of the parents. He states, "the parents of
children with high self-esteem are concerned and attentive
toward their children, that they structure the worlds of
their children along lines they believe to be proper and
appropriate, and that they permit relatively great freedom
within the structures they have established (p. 236).

The second critical element in self-esteem development,
according to Stanwyck, involves social role expectations.

The expectations held by others regarding an individual's
sex, ethnicity, socioeconomic status, and memberships in
family, school, work, or recreational groups influence the
development of self-esteem. Mack (1983) describes the
effect of social role expectations on self-esteem
development. "As the child realizes his or her particular
skills and talents, continuously experiencing just what
expressions of self are valued by the parents and others,
the groundwork for later self-expectations is laid. A
gradual structuring of values and expectations for the self
is internalized in childhood and becomes the specific
measure by which achievements are gauged" (p. 30). Stanwyck
writes, "compliance and noncompliance with social
expectations for role-specific behavior typically result in
judgments of personal worth" (p. 14).

Finally, Stanwyck's third critical element for self-
esteem development is the communication and coping style the
individual learns as a means of protecting one's self-
esteem. He bases his argument on Virginia Satir's belief
that "people function according to their feelings of self-
worth or value" (Satir, Stachowiak, Taschman, 1975, p. 166).
Coopersmith (1967) as well believed that the individual's
manner of responding to devaluation greatly influenced the
person's self-esteem development. Mack (1983) argues
strongly that the protection of self-esteem is one of the
central tasks of childhood. He states, "the maintenance of

positive self-esteem is so fundamental a task that all of
the structures of personality contribute to its
organization" (p. 12).

Coopersmith (1967) defined four major factors
contributing to the development of self-esteem. The first
factor, the importance of significant others, has already
been discussed.   The history of successes and the status
and position an individual holds in the world is the second
major factor contributing to the development of self-esteem.
The individual's power, competence, and virtue effect self-
esteem. The greater one's ability to influence and control
others (power); the greater one's successful performance in
meeting demands for achievement (competence); and the more
one is adherent to moral and ethical standards set for
himself (virtue) the more likely one's self-esteem is to
develop in a positive fashion.

A third factor contributing to the development of self-
esteem, according to Coopersmith, involves the notion that
experiences are interpreted and modified in accord with the
individual's values and aspirations. Coopersmith states
that, "persons at all levels of self-esteem tend to employ
very similar standards to judge their worth. Despite
limitations in ability, performance, and social skills,
persons with low self-esteem are just as likely to attach
importance to intelligence with high self-esteem who tend to
be superior in these regards" (p. 244). The more congruent

one's values and aspirations are with one's abilities the more likely the individual's self-esteem is to be positive.

Coopersmith's fourth contributing factor to the development of self-esteem, in concordance with Stanwyck, involves the individual's manner of responding to devaluation. The greater one is able to defend one's self-esteem from attack, the more likely that person will maintain a positive level of self-esteem. "His manner of dealing with threat and uncertainty represents the individual's way of defending himself against anxiety-or more specifically, of defending his esteem against the devaluation that would come with feelings of incompetence, powerlessness, insignificance, and lack of virtue" (p. 43).

Coopersmith summarizes these four contributing factors to the development of self-esteem stating that such development is dependent upon "the extent to which his successes approached his aspirations in areas of performance that were personally valued, with his defenses acting to define and interpret what is 'truly' valued, the 'actual' level of aspiration, and what is regarded as 'successful'" (p. 242).

Finally, Cotton (1983) cites three major sources of self-esteem which influence the development of self-esteem: the esteem of others, competence, and the "self" as a selective filter.

First, the esteem of others, as previously explained,

provides the context in which the child learns what is valued about him or her as a person. Secondly, competence, in terms of successful interaction with the environment, when matched with parental approval and recognition, leads to a positive development of the self-esteem. And thirdly, the self acts like a "selective filter"-regulating the flow of sources of self-esteem, i.e. significant others and competence, via the interpretation of these sources. Cotton writes, "the structure of the self imparts personal meaning to all life experiences, interpersonal relationships, and individual growth and development" (p. 126).

In summary, Coopersmith (1967), Cotton (1983), and Stanwyck (1983) have defined essential factors or elements in the development of self-esteem. These factors are 1) the esteem of significant others; 2) feelings of competence; 3) self-standards; and 4) means of coping with devaluation.

The development of self-esteem has been described through the use of Erikson's eight stages of psychosocial development. Cotton (1983) argues that there exist multiple sources of self-esteem which influence both the origin and sustenance of self-esteem at different points in the life cycle.

Cotton describes the development of self-esteem regulation from infancy through adolescence in five phases paralleling Erikson's stages of psychosocial development. Self-esteem regulation refers to the "process of organizing

the multiple sources of self-esteem, i.e. the selection of
information, the assignment of value to different sources,
and the synthesis of contradictory information from the
sources" (p. 123). Positive self-esteem and smooth self-
esteem regulation, according to Cotton, depend on the
healthy development of each source of self-esteem, i.e.
significant others, competence, and the "selective filter,"
and a certain degree of working harmony between them.
Conversely, "pathological self-esteem regulation and low
self-esteem will result from the failure to develop or
defective development of any one (source of self-esteem)
and/or conflict in the organization of the (source of self-
esteem)" (p. 123).

During the first stage of development, as Erikson
described as a period of developing either trust or
mistrust, the foundation of positive self-esteem is laid
down. Cotton argues that the infant experiences positive
feelings of well-being if; the mother-infant relationship is
empathetically responsive to the child's temperament,
activity level, needs, and wishes (significant others); and
the infant experiences his own capacity to affect change in
the environment and develop autonomous ego functions
(competence). In regards to the importance of significant
others, Stanwyck (1983) comments, "to the extent that the
family functions in esteem-enhancing, open-system fashion,
the infant will come to trust, rather than mistrust, his or

her world" (p. 16). For the infant, the selective filter is relatively simple. "Starting at birth, the infant begins to construct a self from his interactions with innately given sequences of maturation and environmental events. Parental empathy is the key to early confirming and validating interactions for the development of the self" (p. 126).

The second stage of development, Autonomy vs. Shame and Doubt, is the period from one year to three years old. For the toddler, according to Cotton, self-esteem regulation continues to depend upon parental attitudes, opinions, and behavior. The development of self-esteem in children requires both positive (acceptance and praise) and negative (limit setting) guidelines. "Limits, rules, and appropriate expectations provide structure for the child's burgeoning assertiveness and aggression" (p. 128). Erikson (1963) wrote, "from a sense of self-control without loss of self-esteem comes a lasting sense of autonomy and pride, from a sense of muscular and anal impotence, a loss of self-control and of parental over-control comes a lasting sense of doubt and shame" (p. 68). For the toddler, the number of significant others has grown to include not only parents but siblings and peers as well.

Cotton writes that during the second year in life the child begins to observe him or herself and makes realistic self-evaluations. Since self-esteem presupposes the capacity to evaluate one's self, self-esteem does not exist

before the age of two. "Through imitation and
identification the child begins to incorporate parental
qualities, roles, and power into the developing self,
thereby maintaining self-esteem in a time when it is
particularly vulnerable to the child's new awareness of his
or her relative incompetence and impotence" (p. 130).
Stanwyck adds that if the child imitates behaviors that are
functional he or she will learn a set of behavioral options
for coping with the challenges in a way that protects or
even enhances one's self-esteem (p. 16).

In the third phase of development, early childhood, the
child's radius of significant others continues to expand,
yet each with varying influence on the child's self-esteem.
"The impact of the opinions, attitudes and behaviors of
people who are valued and trusted by the child gradually
becomes more emotionally significant than the responses of
strangers or people peripheral in the life of the child" (p.
131). Secondly, the child faces greater challenges which
test the individual's competence, and hence effect self-
esteem. "Mastery of specific skills and abilities enhances
self-esteem and determines in part what areas of the self
are valued" (p. 146).

During this third phase, the child's self-concept
expands as it incorporates an increasing number of
experiences. In the same way that not all of the child's
significant others have the same impact on the self-esteem,

so too with the self-concept. "The self-concept is a
subjectively organized structure in which some aspects of
the self are central, others are more peripheral" (p. 133).

The period of "latency," the fourth phase of
development, marked by the critical issue of Industry vs.
Inferiority, is a time in which the child's capacity to make
things well (industry) and success in school lead to
positive feelings of self-esteem. On the other hand, it is
as well a period in which self-regulation is particularly
vulnerable to failure, rejection, or defects in the visible
aspects of themselves. The greatest challenge to the young
child's self-esteem, argues Stanwyck, is the omnipresence of
evaluations. Here it is important to introduce the concept
of locus of control. One's locus-of-control determines to
what an individual's behavior is to be attributed. External
locus of control is the attributing of behaviors and
outcomes to sources outside of one's own control. If, for
example, one attributes a failure on a test to a poor test
design by the teacher that individual's self-esteem is
defended. Internal locus of control refers to the
attributing of behaviors and outcomes to sources within the
individual's control (Nowicki and Strickland, 1973). The
individual, for example, that blames himself for making a
wrong choice, when in fact insufficient information was
available, may suffer in decreased self-esteem. Stanwyck
reports that the child with high internal locus of control

is likely to reject evaluations that are inconsistent with
his or her self-esteem and to accept only those that do not
challenge the existing self-esteem level. Once a pattern of
success or failure has been established it will most likely
persist throughout a child's school career unless
intervention occurs.

By the time the child has entered school, the
"selective filter" has become the most important tool for
the regulation of self-esteem. Therefore, according to
Cotton, "the impact of praise on self-esteem is highly
dependent on whether the child values the praising person
and the area of the self which is being praised" (p. 135).

During this fourth stage of development parents
continue to influence self-esteem in their child in major
ways. "The absence of approval and praise from parents is
often the cause of low self-esteem even in the presence of
competence, acceptance among peers, and teacher approval"
(p. 136).

Definition of Adolescence

Adolescence is generally understood to be the period of
development beginning with the onset of puberty and ending
at an ill-defined time when the individual achieves
independence and social productivity. During this period,
besides dramatic physical changes, the adolescent
experiences significant changes in his or her cognitive
abilities. A third significant change during adolescence is

in relationships. Finally, the change from a protective
elementary school to secondary school can have a significant
effect on the self-esteem of an individual. As a result of
these factors, the adolescent's concept of self and the
associated feelings change significantly.

Adolescent Self-Esteem

The period of adolescence was believed to be one of
"storm and stress" in which the adolescent's emotional
state, including his or her self-esteem, was in turmoil.
Yet more recent research (Dusek and Flaherty, 1981) has
revealed that self-esteem during adolescence develops in a
stable and continuous manner. Yet the period of
adolescence, as described in the section above, is a time of
significant changes which dramatically shape the development
of the individual's self-esteem.

The studies relating physical changes and self-esteem
are voluminous. In sum, the changes in the body must also
become incorporated in the early adolescents' views of
themselves. Cotton (1983) warns that self-esteem can
plummet during this process as the adolescent "questions
whether he is still a boy, whether he can control his voice
ever again, or whether his skin will clear" (p. 138).
Stanwyck (1983) states that in regards to the more general
level of self-esteem during adolescence, "the physical and
physiological changes of puberty are not likely to threaten
an individual's self-esteem unless their timing is markedly

different from that of similar changes in peer group members" (p. 21). One exception to this is in the case of early development of boys who in comparison with their peers experience a heightened rather than decreased level of self-esteem.

A second area of change during adolescence which effects the development of self-esteem is the developing cognitive abilities of early adolescents. In early adolescence, according to Piaget, the individual's thought process develops from concrete operational thought to formal operational thinking. The effect of this cognitive development is that it alters the individual's self-image and self-evaluations. While early adolescents may define themselves according to exterior criterion, older adolescents begin to evaluate themselves according to more abstract, psychological characteristics. The new cognitive ability of abstract thinking allows the adolescent to construct and test hypotheses about oneself.

Another major set of changes occurring during adolescence is in the area of relationships. During adolescence, the hierarchy of significant others shifts in some regards from parents to peers. While adolescents still depend upon parents for matters of future goals, physical health, or major difficulties, they depend on peers in matters of social propriety. The importance and influence of peers on an individual's self-esteem is at no time higher than during

adolescence. According to Cotton (1983) "peers may be more appropriate sources of positive self-esteem than parents who `lose touch with,' and even feel alienated from, the younger generation" (p. 140). Stanwyck (1983) reports that adolescence is a period of exploration with members of the opposite sex. The success of failure of such exploration may greatly effect an individual's self-esteem development. Stanwyck cautions against adolescents becoming too serious with a member of the opposite sex too since, "these are often high-risk relationships for self-esteem because the interpersonal skills required for success have not been perfected and because dating usually begins before adolescents fully understand their sexuality or have brought it under control" (p. 22). Even in more casual dating relationships, disapproval or rejection may cause severe blows, if at least temporarily, to self-esteem.

The relationship between the child and parent changes significantly during adolescence. As already mentioned, there is a shift in importance in terms of approval from parents to peers. As part of that shift, and as part of the normal adolescent development, the individual's need for autonomy, while still requiring restraint, is heightened. The achievement of autonomy is another major source of self-esteem during adolescence. Stanwyck (1983) writes, "the low self-esteem youth whose parents have maintained high levels of intra-family dependence will have difficulty in striving

for self-definition" (p. 22). He summarizes, "the more closed and inflexible the family's mode of operation, the more likely it is that full autonomy will be impeded and that the struggle for self-esteem will be carried into adulthood" (p. 23).

Finally, another factor involved in the period of adolescence effecting the development of self-esteem, according to Blyth and Traeger (1983), is the transition from a protective elementary environment to a larger and more complex secondary school environment. The authors state, "a major shift in one's ecological setting can have ramifications on the self-concept and the self-esteem of an individual" (p. 93).

In summary, the factors effecting self-esteem during the developmental stage of adolescence include: 1) physiological changes and how the individual responds to them; 2) the devlopment of cognitive abilities; 3) the change in importance of peer and parent relationships; and 4) the transition from elementary to secondary schools. While each of these factors alone may or may not disturb the adolescent's self-esteem significantly, taken together the impact at one time or another during adolescence is severely felt.

Although self-esteem is neither significantly higher nor lower during adolescence than other times during the life span, self-esteem is significantly lower during early

adolescence than later adolescence. Simmons and Rosenberg
(1973) found that compared to younger children, "the early
adolescent has become distinctly more self-conscious; his
picture of himself has become more shaky and unstable; he
has lowered opinions of himself with regard to more specific
aspects of himself and he has increasingly come to believe
that parents, teachers, and peers of the same sex view him
less favorably" (p. 559). By later adolescence, the
individual has come to integrate many of the changes that
have occurred.

Parenting Tasks and Self-Esteem

In closing this chapter, it is important to discuss some
essential parenting tasks which are crucial to the positive
development of self-esteem. Francis Givelber (1981)
delineates five parenting tasks which are crucial to the
positive development of self-esteem. The first, "good
enough" mothering, refers to a quality of parenting that
responds to the basic physiological and emotional needs of
the infant. Essential features include acceptance,
responsiveness, sensitivity, and tolerance of the infant and
his particular needs. The second parenting task is that of
separateness. Separateness is the parent's ability to
differentiate a child's needs and feelings from his or her
own and to acknowledge and support the child as a separate
person. "Anxiety mastery," the third task, involves the
parent's capacity to teach the child that anxiety can be

tolerated. Mirroring of affect and achievement is the parent's understanding of the child's feelings and responding positively to the child's achievements. Finally, the fifth parenting task is that of promoting growth and maturation. This involves the parent's effort to guide the child toward an increasingly realistic sense of himself and the world.

Parenting as a process of providing means for the child to develop a healthy level of self-esteem involves two essential paradoxes. Givelber states, "the parent needs to accept the child's being, his current level of functioning, while encouraging the child's becoming more mature" (p. 165). And secondly, "the parent must also emphatically and momentarily feel what the child feels while maintaining an ongoing psychological separateness" (p. 165).

If the parenting tasks are successfully completed the child will be more likely to develop a positive sense of self-worth and capability. He or she will be more likely to evaluate him or herself in an increasingly independent and realistic manner. "The loving support of parents," write Mack and Ablon (1983), "remains of critical importance in adolescence though it must be conveyed in subtler form, often to a teenager who seems not to `need' anything, rejects parental overtures, and offers little `space' for closeness to occur" (p. 17).

Summary

This chapter has defined and described the psychological construct of self-esteem. Much attention has been given to the review of the literature regarding the development and maintenance of self-esteem. This material provides the necessary background for understanding the nature and problems of self-esteem in children of alcoholics which will be discussed in Chapter 3.

The literature regarding the specific population of adolescents was examined, defining and describing the issues particular to this group in light of how those issues effect the individual's self-esteem.

Finally, a review of the literature was provided on the essential parenting tasks for the positive development of self-esteem in their children. This material is important for the purpose of contrasting these tasks with the parenting of alcoholic parents and the effects on their children, which will be presented in Chapter 3.

CHAPTER III

ADOLESCENT CHILDREN OF ALCOHOLICS

Chapter 2 concluded with a section depicting the essential parenting tasks which are crucial to the positive development of self-esteem. Chapter 3 will review the nature and effects of parental alcoholism on adolescent children with regard to the development, or lack thereof, of self-esteem. This chapter will first examine the home environment of children of alcoholics. Secondly, those studies which have researched the problems of children of alcoholics will be reviewed. The majority of these studies compare adolescents from alcoholic and non-alcoholic homes. Third, the means by which adolescents react to their alcoholic home environment will be studied. These studies focus on the roles children of alcoholics play as a means of coping with the dysfunctional family environment and the effects that result in terms of their emotional well-being. Fourth, the studies of self-esteem in adolescent children of alcoholics, the central focus of this thesis, will be reviewed. Finally, some conclusions will be drawn regarding the development of self-esteem of children of alcoholics. Such conclusions will be based upon the literature defining those elements which are essential to the development of self-esteem (chapter 2) and the literature describing the home environment of children of alcoholics.

The Home Environment of Adolescent Children of Alcoholics

Several authors have provided demographic information regarding the prevalence of alcoholic families in the United States. According to Booz-Allen & Hamilton (1974), children living in homes where alcohol abuse is occurring or has occurred in the past totaled 28-34 million. Adolescents from alcoholic families have statistically fewer intact families, with more single-parent family structures (Huber, 1984; Chafetz et al., 1971; Kammaier, 1971). Bosma's (1972) study further states that if those members remain together the climate is one which is certainly ill-conducive to providing a stable atmosphere for the members. The presence of alcoholism in one or both of the parents may have severe emotional effects upon the children. Peitler (1980) writes, "the alcoholic home environment very often has a negative impact on the child's emotional development and later adjustment. Conditions essential to the acquisition of healthy feelings of self-esteem are not consistently present" (p. 31).

Charles Deutsch, in Broken Bottles Broken Dreams (1982), outlines six general characteristics that are consistently found in the homes of alcoholic parents, which are generally not found in functional, non-alcoholic homes. These characteristics are 1) the centrality of the alcoholic and alcohol related behavior; 2) denial and shame; 3) inconsistency; 4) insecurity and fear; 5) anger and hatred;

and 6) guilt and blame. The first characteristic is the centrality of the alcoholic and alcohol-related behavior. As the parent's (or parents') alcoholism develops, the family's functioning becomes more determined by the negative consequences of the illness. Deutsch writes that "every (alcohol-related) incident becomes part of a chain with accumulated feelings and past reactions coloring what each family member does and feels on each new occasion" (p. 33). The family members become obsessed with attempts to prevent and preempt the alcoholic's need to drink. This obsession pervades the family even when the alcoholic is not drinking.

Children's behaviors are shaped around the presence of the alcoholic and his or her behaviors. The child may, for example, avoid confronting the alcoholic paren completely when the child knows he or she is drinking. More often the child seeks to prevent the alcoholic from drinking by hiding bottles, pouring out the alcohol, distracting the parent, etc. Such influence of the alcoholic effects even the child's social relationships. The child, for example, may refuse invitations to other children's homes for fear of having to return the invitation and allowing friends to see the alcoholic parent.

The non-alcoholic spouse as well becomes caught in the face of the illness. While seeking all means to limit the spouse's drinking, he or she seeks as well to limit the alcoholic's harm to the children. Most often, the spouse

fails in both attempts.

The second characteristic found in most alcoholic homes, according to Deutsch, is that of denial and shame. For the alcoholic, denial of the alcoholism becomes a necessary defense mechanism. The alcoholic is caught in a double bind. He or she cannot face the guilt and shame that the illness causes, yet to face the problem would mean giving up the booze. Denial of the problem, even in the face of obvious facts, becomes the only acceptable solution.

The alcoholic, however, is not alone in maintaining a system of denial. Deutsch writes, "denial is equally characteristic of the alcoholic's spouse and children. They too develop an unconscious screening process that keeps out or distorts the evidence they cannot bear to face" (p. 38). The spouse's denial protects him/her from the truth, namely, the bottle has become more important to the alcoholic than he/she. Therefore, "the nonalcoholic spouse usually reinforces the alcoholics denial in overt as well as oblique ways, but for his/her own reasons" (p. 39).

The children of alcoholics accept the parents' denial as well. With so few consistent ground rules and surety about which behaviors result in approval or disapproval, the children learn, whether consciously or not, that accepting their parents' denial is the way to peace, while openly challenging it is the gravest of offenses. The children's denial of the problem is the result of other factors as

well. With the newly developed ability for formal

operational thought, adolescents are capable of imagining

how parents "should" behave as parents. For the child of an

alcoholic, the gap between the ideal and the reality is so

great it becomes too difficult to accept. Hence, the child

downplays the effects of the alcoholism and grandizes the

alcoholic's positive attributes.

A further reason for the child's acceptance of the

parents' denial of alcoholism is the fact that he or she has

nowhere to go. While relatives of friends of the family are

unable to recognize or unwilling to interfere in the

alcoholic's family, the child is forced to deal as best

he/she can. Often, it is most easily dealt with by denial.

Finally, the social stigma of alcoholism is so great,

especially to the adolescent, in which peer approval has

become so important, that acknowledgement of the problem

would bring about great shame to the alcoholic and the rest

of the family as well. Again, to the child, denial becomes

the best defense mechanism. Deutsch writes about the

serious consequences of the family's denial of the parental

alcoholism:

> The habitual practice of denial and deception has
> profound consequences for children of alcoholics.
> They may methodically suppress all threatening
> feelings; experience a loss of values, because what
> they feel is right is subordinated to what is
> necessary and tolerable; retain deep-seated shame, the
> solution for which has always been isolation, and
> consistently confuse reality and fantasy (p. 41).

Of the several common characteristics found in

alcoholic homes, the most prominent characteristic is
inconsistency. Deutsch states, "inconsistency is the
hallmark of most active alcoholics, when they are drinking
and when they are not" (p. 41). A common phrase used among
children of alcoholics in reference to the alcoholic parent
is "Dr Jekyll and Mr. Hyde." Like the fictional character
created by Robert Louis Stevenson, the alcoholic possesses
two personalities, one while sober, the other when drunk.
The adolescent becomes confused, not knowing what to
believe, and frustrated when promises are not kept. Wilson
& Orford (1978) found that many of these children who felt
affectionate toward and close to their drinking parent when
the latter was sober would ignore the same parent, withdraw
to another room, leave the house or sometimes become angry
or hostile while the parent was drinking. The emotional
consequence of the alcoholic's inconsistent parenting on the
child is insecurity. And according to Deutsch, "once the
condition of insecurity is established, it becomes a way of
life, a way of apprehending the universe and its
uncertainty" (p. 42). The message that becomes indelibly
imprinted is "Don't count on anything." This is only
reinforced by the inconsistency of the non-alcoholic parent.

Peitler (1980) summarizes the opinion of several
writers regarding the effects of inconsistent parenting on
the child.

> The inconsistent or unpredictable moods of the
> alcoholic parent i.e. aggressive during drinking

episodes and docile and remorseful when sober, presented these children with different and distorted parental role models so that the formation of a balanced self-concept became quite difficult (pp. 36-37).

Another common characteristic found in alcoholic homes, which is closely connected to the characteristic of inconsistency is insecurity and fear. And, writes Deutsch, "nothing contributes to children's insecurity and fear more than recurring violence" (p. 43). Scott (1974), Marsden & Owen (1975), and Steward (1970) reported a strong association between family violence, such as wife beating and child abuse, and family alcoholism (Peitler, 1980, p. 36). The adolescent child of an alcoholic parent is consumed by fear. The adolescent fears not only for his or her own personal safety and security, but for the non-alcoholic parent as well. The adolescent also fears for the safety of the alcoholic parent, particularly when the alcoholic drives drunk.

Deutsch lists anger and hatred as further common characteristics in alcoholic families. These are commonly the result of "being repeatedly disappointed, neglected, or abused by the people they love and need the most" (p. 46). Adolescents become confused and ambivalent in their feelings towards the alcoholic parent. On the one hand, the adolescent loves the parent and respects the position of guardian. And yet the hurt caused by the alcoholism results in the adolescent's feelings of anger and hatred. Deutsch

reports that "because their feelings of anger, even when unexpressed, provoke a great deal of guilt and anxiety, many children deny those feelings altogether" (p. 46).

Deutsch's final characteristics commonly found in alcoholic homes are guilt and blame. "Guilt usually coexists with fear and anger in the alcoholic home" (p. 47). Guilt is the product of both the parents' blaming, including the non-alcoholic, and the adolescent's need for control. The alcoholic parent's need to defend his or her drinking may take the form of shifting the responsibility for the drinking onto the child. Guilt, according to Deutsch, serves as a defense mechanism against helplessness and hopelessness. "Instead of concluding that they simply cannot influence it (their parent's drinking), they blame themselves for going at it incorrectly" (p. 48). Because adolescents confuse the disease of alcoholism with a notion of moral weakness, they attempt to make the alcoholic change by making major changes in themselves. The failure to achieve the desired goal results in even greater feelings of guilt. Deutsch concludes, "thus the children's positive self-concept (self-esteem) is damaged not simply by the original feelings of guilt, but by repeated failure to control that which is most important to them" (p. 48).

Deutsch has outlined general characteristics found in alcoholic homes which are not commonly found in functioning, non-alcoholic homes. The effect of these characteristics is

often the psychological damage of the children within the
alcoholic home. Researchers meeting at a symposium on the
topic of services for children of alcoholics summarized the
alcoholic home situation:

> The lack of family stability, the inadequate or
> inappropriate role model displayed by the alcoholic
> parent, the unpredictable behavior of that parent, the
> fear of stigma that adversely affects healthy peer and
> other interpersonal relationships, the often frequent
> incidents of family violence, together with the
> emotional deprivation and even occasional physical
> abuse that occurs, are all faced by a child in this
> (alcoholic home) situation (Services for children of
> alcoholics, 1981, v.).

While common characteristics of alcoholic homes have
been described, more specific psychological characteristics
of the alcoholic parent have been isolated as well.
Peitler's (1980) list includes "excessive dependency needs,
emotional immaturity, low frustration tolerance, an
inability to express emotions in an adaptive way and high
levels of anxiety in interpersonal relationships" (p. 37).
Greenleaf (1981) comments on the psychological
characteristics of alcoholic parents and the effect on their
children. She writes,

> Whether they are alcoholic or co-alcoholic, parents
> whose self-esteem is poor will set a low ceiling on
> self-esteem in their families; if they are unsure of
> their ability to cope, they will be threatened by
> another's competence; if they feel inadequate, they
> will be envious of other's achievements; if they are
> confused, they will bestow confusion on those around
> them; and if their expectations of themselves are
> unrealistic, they will have unrealistic expectations of
> others (p. 65).

The result of parental emotional disturbances is to pass on

those very same deficient characteristics to their children.

Several studies (Cork, 1969; Peitler, 1980) have examined the home situation in which the alcoholic is no longer drinking. These studies found that the home life of abstainers was not significantly different from those who continued to drink. For the child whose parent goes "on the wagon" matters tend to become worse, since the child's hope for permanent sobriety is too often shattered. Yet even the parent's "long term sobriety" does not ensure "normal" family life. Initially, the recovering alcoholic is too preoccupied with Alcoholics Anonymous meetings to reestablish relationships with the child. Further, the behavior patterns the alcoholic grew to depend upon persist after the drinking has ceased. And finally, without family treatment, the dynamics of the family system that developed during the development of the alcoholic's illness will continue to persist even after the alcoholic ceases drinking.

In this section, the literature regarding the home environment of children of alcoholics, including the psychological disturbances in the alcoholic parent, and the alcoholic who is no longer drinking, has been reviewed. The findings suggest that the home environment of children of alcoholics is not conducive to providing a stable atmosphere, but rather, may have severe emotional effects upon the children.

Problems of Adolescent Children of Alcoholics

The degree to which a child of an alcoholic parent is negatively effected depends upon several factors. Those factors include: 1) the age of the child at the onset of the problem drinking; 2) the reaction to the alcoholism by the non-alcoholic spouse; 3) the perception of the situation by the child; and 4) the coping resources available to the child.

Wilson and Orford (1978) state that the length of exposure to parental drinking will, in part, determine the severity of the effects on the child. "An 8-year old girl living with an alcoholic parent since infancy and an 18 year old boy living with a parent whose alcoholism is of recent onset are both "children of alcoholic parents," but the impact must be expected to be quite different" (p. 140).

How the non-alcoholic spouse handles the alcoholic situation greatly determines how the child will be effected (Wilson & Orford, 1978; Strachan, 1972). Often, the non-alcoholic spouse becomes preoccupied with the alcoholic adding to the centrality of the alcoholic, and is often blamed for the drinking. Deutsch (1982) states that this is a reflection of the responsibility for controlling it which he/she assumes and passes on to the children (p. 36). The greater the non-alcoholic spouse is capable of resisting the centrality of the alcoholic and focusing on meeting his/her

own needs and those of the children, the less likely are the children to be adversely effected by the alcoholic parent.

The manner in which the alcoholic home environment is perceived by the child will play a part in determining the severity of the effects (Ackerman, 1978, Deutsch, 1982). The problem of children of alcoholics does not lie with the parent's drinking and the behavior that goes with it but rather, the child's interpretation of family events (including the non-alcoholics in the family), and the self-image and defense patterns based on that interpretation (Deutsch, p. 49). More frightening to the child than the parent's drinking is the fighting between the parents (Cork, 1969). The parent's fighting is often perceived by the child to be a result of some action or actions on his/her own part. The more the child perceives the alcoholic's drinking is due to their own behavior or their inability to stop the drinking, the greater the emotional harm (Cork, 1969).

The more resources a child has to his/her disposal in dealing with the parental alcoholism, the less likely the child is to suffer damaging effects (Ackerman, 1978). One major resource is that of others outside the home to whom the child can turn for support and guidance. "Children who were able to establish primary relationships outside the home were not as likely to become alcoholic in their adult lives as children who did not establish these relationships

(Ackerman, 1978, p. 24). Therefore, there are several factors which determine the severity of the alcoholic parent's effect on the child's physical and psychological well being, and in particular, the child's self-esteem. With these factors in mind, the specific problems experienced by children of alcoholics, as reported in the literature, as a result of living in an alcoholic family will be discussed.

Adolescent children of alcoholics come from homes which in most cases do not provide for the physical and emotional needs of the children. The problems that adolescent children of alcoholics encounter include: the likelihood of becoming alcoholics themselves, adjustment difficulties, emotional neglect, and developmental difficulties, as well as school and social relationship problems. Each of these problems will be discussed in greater detail.

A problem of children of alcoholics that concerns many health care professionals is the fact that approximately 40 to 60 percent of children of alcoholics become alcoholics themselves, thus perpetuating the disease (Hindman, 1975). Jellinek's (1945) early study showed that 52 percent of 4,000 alcoholics had an alcoholic parent. A more recent study (Rathod & Thompson, 1971) found that 12 of 30 female alcoholics and 18 of 30 male alcoholics had an alcoholic parent. Other studies investigating the occurrence of alcoholism and alcohol-related problems in children of

alcoholics include Fox, 1968; Dordevic-Bankovic & Sedmak, 1972; Bosma, 1975; Goodwin, Schulsinger, Hermansen, Gruze & Winokur, 1973; and Peitler, 1980.

Many clinical reports indicate that children of alcoholics have major emotional problems and adjustment difficulties stemming from their interactions with their alcoholic parents. These adjustment problems include aggressive and antisocial behaviors, difficulty with peers, general emotional problems, and poor social adjustment (Ackerman, 1983; Black, 1979; Cork, 1969; Hindman, 1975). Peitler's (1980) study of adolescent sons of alcoholic fathers revealed that "those adolescent sons of alcoholic fathers who were seven or younger when paternal drinking became problematic tend to be less adjusted than those sons who were older when the father's drinking began to be a problem such that adverse effects are felt on family life" (p. 110). Adjustment was defined in terms of tendencies toward withdrawal, antisocial behavior and feelings of self-worth. Kammeier (1969) compared adolescents from alcoholic families and those from non-alcoholic homes. Based upon scores on the Minnesota Counseling Inventory and the Personal Orientation Inventory, Kammeier reported that "there would appear to be a trend in general for the students from families with identifiable alcohol problems to experience more severely the adjustment problems of adolescence than do students from families without

identifiable alcohol problems. The adjustment difference exists most dramatically for girls, especially girls in the ninth and tenth grades" (p. 13).

Booz-Allen & Hamilton's (1974) assessment of children of alcoholics found that one of the most frequent problems among them is emotional neglect. "Emotional neglect occurred when the alcoholic withdrew from the child, building a wall that did not provide the child with communication, affection, or parenting" (Lawson, et. al., 1983, p. 175). The neglect is felt in one of Cork's (1969) "forgotten children" who states, "I wouldn't mind her drinking if I could just be noticed" (p. 31). Cork adds, "while in most instances there appeared to be reasonably adequate physical care of the children, their emotional needs seemed to be almost entirely unmet" (p. 44).

Cork argues that the most important external influence for any child is the emotional relationship between the child and his (or her) parents. The greater the breakdown in affectionate relationships the more the emotional development of the child will be distorted (p. 49). Most children of alcoholics, according to Cork, felt rejected by both parents. Her study of alcoholic fathers found them to be poor models for their children and unable to understand them, to love them in a mature way, or to teach them (p. 50). Yet, the non-alcoholic mothers, in Cork's study, were frequently no better than the alcoholic at relating warmly

or closely to her children. More often she becomes more mothering to her alcoholic husband than she is to her children (p. 51).

Jael Greenleaf, in <u>Changing Legacies</u> (1984) writes of the emotional neglect felt by the oldest child. "Though oldest children are skillful at gaining attention, in the chemically dependent family they find that mother and dad are too busy, too harassed, or too unconcerned to tolerate demands. The outcome of this family struggle is that the oldest child trains him/herself for emotional isolation" (p. 20).

The parents do not willfully neglect their children "but their constant quarreling, their inability to recognize or meet their children's needs, and their failure to love wisely and to understand their children would seem to constitute a form of rejection that clearly amounts to neglect" (Cork, p. 51).

In the alcoholic home, the family tries to deny, deflect, contain, or diffuse the problems caused by the drinking in the children's interest. "By enlisting each child in this effort from the outset, it drastically curtails (the child's) development. The process of becoming an individual is therefore subordinated to that of meeting the family's needs," or more specifically, the alcoholic's needs (Deutsch, 1982, p. 56). Brooks (1982) has studied the psycho-social development of adult children of alcoholics

according to the framework of Erikson's eight stages.
Brooks treats each of the developmental stages separately,
describing the problems of successfully completing each
stage as a result of living in an alcoholic home.

Brooks argues that the child, even in his/her earliest
development is able to perceive a problem within the family.
"As events and adults are unconsciously perceived to be at
the very least inconsistent, if not overtly harmful, the
child will sense the dis-ease in the environment, and will
not be able to find that surety of psychological position
defined as Trust" (p. 2). Cork (1969) argues that if there
is a lack of trust in one's parents, the child is left with
negative attitudes toward authority which will carry over
into adulthood. "Because they felt no basic trust in their
parents, they believed that adults generally could not be
trusted" (p. 40).

The goal of the second stage, autonomy vs. shame and
doubt, is to establish a sense of self separate from others
and the environment around the child. The nature of the
alcoholic family, however, is such that its members become
enmeshed in the problem of alcoholism. For the child in
later infancy, achieving autonomy in this home environment
is very difficult. While the child in a normal healthy home
environment at this stage begins to separate his/her self
from the environment, the child in an alcoholic home
struggles and often fails to achieve autonomy. Brooks

states the position of the child, "for how can I feel good
about myself if I feel bad about what is going on around me,
and I am what is going on around me-I have no autonomy" (p.
3). The child therefore, views the self with shame and
doubt.

During the developmental period of early childhood, the
child begins testing reality, developing his/her own sense
of what is real, what is not real. The child in the
alcoholic family, however, is surrounded by a family system
that prohibits reality. The family is in fact, unable to
accept reality, and thus is characterized by denial. The
child then is not only confused in terms of what is real,
what is not, but is also made to feel guilty in searching
for the truth. Brooks notes that "this child may become
locked into being a follower, letting others exercise their
imaginations, and letting others define reality (p. 3).

If the family alcoholism was present at the time of the
child's birth, the child's development to this point may
likely have been one of mistrust, shame and doubt, and
guilt. If such is the case, feelings of inferiority is are
virtually inevitable. Erikson's fourth stage of
psychosocial development involves the child's gaining a
realistic sense of what he/she can and cannot do. The child
in the alcoholic family, however, fails to receive
acknowledgment for his or her achievements and never learns
a healthy mode of industry. The result is often a sense of

inferiority (Brooks, pp. 4-5). The child may grow to take

on more projects than can be realistically managed, and yet

never finding personal satisfaction, or take the opposite

extreme of avoiding projects for fear of failure.

By the time a child reaches the next developmental

stage, puberty and adolescence, "one needs all the successes

of the previous (psychosocial) stages to cope with the

turmoils and mysteries of this period" (Brooks, p. 5). For

the child that fails to successfully pass through these

stages, role confusion is inevitable. The sense of self

that is achieved, if it is achieved at all, is negative.

The adolescent perceives him/herself to be non-trusting,

shameful, self-doubting, guilty, as well as inferior (p. 5).

The alcoholic family and its individual members struggle

with their own identity. Often the non-alcoholic spouse

takes over responsibilities for the alcoholic. The children

as well take on responsibilities for the parents.

Male/female roles are often reversed. Such instability and

inconsistency of roles leaves the adolescent without

necessary references by which to establish his/her own

identity. Wilson and Orford (1978) state that deficient or

distorted parental role models may result in the inability

of their children to develop stable sex roles (p. 31).

An essential part of the personality developmental

process during adolescence is the shifting of importance of

significant others from parents to peers. Cork (1969)

argues that "while the child is growing away from his
parents he must still feel the support and strength of . . .
being a completely accepted member of that family. He needs
and wants wise limits, encouragement to grow up and to test
himself in new experiences and relationships" (p. 36). In
the alcoholic home, where inconsistency, poor parental
modeling, dependency, and emotional neglect are the norm,
the process of developing an individuated identity is
inhibited. "They have no opportunity to experience the
normal process of breaking away from parents" (Cork, p. 37).
This is felt in the child that states, "they (parents) make
you feel you're just somebody to boss around, even though
you're old enough to look after the little kids for them. I
want to be somebody but I feel like a nobody" (pp. 36-37).

Ackerman (1983), Wilson & Orford (1978), Peitler
(1980), Deutsch (1982), and Cork (1969) concur with Brooks
in the findings that children of alcoholics suffer in their
personality development as a result of living in an
alcoholic family. Ackerman (1983) points out that for many
children of alcoholics the crises confronted in successive
psychosocial stages are compounded by unresolved problems
carried over from previous stages, plus the continuing
stresses caused by living with an alcoholic parent. "This
compounding effect can have detrimental consequences for
adequate personality development" (p. 67).

Children of alcoholics suffer from a variety of

psychological and emotional problems as a result of having

an alcoholic parent or parents. The severity of

psychological disturbances varies among these children from

bewilderment and confusion (Fox, 1977) to suicidal

tendencies (Deutsch, 1982).

Cork's (1969) study of 115 children of alcoholics

between 10 and 16 years of age revealed that because the

home life provided so few standards of behavior, little or

no discipline or guidelines, the children were left feeling

confused, unsure of themselves, and uncertain of their role

in the family (pp. 10-11). Further, Cork found that these

children had little or no opportunity for the fun and

laughter that is essential to childhood and to the growth of

personality (p. 28). Wilson & Orford (1978) found that

"quite a few children mentioned feelings of nervousness,

tension, aggression, irritation or depression which they

felt resulted from the atmosphere in the home" (p. 135).

More severe psychological problems resulting from

living in an alcoholic family include anxiety and depression

(Wilson & Orford, 1978). Fox (1977) states, "the children

of alcoholics tend to be neurotic because the sense of

security necessary for building a strong and independent ego

is usually missing" (p. 51). Deutsch (1982) found that

children of alcoholics are more likely than others to be

chronically depressed and suicidal (p. 47). Rouse, Waller,

& Ewing's (1973) study of children of alcoholics focused

explicitly on coping behaviors. Their findings suggest that children of alcoholic fathers showed less variety in their coping behavior than did children whose fathers were not alcoholic. Also, children of alcoholic fathers resorted to solitary activities, such as smoking, trying to forget, as a means of coping, while children of abstainers coped with stress by talking with friends and relatives, eating, and church activities (p. 682).

A number of studies have examined the effect of having an alcoholic parent or parents on the child's school performance. Chafetz, Blane, & Hill (1971) in their comparison of children of alcoholics seen in a child guidance clinic and children not from alcoholic homes, found that most children of alcoholics indicated that their school work was effected by their parent's alcoholism (p. 42). Kammeier (1969) found that students from alcoholic families tend to be absent more often than non-alcoholic family students. Children of alcoholics have a more difficult time concentrating in school than children who are not from alcoholic homes (Cork, 1969; Wilson & Orford, 1978). Part of the child's distraction is the concern the child feels for the alcoholic and the uncertainty of the situation when he/she arrives back home.

Children of alcoholics suffer several other problems as a result of their parental alcoholism. Serious illnesses and accidents were more frequent among children of

alcoholics than children from non-alcoholic families
(Chafetz, et. al., 1971). Rebecca Black in <u>Changing</u>
<u>Legacies</u> (1984) states, "serious neglect of a child was
determined to have occurred in 42 percent of the families
with an alcoholic parent. The incidence of child abuse and
neglect in families with alcoholic parents appear to be
three or more times higher than the incidence in the general
population (pp. 37-38).

Children of alcoholics were found to have higher rates
of arrest or involvement with police and courts than
children from non-alcoholic families (Wilson & Orford,
1978). Ackerman (1983) reported that 20 percent of juvenile
delinquents come from homes of alcoholism. Besides being
more likely to abuse alcohol than their peers not from
alcoholic home, children of alcoholics were also more likely
to abuse drugs (Wilson & Orford, 1978).

Lastly, children of alcoholics suffer more social
problems than those children not from alcoholic families
(Hindman, 1975; Wilson & Orford, 1978; Booz-Allen &
Hamilton, 1974; and Cork, 1969). Hindman (1975) reported
that because of the chaotic, confusing nature of the
alcoholic home environment, children of alcoholics become
isolated, socially withdrawn, and have difficulty with peer
relationships. Cork (1969) states, "at a period in their
lives when most youngsters are forming and consolidating
friendships, most of the (children of alcoholics) seemed to

have relationships that were limited by insecurity, fear, and lack of trust" (p. 24). The stigma associated with alcoholism also inhibits children of alcoholics from developing peer relationships. As one child stated, "I don't go places with my friends and their parents because I can't ever take my friends places" (Cork, p. 24).

While all children of alcoholics do not suffer from their home environment equally, all seem to experience many problems which effect their emotioanl and psychological well-being both now and, if untreated, in their future. These children experience difficulties as a result of, in part, the emotional neglect of not only the alcoholic parent but the non-alcoholic parent as well. In comparison to children who are not from alcoholic families, children of alcoholics experience greater emotional problems, fall behind in school performance, and suffer greater social problems.

Roles of Children of Alcoholics

Children of alcoholics seek some means of coping with the inconsistency, unpredictability, and inability to control situations found in the home environment. That means of coping is often achieved in the attainment of a particular role within the family. Roles exist within families not dominated by alcoholism as well. Roles within a normal family change as the child gets older. "The alcoholic family, however, is too insecure and fragile to

permit flexibility" (Deutsch, 1982, p. 46). The goal of role behavior in children of alcoholics is to stop the alcoholic from drinking and to create a harmonious family. Yet, according to Deutsch, these roles are empty and unfulfilling because in each case their goal is unattainable (p. 46). Although the roles provide the children of alcoholics with an immediate means of coping and often result in secondary gains, they become rigid and inflexible, failing to meet the physical and psychological changes in their lives.

Wegscheider (1981) in her studies of children of alcoholics has defined four role behaviors specific to this group. These roles, the "hero," "scapegoat," "lost child," and "mascot," each in their own way, enable the child to gain at least a minimum amount of control in their home environment. Each role has its own advantages as well as drawbacks.

The first role, the "hero," is most often found in the eldest child. Other names for this role include "superkid," "manager," "controller," and "goody-two-shoes."

As the alcoholic neglects more of the parental duties, or if the non-alcoholic spouse spends greater amounts of time with the alcoholic, it is most often that the eldest child takes on the neglected parental responsibilities. The oldest learns to organize, plan, manage, and control family responsibilities far beyond the capability of most children

their age (Wegscheider, 1981). Because of the "hero's" perceived maturity and drive for excellence in academics and/or athletics, he/she is seen by others to be not only well-adjusted but exceptional. Those outside the home who are aware of the family alcoholism believe the "hero" has "wrested strength, responsibility, and self-esteem from the jaws of adversity" (Deutsch, p. 58). Within the family, the "hero" is praised and encouraged since his/her success brought to the family distracts from the problems created by the alcoholic's drinking. Deutsch writes, "the son's ("hero's") mission is to rescue and redeem the family" (p. 59).

The origin of the "hero" role is the child's hidden hope that through achievement and personal sacrifice family harmony will return as well as the love and connectedness the family is supposed to deliver. Failure in achieving this end results in the "hero's" perfectionistic personality, never being satisfied with him/herself. Brooks (1982) writes, "self-worth (for the "hero") is predicated upon the quality and quantity of achievement" (p. 22). According to Brooks, the "hero" internalizes an obligation to correct the family imbalance. Compulsive drives to achieve impossible goals (eg. making the alcoholic cease drinking) lead toward overachievement (p. 21).

Though "heroes" experience successes in their endeavors, they remain highly self-critical, fearful of

failure, and controlling. "Because they need to feel in
control, independent, and without needs, "heroes" cannot
tolerate being wrong or slow and have great difficulty
admitting that they don't understand something" (Deutsch, p.
60).

Family "heroes" often have admirers but few close
friends. They are resented by peers and siblings for their
achievement as well as for being competitive,
perfectionistic, and good at obtaining adult approval.
"Heroes" succeed in their role by pleasing, so they are
always giving and never receiving, which creates problems in
developing intimate relationships.

A second role for children of alcoholics, which is most
commonly held by the second oldest child, is the
"scapegoat." Because the "scapegoat" cannot compete with
the overachieving "hero," the "scapegoat" chooses a second
alternative, namely, the attainment of attention through
causing trouble. The benefit of this role, according to
Wegscheider, is the consistent and predictable, even though
negative, attention and care. Typical characteristics of
"scapegoats" include: troublemaking, grades which do not
reflect their potential, alcohol and drug abuse, trouble
with the law, running away from home, and among girls, high
teenage pregnancy (Deutsch, 1982).

The "scapegoat" serves the alcoholic's purpose by
shifting the blame for family troubles onto that child for

his/her behavior. The "scapegoat," rather than the alcoholic, becomes the focus of the family's anger, disappointment, and frustration. Ironically, "the 'scapegoat' gets so much anger and criticism from siblings and the nonalcoholic parent, that the alcoholic can lead the way in forgiveness and understanding, assuring a pedestal in the child's eyes."

The inner conviction of the "scapegoat" is that if enough trouble is caused the alcoholic will have to stop drinking and the family unite in order to save him/her. In other words, to unite the family through failure. Often, however, "scapegoats" are cast out of the home at an early age. This serves the family's purpose beyond the elimination of the physical battles brought on by the presence of the "scapegoat." Deutsch writes, "it is the ultimate expression of anger and blame, and either of two contradictory hopes can be embedded in it: 'Certainly this will be enough of a crisis to unite the family in order to save the child.' Or more often, 'With the "scapegoat" out of the way, the family will become loving, harmonious, and sober'" (p. 65).

The child's acquisition of the "scapegoat" role may be difficult to distinguish from the normal adolescent struggle for autonomy. Deutsch writes,

> limit-testing and experimentation are natural
> adolescent traits. Some form of rebellion seems
> central to the process of becoming individuals separate
> from their parents, and most adolescents rebel in

small, daily ways without really challenging or rejecting adult values. The delinquency of "scapegoats," however, is not real rebellion. For them it is not a process of individuation; it is more of the acceptance of a very limited role, the fulfilling of other's expectations (p. 65).

Unlike the "scapegoat" whose behavior serves the purpose of gaining attention, the "lost child," a third role common among children of alcoholics, seeks to avoid any confrontation. This role is common among middle children, although none of the roles are dependent upon family position. Middle children, even in normal, healthy families are often believed to receive less attention than their siblings. In the alcoholic family, this tendency is often exacerbated, with the "lost child" feeling even less certain of his/her contribution or place in the family (Wegscheider, 1981). The role of the "lost child" in the family is to keep from disturbing the alcoholic family balance. "The central task of 'lost children' is the avoidance of all conflict" (Deutsch, p. 67). The result of this role is learned helplessness. Any participation in conflict results in a losing proposition. They adjust silently to every demand and situation.

Characteristics of "lost children" include: tendencies to withdraw, social isolation, shyness, if in a group it is as a follower, passive resistance, and above all, agreeable. "Lost children" feel lonely, afraid, and unimportant, subject to the whims of every other family member and unable to express their desires and fears" (Deutsch, p. 68).

While "lost children" are fearful of conflict
situations, and thus tend to keep to themselves, they need,
according to Deutsch, the direction of others. "They only
know who they are and how to function with reference to the
responses and adjustments required of them by others" (p.
69).

Of the different roles of children of alcoholics, the
"lost child" is the most difficult to identify. Deutsch
states, "they are determined to pass through life unnoticed"
(p. 69).

Finally, a fourth role common among children of
alcoholics is that of the "mascot." This role is generally
reserved for the youngest child in the alcoholic family.
The role of the "mascot" is to provide fun and humor and
distract family members from the negative effects of the
alcoholic (Lawson, et. al., 1983, p. 181). More
specifically, "they are assigned the responsibility for
defusing explosive situations. They are constantly attuned
to stress and conflict" (Deutsch, p. 73). They feel a sense
of responsibility for all stressful situations and feel a
need to respond to them.

Characteristics of the "mascot" include: class clown,
i.e. they are able to make a joke out of everything;
nervous, high strung, hyperactive, unable to concentrate on
any one activity for a suitable period. They have
difficulty with stress and may avoid competition. "Mascots"

are masters at manipulation. "'Mascots' may be slow to make
developmental transition at every age, and they also regress
when they are feeling most insecure."

The family members view the "mascot" as the immature
and fragile object of their protection. The "hero," in
his/her need to control, welcomes the "mascot" as someone to
take care of. The "scapegoat" looks to the "mascot" as
someone that will like him/her. And the "lost child" though
resentful of the attention, finds it easier to withdraw
since conflict is addressed by someone else (Wegscheider).

Claudia Black (1981) found four consistent patterns of
role behavior among children of alcoholics which parallel
Wegscheider's (1981). The first is "responsible." Much
like Wegscheider's "heroes" the "responsible" ones provide
structure for the family and become angry at themselves if
they cannot control. Their self-reliance leads to
loneliness, and they often marry alcoholics (Lawson, et.
al., 1983).

"Adjusters," the second role, according to Black,
follow directions and are flexible in dealing with the
inconsistency in the home. The "adjuster" parallels
Wegscheider's "lost child." They feel they have no power
over their own lives. "'Adjusters' work hard at taking care
of others and deny any feelings of their own. They are
adaptable and adjust to many situations, but they are
manipulated by others and can lose their self-esteem"

(Lawson, et. al., p. 183).

"Placaters," like the "mascot," take care of the others' needs before their own. "They smooth over conflicts and are rewarded for their help" (Lawson, et. al., p. 183).

Wegscheider's "scapegoat" is described by Black as the "acting out" child. Black emphasizes the dysfunctional effects of the alcoholic family's norms of "don't talk," "don't trust," and "don't feel." The "acting out" child attempts to break these norms through disobedience and troublemaking with the hope of gaining attention and care.

Rhodes (1984) studied adolescent children of alcoholics' perception of their roles in the family according to Claudia Black's (1981) descriptions. Her results suggest that adolescents from alcoholic families showed significantly more self-reported role behavior, as described by Black's theory, than adolescents from non-alcoholic families.

Booz-Allen & Hamilton (1974) identified four coping mechanisms that parallel the role behaviors described by Black (1981) and Wegscheider (1981). These coping mechanisms are flight, fight, perfect child, and supercoper. "Flight" describes those children who avoid the alcoholic and all conflict situations (the "lost child," the "adjuster"). "Fight" is the description of those children of alcoholics that are rebellious, acting-out children that are commonly seen as having behavioral problems

("scapegoat," "acting-out" child). The "perfect child" is
one that excels in school and sports ("mascot," "placater").
And "supercoper" is the description of those children who
take on responsibilities far greater than most children
their age. While being more mature than their peers in some
areas, they remain immature, in comparison, in others
(Strachan, 1972, p. 188).

While children of alcoholics can be generally
identified according to a specific role behavior, they have
blends of other roles as well, favoring some roles over
others at different times.

As previously stated, the roles that children of
alcoholics acquire serve an important and immediate purpose,
namely, the coping within an inconsistent, unpredictable,
and often neglectful home environment. The roles provide
secondary gains as well, such as praise, respect and
attention from others. Yet these roles have damaging
effects that, left untreated, will carry into their adult
life. Deutsch (1982) summarizes this problem:

> Because many alcoholic family systems are closed,
> conflict-ridden, inconsistent, inhibiting of direct
> communication, and convinced of their fragility,
> children have difficulty initiating new roles that
> reflect their own desires and physical and
> psychological changes. The closed systems require the
> children's reactions to be above all consistent and
> predictable (p. 57).

This section has provided the literature on the roles
taken by children of alcoholics as a result of living in an
alcoholic home. Each role serves the child's purpose of

gaining some control over his/her life in the chaotic and inconsistent home environment. Yet these roles become rigid, inflexible means of dealing with all problems which fail to meet the physical and psychological changes as the child develops.

Conclusions Regarding the Self-Esteem in Adolescent Children of Alchoholics

Several studies have established that when compared with children from non-alcoholic families, children of alcoholics maintain a significantly lower level of self-esteem. A few studies have examined the self-esteem of specifically adolescent children of alcoholics (Huber, 1985; Davis, 1983; Woititz, 1976; and Peitler, 1980) and found their levels of self-esteem as well to be significantly lower than their peers who are not from alcoholic homes. Huber (1985) for example, compared 44 adolescents from alcoholic homes with 77 control subjects on Rosenberg's Self-Esteem Scale. In a similar study, Woititz (1976) compared 100 children of alcoholics, 50 of whom attended Alateen, with 50 adolescents who were not of alcoholic parents. In both studies children of alcoholics had significantly lower levels of self-esteem than those adolescents not from alcoholic homes.

Peitler (1980) studied the effect of paternal alcoholism on their sons' self-esteem as determined by the age of the child at the onset of the problem drinking. His

findings reveal that adolescent sons of alcoholic fathers who were seven or younger at the time of paternal alcholism, have lower feelings of self-worth than do those who were older at the time the paternal alcoholism began.

In Chapter 2, Coopersmith (1967), Stanwyck (1983), and Cotton (1983) presented factors which are essential to the development of self-esteem. These factors, again, are: 1) the esteem received from significant others; 2) the experience of success and feelings of competence; 3) self-standards; and 4) means of coping with devaluation. Also in Chapter 2, Givelber (1981) described those parenting tasks which are essential to the positive development of self-esteem in their children. These tasks, once again, are: 1) "good enough" mothering; 2) separateness; 3) the teaching of anxiety mastery; 4) mirroring of affect and achievement; and 5) promoting growth and maturation.

In order for _positive_ self-esteem development, the child must experience a sense that he/she is valued, worthy, and loved, in general, esteemed by significant others. Second, the child must experience successes in interacting with the world. The development of competence and mastery, with a healthy understanding of his/her limitations serves to build self-esteem. Thirdly, the child establishes self-standards by which to judge his/her behavior. As previously stated (p. ?) the more congruent one's values and aspirations are with one's abilities the more likely the

individual's self-esteem is to be positive. And fourth, the more the child is able to cope or defend oneself against devaluation, by others or by him/herself, the more likely that child will maintain a positive level of self-esteem.

For children of alcoholics, however, those elements for building healthy and positive self-esteem are often missing or only inconsistently provided. This section will attempt to draw conclusions regarding the self-esteem in adolescent children of alcoholics based upon the literature defining self-esteem development and the home environment of children of alcoholics.

1. The esteem of significant others is lacking in adolescent children of alcoholics.

Children of alcoholics are often deprived of receiving esteem from significant others, particularly the parents. Because of the alcohol dependency of the parent, everything, including the needs of the child, becomes secondary to satisfying the need to drink (Deutsch, 1982). Responding to the basic physiological and emotional needs of the infant, the requirements for "good enough" mothering, according to Givelber (1981), are thus not always met. As Deutsch reports, the alcoholic parent is not the only one seeking to satisfy the drinking needs, but the entire family's focus, including the non-alcoholic parent, is upon the problems caused by the alcoholism. With the family's focus centered upon the alcoholic and the alcohol related problems, the

child's esteem needs are often left unattended, or at best,
receive "second place" attention.

The child of an alcoholic parent(s) often suffers from
lack of esteem from parents in terms of the inconsistency in
which the parents give attention and affection to their
child. The child may be confused by the put-downs made by
the alcoholic parent when drunk and the praise and attention
given when sober. The verbal put-downs, which often include
blaming for the parent's drinking, may well be more damaging
to the child's self-esteem than any physical abuse.

For the adolescent children of alcoholics, the esteem
of their parents is still important to the development and
maintenance of their self-esteem, even though they may be
placing more dependence upon their peers (Mack and Ablon,
1983). Yet the alcoholic parent, whose dependence upon the
adolescent for supporting his/her needs, may attempt to
quell the child's attempts at achieving separateness
(Givelber, 1981) or autonomy.

Many adolescent children of alcoholics lack the esteem
of their peers either as a result of being rejected for
having an alcoholic parent, or as a result of withdrawing
from peers out of fear for such rejection (Cork, 1969).

2. Experiences of success and feelings of competence
are lacking in adolescent children of alcoholics.

Children of alcoholics suffer in self-esteem as a
result of feelings of incompetence and experiences of

failure rather than success. The alcoholic parent's
inconsistency in behavior, sometimes rewarding a child's
behavior and at other times punishing the same behavior,
leaves the child confused and doubting his/her competence.
Givelber's (1981) parenting tasks of praising achievement
and promoting growth and maturation are often lacking in
alcoholic parents. Again because of the inconsistency of
the alcoholic parent's behavior, as well as the central
focus upon the alcoholic (Deutsch, 1982), the child is often
not given the necessary recognition for his or her
achievements. Often, the alcholic parent's expectations of
their child's behavior is beyond their capacity. Thus, the
child fails to experience success and competence as
determined by the parents.

Children of alcoholics often obtain faulty beliefs
which inhibit a healthy sense of competence and success.
The first is the belief that they are responsible for the
alcoholic's drinking and behavior. Often this is obtained
from the parent's direct blaming of the child, while at
other times the child makes the faulty assumption alone.
Regardless, the child makes attempts at stopping the
alcoholic from drinking by, for example, removing bottles
from the home, distracting the parent from drinking, or by
attempting to relieve the alcoholic's need for alcohol. All
attempts, however, fail to meet the objective, leaving the
child with a deeper sense of incompetence and failure. The

second faulty belief held by the child is that the parent's
alcoholism is the result of moral weakness, a lack of will-
power. The child may attempt to make great changes in
him/herself in the hope of modeling changes the parent can
follow. Again, such attempts fail not only in getting the
alcoholic parent to change, but also in achieving and
maintaining the self-goals.

3. Healthy self-standards are lacking in adolescent
children of alcoholics.

A third element in self-esteem development which is ⫪
often deficient in the lives of children of alcoholics is
the attainment of healthy self-standards (Coopersmith, 1967;
Stanwyck, 1983). Mack (1983) writes, "as the child realizes
his or her particular skills and talents, continuously
experiencing just what expressions of self are valued by the
parents and others, the groundwork for later self-
expectations are laid" (p. 30). In the alcoholic home,
however, the child does not know which expressions are
valued due to the inconsistency of the alcoholic parent.
Values may be upheld one moment, while disregarded the next.
The child therefore, has difficulty in establishing stable
self-standards by which to judge the self's behaviors.

As the child progresses into the adolescent stage of
development, he/she, according to Piaget, develops "formal
operational thought." This new cognitive capacity enables
the adolescent to question what "could" or "should" be. The

adolescent of an alcoholic parent begins to ask how "should" the parent behave and finds many faults in that parent. The adolescent then questions the values and standards of the alcoholic parent and will often reject them. This may result in either of two options. The adolescent may set up unrealistically high expectations for him/herself, attempting to live the life of his/her perception of what "should" be. Achieving and maintaining this self-standard, however, is impossible and the adolescent experiences failure, confusion, and hence, lowered self-esteem. The other option the adolescent may take is that of rejecting the values the alcoholic proclaims but fails to live by. Living with little or no standards of behavior, the adolescent fails to try to experience the success of achieving self-standards. In both cases, the adolescent does not seek appropriate, healthy, growthful self-standards which lead to positive self-esteem.

4. Appropriate means of coping with devaluation are deficient in adolescent children of alcoholics.

The fourth element necessary for positive self-esteem development is a healthy manner of dealing with devaluation, or attacks on the self-esteem (Coopersmith, 1967; Stanwyck, 1983; and Cotton, 1983). While most children learn ways of handling threats to their competence or worth by addressing them directly, children of alcoholics learn to cope from the example of their parents, namely, through denial. One of

the family rules, according to Black (1982), is "don't

talk." The children of alcoholics are taught to ignore the

problems caused by the alcoholic, and more generally, all

problems not easily resolved. The child whose alcoholic

parent blames him/her for causing the drinking, learns to

bury the devaluation rather than confronting it.

Givelber's (1981) third parenting task for positive

development of self-esteem in their child, "anxiety mastery"

involves the parent's capacity to teach the child that

anxiety can be tolerated. This presupposes that the parents

themselves can master their own anxiety. But as Deutsch

(1982) noted, the home environment of alcholic families is

dominated by insecurity and fear. Therefore, the parents

are unable to teach the child proper means of handling

anxiety and attacks on self-esteem.

For adolescent children of alcoholics, the negative

effects on self-esteem resulting from the inability to

handle devaluation, by parents or peers, is heightened by

the many changes typical to that developmental period. For

the child of an alcoholic parent, physical changes, such as

facial blemishes, may have far greater detrimental effects

on that individual's self-esteem than on the adolescent who

does not have an alcoholic parent.

General conclusions

In this section, those factors which have been found to

be important in the development of self-esteem, namely, the

esteem of others, feelings of competence, self-standards, and means of coping with devaluation, have been shown to be deficient in children of alcoholics by drawing on the literature regarding the home environment of children of alcoholics. The result of the deficiency in these self-esteem factors is lowered self-esteem. For adolescents, who are already experiencing threats to their self-esteem due to their stage of development, the deficiency in these factors due to living in an alcoholic home results in even lower self-esteem.

GROUP TREATMENT FOR ADOLESCENT

CHILDREN OF ALCOHOLICS

Need For Treatment

In Chapter 3, a review of the literature regarding the
problems of children of alcoholics, including the roles they
assume, revealed the damaging effects of living in an
alcoholic home. In sum, growing up in a home where there is
alcoholism disrupts and severely interferes with a child's
normal development. Particularly in adolescence, when a
host of changes occur, the child of an alcoholic parent does
not have the guidance and support of a normally functioning
adult. One most important negative effect of this is the
significant deterioration of self-esteem. It is also
estimated that 40 to 60 percent of children of alcoholics
become alcoholic themselves (Hindman, 1975). Cork (1969)
writes, "unless they get outside help, they would appear to
be among those most likely to misuse alcohol and become
dependent on it as adults" (p. 72). The need for treatment
for the children of alcoholics therefore, is clearly
evident. Jersild (1957) writes of the consequences of
children growing up without the adequate support and
affection of their parents or the positive interventions of
other adults. "The lot of adolescents who are unloved or
rejected by their parents is a hard one . . . Unless they

can find a substitute parent or crumbs of affection outside
the home . . . they will fail to grow normally through
adolescence into adulthood. They tend to develop symptoms
which may be severe enough to keep them at a preadolescent
level of behavior for the rest of their lives" (pp. 178-
179).

Unfortunately, according to Deutsch (1982), it is
estimated that no more than five percent of the
approximately 28 to 34 million children with parental
alcoholism receive any help in understanding and coping with
their problem. Therefore, "most children of alcoholics have
no one, least of all their parents and relatives, who help
them understand what is going on in the home, their own
powerful and frightening emotions, or their own and their
parents' inexplicable behavior" (p. 44). Only since the
publication of Margaret Cork's book The Forgotten Children
(1969) have the children of alcoholics received individual
treatment. Cork writes, "traditionally the alcoholic has
generally had to bear full blame for the disruption in his
(or her) family life, and most attempts to help the family
have bee concentrated on treatment of the drinking problem"
(p. 65). Yet Booz-Allen and Hamiltion (1974) found that the
treatment and recovery of the alcoholic parent did not
reduce the problems experienced by the children. The need
for treatment for the children of alcoholics, then,
regardless of whether or not the alcoholic parent receives

treatment, is essential for the physical and psychological

health and future growth of the child.

Group Treatment Over Individual Therapy

For the treatment of adolescent children of alcoholics,

the group format is preferred over individual therapy.

Deutsch (1982) writes, "for most children of alcoholics,

groups are the mode of choice; and peer-led groups should be

seriously considered for adolescents" (p. 27).

Group treatment over individual counseling provides

several advantages in the building of self-esteem of

adolescents. First, Yalom (1985) notes that the therapeutic

factor of universality, the sense that one's problems are

not entirely unique, is much more possible in group therapy.

He states that the most common secret of group members is a

deep conviction of basic inadequacy (low self-esteem). In

therapy groups the disconfirmation of a member's feelings of

uniqueness is a powerful source of relief. For children of

alcoholics the discovery that other children come from

inconsistent, unpredictable, and fearful homes enables them

to break down the family norm of denial and silence about

the alcoholism. Hawley and Brown (1981) add, "treatment

groups help reduce feelings of isolation and embarrassment;

therefore they can be used to establish and restore the peer

relationships . . . Groups lessen the stigma (of being from

an alcoholic home)" (p. 42).

Also, unlike in individual therapy, a group has the

possibility of providing the individual member with a
multiple number of responses besides the therapist's.
Consensual validation, or the agreement of many members in
the group, serves as a voice of authority far greater than
an individual therapist may provide. This is especially
true in when the other group members are often one's peers.
According to Yalom, members of a group may not be able to
differentiate objectionable aspects of their behavior from a
self-concept as a totally unacceptable person. The therapy
group, through consensual validation, makes such
discrimination possible.

   Ball and Meck (1979) believe group counseling in general
provides a preferred alternative to individual counseling of
adolescents. As adolescents strive for independence,
resisting conformity to authority figures, "young persons
are apt to be less threatened by authority figures when they
are in company with peers" (p. 530). Josselyn (1952) adds,
"the average adolescent can understand, accept, and
assimilate the teachings of his (or her) own peers with
greater facility than he (or she) can the teaching offered
by individuals from a more psychologically alien world" (p.
166). Ball and Meck argue that, "the group format provides
a setting which is conducive to socialization through peer
interaction" (531).

   Josselyn emphasizes the advantages of group treatment
for adolescents over individual therapy. "Although group

experience has value at any age, at adolescence, because of the responsiveness and the needs of the individual, it can be especially significant" (p. 166).

Kraft (1961) makes some additional arguments for the preference of group treatment over individual therapy. First, the adolescent is primarily peer-oriented and his/her adjustments emphasize peer problems. Group treatment with peers is often the device by which problems can be elucidated and worked out. Secondly, the adolescent needs to let out the explosive feelings that have been repressed and denied. This is difficult to do in individual therapy with its threatening adolescent-adult configuration, while in a group situation it is quite feasible and acceptable. Third, there are several types of adolescent problems among children of alcoholics that are extremely difficult to diagnose. By placing these children in a group, one can obtain observations over a period of time which may clarify the diagnosis. Finally, Kraft states that withdrawn adolescents may gain strength from the group vicariously. They can see themselves in contrast in a way that is not critical or belittling. In summary, the presence and interaction of peers seems to be a decided advantage in group treatment which cannot be matched by individual therapy.

Five Stages of Intervention

Charles Deutsch (1982) has outlined five stages of

systematic intervention for children of alcoholics. These

stages are: pre-identification, identification, referral and

intake, the group experience, and reinforcement and follow

up. Before any child can receive help through a group

treatment program, argues Deutsch, a pre-planned strategy

for identifying and reaching the children of alcoholics,

treating the children, and follow up must be established

within the community.

Pre-identification involves the building of a network

of professionals and non-professionals to identify children

of alcoholics. Since most children of alcoholics are

children whose parents are not in treatment, strategies must

be devised which will make it more likely that sizable

numbers of young people will identify themselves. Deutsch

emphasizes that children of alcoholics can receive

meaningful help whether or not their parents are in

treatment.

The second stage of intervention, identification, may

well be the most difficult. Deutsch writes, "the main

problem in working with this population is reaching (i.e.

identifying and maintaining contact with) the children.

Because of the family system of denial and, according to

Black (1981), the norm of "don't talk," children of

alcoholics are resistant to seeking or accepting help. They

feel ashamed of their families and are certain that no other

family is like their own. They have often been warned about

revealing the family secret, either explicitly or by the shame that surrounds the drinking. Deutsch also notes that "their own sense of loyalty is exaggerated by guilt, insecurity, and low self-esteem, resulting in their own need to deny the drinking they see" (p. 50). DiCicco (1984) gives further reasons for the adolescent's resistance to seeking help. First, the children want to avoid the stigma attached to having an alcoholic parent. Also, to the adolescent, seeking help may be perceived as juvenile and unsophisticated. DiCicco states, "attracting alcoholics to AA, and non-alcoholic spouses to Al-Anon, is easier than attracting teens to Alateen without strong parental support" (p. 46). Deutsch argues that reaching large numbers of the children most in need, therefore, depends upon a network of trained and motivated youth professionals providing attractive and easily accessible facilities.

Because of the resistance to treatment, the third stage of intervention, referral and intake, is critical in its appearance to the child. Deutsch writes, "before the treatment process can win them over, they must see enough in the program for themselves and enough to protect them from parents and friends, to give it a try" (p. 30). Services, therefore, must be carefully designed to maximize their accessibility, appeal, and security.

In the fourth stage of intervention, the actual group experience, "leaders work from detailed lesson plans with

activities designed to promote maximum participation and to
realize specific cognitive and affective objectives"
(Deutsch, p. 31).

The fifth stage of intervention is the reinforcement
and follow up once the group treatment has been completed.
Bi-monthly meetings, for example, as a means of continuing
support and evaluation of the treatment is an essential
process of encouraging the psychological growth of the child
as well as revising the treatment program.

While different group treatment programs for children
of alcoholics exist, such as Alateen, CASPAR, and family
therapy, the stages of intervention remain relatively the
same. Each program attempts to provide a short-term
educational and supportive treatment experience which may
lead to ongoing and more informal help and stimulate
important changes in feelings and behaviors.

Alateen

Deutsch (1982) argues that children of alcoholics
remain almost as neglected a population today as they were
ten or twenty years ago. Yet these children have developed
defenses, personality traits, and self-images based on
fallacious views of family alcoholism and their own
involvement in it. According to Deutsch, "they need to
learn a new perception of their experience and to try out
new ways of responding, both emotionally and behaviorally"
(p. 189). Alateen, one source of group treatment for

children of alcoholics, "can be enormously beneficial to those who attend regularly" (Deutsch, p. 44).

Alateen, according to the Al-Anon Family Group Headquarters (1973), is part of Al-Anon Family Groups. It is a self-help organization for young people, most of them teenagers, who are close to an alcoholic. The alcoholic may be a sibling, other relative, or close friend, but is most often a parent. The first Alateen group began in 1957. Since then, this treatment form has spread worldwide totalling more than 3,000 groups.

The presupposition of Alateen is that the alcoholic parent(s)' drinking is separate from and beyond the control of either the non-alcoholic parent or the child. The only recourse for the family is to understand their own feelings and reactions and learn new ways of living with a persona they can accept or reject but cannot control.

The structure and format for Alateen meetings is relatively simple. Each group is required to have an adult sponsor who is an active member in Al-Anon, the support group for adults effected by another's alcoholism. The sponsor's role, however, is one of guidance and support, not direction. Each meeting has a teen leader who opens the meeting, introduces the evening's theme or topic, and closes the meeting. The topics for discussion are drawn from the Twelve Steps, Twelve Traditions, and Slogans which are the basis of the recovery process used by Alcoholics Anonymous

(See appendices A, B, C). Lawrence, in Al-Anon Faces
Alcoholism (1977) reports that children of alcoholics "meet
other children who have endured similar feelings of
rejection. They share experiences, solve mutual problems,
assist each other in being the fine young people they want
to be and most certainly can be" (pp. 62-63).

The goals of Alateen are to educate, enlighten, and
foster change in the adolescent's life. Education involves
learning the disease concept of alcoholism. Lawrence (1977)
writes, "ninety percent of those who come to Alateen learn
for the first time, as a complete revelation, that
alcoholism is a disease" (p. 62). Adolescent children of
alcoholics are taught effective means of coping in their
chaotic home environment. Secondly, Alateen members are
enlightened to the fact that they possess faults and
failings which may or may not come from living with an
alcoholic. Through learning and practicing the principles
taught in the Twelve Steps, Twelve Traditions, and Slogans,
adolescent children of alcoholics come to accept their
weaknesses as part of being human. The third goal of
Alateen is to foster a determination to improve one's
teenage years by "a more sympathetic understanding of
others, the elimination of personal imperfections, and a
greater cooperation with God's grace" (Lawrence, p. 57).

Two studies have examined the effect of Alateen on the
self-esteem of adolescent children of alcoholics. Hughes

(1977) compared the self-esteem of adolescent children of
alcoholics in Alateen, adolescent children of alcoholics not
in Alateen, and adolescents whose parents were not
alcoholic. Self-esteem in adolescent children of
alcoholics, in or out of Alateen, was significantly lower
than those children whose parents were not alcoholic.
Hughes also found that the self-esteem of adolescent
children of alcoholics not in Alateen was significantly
lower than those adolescent children of alcoholics in
Alateen. In an identical study, Woititz (1976) found
similar results except for the comparison of self-esteem
between those children of alcoholics in Alateen versus those
not in Alateen. Her findings revealed that children of
alcoholics in Alateen had lower self-esteem scores than
children of alcoholics not in treatment. Woititz explains
this seemingly apparent discrepancy. "This researcher
suggests that the non-Alateen group scores were
significantly higher than the Alateen group scores because
the non-Alateen children are still in the process of denial"
(p. 66). Those seeking help in Alateen, suggests Woititz,
are at a stage in which the individual can no longer
maintain the defense of denial and feels he/she can no
longer deal with the problems alone.

Lawrence's (1977) statement summarizes the benefits of
Alateen. "Voiced, analyzed, and discussed, even with young
people their own age, they provide valuable therapy in

eliminating these mental and emotional difficulties" (p. 64). Deutsch (1982) concludes, "when new ways (of perceiving their experience) prove more satisfying many children of alcoholics can internalize what they have learned and achieve lasting, remarkable changes" (p. 189).

Group Treatment Programs

While Alateen is the most popular and accessible means of treatment for children of alcoholics, other group treatment programs exist for adolescents which may produce even more positive results. Three models of group treatment will be reviewed: Peitler's (1980) group counseling, which is compared to the effectiveness of Alateen on the psychological factors of self-worth, withdrawal tendencies, and social tendencies; the Cambridge and Sommerville Program of Alcoholism Rehabilitation (CASPAR); and a third model proposed by Hawley and Brown (1981).

Peitler's (1980) group counseling: Peitler's group consisted of twelve adolescent males, ages fourteen through sixteen, who were sons of alcoholic fathers. The group met for twenty sessions, ninety minutes per week. The group was led by a male graduate student in counseling who was also on the staff of the Psychology Department in a private psychiatric hospital. The purposes of the group included: 1) education about the disease of alcoholism; 2) emotional support in coping with various aspects of paternal alcoholism; 3) increased personal understanding and; 4) an

opportunity to discuss openly in a secure environment concerns of a personal nature (pp. 13-14).

Peitler's study examined two hypotheses. First, adolescent sons of male alcoholics who participate in group counseling will show significantly greater increases in feelings of self-worth (self-esteem) and reduction in withdrawal and antisocial tendencies than those who participate in an Alateen group. Second, Peitler's group counseling will prove significantly more beneficial for adolescent sons whose fathers were alcoholic during the child's earlier developmental years than will Alateen for the same population.

Peitler's findings support the hypotheses. While Alateen can have significant gains over no treatment at all, Peitler's group counseling was significantly more effective than Alateen at ameliorating adjustment patterns. Also, the age of the child at the onset of the father's alcoholism is a significant factor when considering the effectiveness of various treatment programs for this population.

The Cambridge and Sommerville Program for Alcoholism Rehabilitation (CASPAR): CASPAR provides alcohol education and support groups for children from alcoholic families. It is the first of such a group to be funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

The central goal of CASPAR is to break the passing of alcoholism from generation to generation through the

promotion of responsible decision making about drinking.
Deutsch (1982) writes, "make alcohol education available,
appealing, and non-moralizing and persons who live with
alcohol abuse will identify themselves and ask for help" (p.
167).

The CASPAR model follows Deutsch's five stages of
systematic intervention for children of alcoholics (see page
72). The pre-identification stage in the CASPAR model
involves the training of teachers, youth professionals, and
peer leaders and the implementation of alcohol education
activities in the classroom and community.

As it has been previously stated, the identification of
children of alcoholics is very difficult because of the
child's denial of the family problem as well as the family
norm to maintain silence. The CASPAR program, claims
Deutsch, makes it easier for these children to ask for help.
This is possible for two reasons. First, those students who
choose to enter the program are paid for their
participation. Their time at the treatment center is
interpreted to their parents, by the child, as their "job."
Secondly, because of the popularity of the program, students
felt less stigmatized and thus less inhibited to enter the
program.

The referral and intake procedure required the
assistance of the teachers and counselors from those schools
participating in the program. Any student identified by a

teacher or counselor was recommended to obtain information from the CASPAR center. There, detailed information was administered and if the student was interested, he/she would be assigned to a group.

The fourth stage of intervention, the actual group experience, held five major objectives: 1) helping children learn a new way of understanding family alcoholism; 2) helping children evaluate, practice, and reinforce constructive coping options. Ackerman (1983) recommends that children be helped to separate their powerlessness over their parent's drinking from their perceived powerlessness over all of life; 3) helping children feel better about themselves; 4) helping members clarify attitudes about drinking; and 5) increase children's receptivity to future help, including openness to friendship (p. 31).

The groups consisted of 6 to 12 members with two peer leaders as facilitators. The groups met for 10 to 12 sessions, two hours for each session. The peer leaders used detailed lesson plans with activities to encourage group participation. At the end of each session, participants wrote in journals whatever they felt they had learned or wished to express. These journals were given to the CASPAR leaders which were used for evaluation and as a means of preparing for the proceeding session. The final session was a full day retreat of learning and recreation and social bonding.

Reinforcement and follow up was maintained for six months through contacts by the peer leaders. Participants were encouraged to join Alateen or Al-Anon groups.

The essential elements of the CASPAR model include:

1) solid community support; 2) systematic repeated student-centered alcohol education directed toward all children; 3) a network of youth professionals, trained in identifying and intervening with children of alcoholics; 4) a treatment resource accessible to children without requiring parental assistance; 5) incentives and protection for the children who participate and; 6) a major intervention and treatment role for trained peer leaders.

Davis (1983) evaluated the impact of the CASPAR program for children of alcoholics on their self-esteem. Her study included 255 seventh to tenth graders, 75 of which were participants in CASPAR. All subjects were administered a coded, anonymous, pretest/posttest questionnaire. Self-esteem was assessed through the use of the Rosenberg Self-Esteem Scale (1965) and the Coopersmith Self-Esteem Inventory (1967). Davis' findings revealed that adolescents from alcoholic families scored lower in self-esteem than adolescents from non-alcoholic families. However, no significant differences were found for CASPAR group subjects after participating in the group treatment.

Hawley and Brown's (1981) group treatment model: Hawley and Brown cite two problems with the Alateen treatment approach. Though it is designed to help adolescents learn about alcoholism and how to live with it, "it is not available to children under eleven and has uneven

adult leadership" (p. 41). The authors, therefore, provide a model of group treatment for both latency age (6-12 years old) and adolescent (12-17 years old) children of alcoholics. Each group was led by a woman and a man.

The groups consisted of eight to twelve boys and girls ranging from relatively disturbed to more neurotic. Duration of the groups was both short- and long-term, ranging from twelve to sixteen weeks to the length of the school year.

Referrals to the group came from the alcoholic program for which the authors worked, from hospital staff, school nurses, and counselors. All group sessions were held in a local hospital, school, or community center.

The sessions for the children lasted approximately one hour. The format for the adolescent groups involved an educational activity format in which basic words and concepts related to alcoholism were taught. Also, the adolescents were encouraged to relate what had happened during the week or to discuss what they would like to do in the group that day.

An essential element of Hawley and Brown's program is the participation of the parents. Regular meetings of the parents were held every four to six weeks. During these sessions, parents could express their own feelings and concerns, stay informed of their child's progress in the group, and receive help and support with parenting skills.

The therapists established physical and verbal limits to alcoholic parental behavior that the children were taught to reinforce.

Periodically, both children and parents were brought together to practice more open communication and healthy family interaction. Some parents who had not been in treatment before this program began to seek additional help for themselves.

The role of the therapists was to combine their knowledge of alcoholism, group therapy, and child development. Hawley and Brown write, "(the therapists) intervened by supporting individuals and the group process, confronting members, setting limits, clarifying goals, and selectively interpreting the behavior of children or of situations they brought to the group" (p. 43). Hawley and Brown list several benefits from their model of treatment. First, in learning that alcoholism is an illness, the child begins to understand the confusing, often traumatizing, emotional experience. Relabeling the parent's behavior helps the child feel less out of control. Secondly, the realization that the parent's illness is not caused by the child reduces anxiety, anger, guilt, and improves the child's reality testing. Third, the groups offered more adaptive ways to deal with the harsh realities in their lives. The group offered the children a forum in which to ventilate their feelings and identify with other children.

Finally, the group program provides a means of preventing future alcoholism by teaching the concept of responsible drinking.

No studies exist which examine the effectiveness of Hawley and Brown's group treatment model, particularly in relation to the improvement in self-esteem in the adolescent children.

Family Therapy

Lawson, Peterson, and Lawson (1983) argue that the best way to help children of alcoholics is to improve the functioning of the nuclear family. "Improvement in family communication patterns, rebuilding of marital and parental relationships, reestablishment of trust and respect, and facilitation of emotional contact will change the environment that is damaging to children" (p. 185) Family therapy, writes Deutsch (1982) "requires all family members to say and hear painful things about one another" (p. 159). While family therapy may be the best mode of treating the problems experienced by children of alcoholics, restricting therapy only to family therapy, according to Cork (1969) "would result in the failure to treat ninety percent of the children who have really severe problems" (p. 89). Deutsch agrees, adding, "in the majority of alcoholic families, family treatment is possible only after one or more members have received substantial prior help and pushed other members toward joint treatment" (p. 159).

While the situation for most children of alcoholics is not conducive to receiving family therapy, the Children from Alcoholic Families (CAF) program is a model of family treatment for those families who are capable of receiving help. It was created to prevent alcoholism by interrupting the intergenerational processes of alcoholism.

The CAF program has five components: intake, parent's, children's, family, and aftercare. The intake component involves the screening and evaluating of families to determine family goals, degree of risk, and specific areas of need. At the intake, children are referred to an age-appropriate group, while parents are assigned to a parents' group. A therapist is assigned to the family. The groups are closed and time limited to six weeks. Family therapy occurs once a week in addition to the groups. Though preferred, the alcoholic parent is not required for the family to be accepted for treatment.

In the parent's component, the group provides a forum for discussion of prevention strategies, role behaviors, family systems, and parenting education. "Parents become more aware of the model they are setting for their children, and they talk about appropriate and inappropriate drinking with their children" (p. 186). If the alcoholic parent does not attend, the non-alcoholic spouse receives help in improving the family environment and in changing the family system.

The children's component provides alcohol education, socialization, and treatment for emotional and behavioral problems through a peer group modality. The goals for the children's component are:

> 1) to let the children know that they are not alone (universality); 2) to inform them that it is not their fault that their parents are alcoholics; 3) to teach the children about the nature of addictions and the difficulty their parents have in achieving and maintaining sobriety; 4) to reassure them that alcoholism is treatable; 5) to help them learn about themselves and take care of themselves; 6) to allow for expression of positive and negative feelings; 7) to foster improved peer relationship skills; 8) to teach problem-solving techniques; and 9) to evaluate the level of coping skills, social skills, and overall function in conjunction with the family (pp. 188-189).

In sum, the focus of the children's component is to increase the coping skills of the children, give them competence, and improve their self-esteem.

The goal of the family component is "to allow the family to view the effects of alcoholism on each member and the system as a whole" (p. 189). With help from the therapist, the family moves toward healthy interaction. The family moves from secrets and limited intimacy, and hidden rules in which only performance has value, to a healthier family system. The family therapy improves the communication skills, enhances family relationships, and increases problem-solving abilities.

Finally, the aftercare component involves the assessment of each family member at the conclusion of the six week family therapy. Referrals to self-help groups, or

other treatment programs are made on the basis of the assessment.

No studies exist which assess the effectiveness of the Children from Alcoholic Families program, particularly in regards to the improvement of self-esteem in adolescent children.

Summary

In this chapter, the need for an effective, systematic group treatment program for adolescent children of alcoholics has been documented through a review of the literature. Deutsch's (1982) stages of intervention provide those elements which should be included in any group treatment program for adolescent children of alcoholics.

A review of the literature examined the different group treatment programs, presently available, for the treatment of adolescent children of alcoholics. The first program reviewed, Alateen, is the most popular and accessible treatment program for this population. It's effectiveness, however, in terms of improvement in self-esteem of the participants, has been supported by one study (Hughes, 1977), but refuted by another (Woititz, 1976). Three other group treatment programs were reviewed: Peitler's group counseling, CASPAR, and a model proposed by Hawley and Brown (1981). These programs, however, have not been substantiated by other studies as to their effectiveness in increasing the self-esteem of the participants. Finally,

one model of family therapy, the Children from Alcoholic
Families, was reviewed. While some authors claim that
family therapy is the best treatment mode for this
population, others argue that it does not reach the vast
majority of children of alcoholics whose parents are not
seeking help.

CHAPTER V

SUMMARY AND CONCLUSION

This thesis has attempted to provide a review and
synthesis of the literature regarding the self-esteem in
adolescent children of alcoholics and the prevailing group
treatment programs available for this population. This was
achieved in three parts. First, a review of the literature
was provided on the psychological construct self-esteem, its
definition, description, and development. Also, the
adolescent stage of development was defined. Second, the
literature was reviewed concerning the nature and problems
of adolescent children of alcoholics. The home environment,
problems, and roles of children of alcoholics were examined
for the purpose of examining the effects on adolescents'
self-esteem. Third, several group treatment programs for
adolescent children of alcoholics were reviewed as potential
ways of improving the self-esteem of the participants.
Those programs reviewed included Alateen, Peitler's (1980)
group counseling, the Cambridge and Sommerville Program for
Alcohol Rehabilitation (CASPAR), Hawley and Brown's (1981)
group treatment model, and the Children from Alcoholic
Families program.

The psychological construct of self-esteem has been
confused in the literature with that of self-concept. Blyth
and Traeger (1983) make the distinction that while self-

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concept encompasses the total "picture" one has of
him/herself, self-esteem involves the evaluation of good or
bad about oneself. Coopersmith's (1967) definition of self-
esteem seems to be the most agreed upon by recent
researchers of the topic. Coopersmith writes, "Self-esteem
is the evaluation which an individual makes and customarily
maintains with regard to himself; it expresses an attitude
of approval or disproval (sic), and indicates the extent to
which the individual believes himself to be capable,
significant, successful, and worthy" (p. 4-5).

Stanwyck (1983), Coopersmith (1967), and Cotton (1983)
cite major factors in the development of self-esteem. These
factors are 1) the esteem from significant others; 2)
feelings of competence; 3) self-standards and; 4) the means
of coping with devaluation. Cotton has described the
development of self-esteem using Erikson's stages of
psychosocial development, stating that any failure to
successfully pass from one psychosocial stage to the next
results in hinderance to the development of self-esteem.

The period of adolescence, defined as the period of
development beginning with the onset of puberty and ending
at an ill-defined time when the individual achieves
independence and social productivity, is a time of many
changes which effect the self-esteem in the individual. The
changes in this period of development effecting self-esteem
include changes in physiology and greater cognitive

abilities. Also, the period of adolescence brings a change in emphasis of importance of significant others from parents to peers. Finally, the change from elementary to secondary schools can effect the self-esteem in an individual.

The parenting provided plays a crucial role in the development of self-esteem. Givelber (1981) cites five parenting tasks which are essential for positive self-esteem development in their child. These tasks are: 1) "good enough" mothering; 2) separateness; 3) the teaching of anxiety mastery; 4) mirroring of affect and achievement and; 5) the promotion of growth and maturation. Givelber states that if the parenting tasks are successfully completed, the child will more likely develop a positive sense of self-worth and capability.

Deutsch (1982) describes six characteristics typically found in the alcoholic home which are not generally found in functional, non-alcoholic homes and thus diminish self-esteem in the children. These characteristics are: 1) the centrality of the alcoholic and alcohol related behavior; 2) denial and shame; 3) inconsistency; 4) insecurity and fear; 5) anger and hatred; and 6) guilt and blame.

The parenting provided by alcoholics with these characteristics, as well as the non-alcoholic spouses, may negatively effect the self-esteem development in their children. Hence, children of alcoholics, according to the literature, often experience emotional and psychological

problems and adjustment difficulties.

Although the degree of severity of problems experienced by the children of alcoholics resulting from living in the alcoholic home environment depends on such factors as the age of the child at the onset of the parent's drinking and the coping resources available to the child, the psychological damage is often quite severe. Brooks (1982) study of the psychosocial development of adult children of alcoholics found that most suffer in their personality development as a result of their parent's alcoholism. Children of alcoholics tend to have poorer coping behaviors than children who are not from alcoholic homes. Other problems experienced by most children of alcoholics include decreased school performance, greater trouble with the law, and more difficulty in developing and maintaining social relationships. Finally, it is estimated that between forty and sixty percent of all children of alcoholics become alcoholic themselves.

Wegscheider (1981) has discovered that children of alcoholics characteristically portray one of four roles as means of coping with the chaotic, unpredictable home environment. These roles are: 1) the "hero;" 2) the "scapegoat;" 3) the "lost child" and; 4) the "mascot." Each role has advantages and disadvantages and has as its ultimate, but futile, goal of getting the alcoholic parent to cease drinking. The "hero" takes on the responsibilities

that the alcoholic parent has neglected. The "hero" is
praised for his/her perceived maturity and achievements yet
suffers from perfectionism and overachievement.
The "scapegoat" distracts the family and others from the
parent's alcoholism by drawing attention to his/her own
problems. The inner conviction of the "scapegoat" is that
if he/she can cause enough trouble the alcoholic will be
forced to stop drinking in order to save the child.
Unfortunately, this ideal is rarely realized. The "lost
child" avoids confrontation at all costs. If he/she can
keep from causing the alcoholic any trouble, it is believed,
then perhaps the parent will not need to drink. This too is
a faulty belief that results in frustration and
hopelessness. The "lost child" is the most difficult of the
children of alcoholics to identify. (Finally,) the "mascot"
serves the family's purpose by distracting the family of the
alcoholism through fun and humor. The "mascot" becomes
constantly attuned to stress and conflict and feels an
obligation to solve any problems.

Black (1981) has described four patterns of role
behavior which parallel Wegscheider's. These roles are:
"responsible," "adjuster," "placater," and "acting out."
While children of alcoholics can be generally identified
according to a specific role behavior, they have blends of
other roles as well. Although the roles help the child cope
with the inconsistent alcoholic home environment, they

become rigid, hindering the development of new roles that meet their growing and changing needs.

The central issue addressed in this thesis has been the problem of low self-esteem in adolescent children of alcoholics. Three studies reviewed, Huber (1985), Davis (1983), and Woititz (1976) established the fact that children from alcoholic homes have significantly lower self-esteem than children not from alcoholic families.

A synthesis of the literature on the four essential elements of positive self-esteem development and the problems experienced by adolescent children of alcoholics examined how self-esteem is hindered in children as a result of living in an alcoholic home environment. In summary, adolescent children of alcoholics are very prone to suffering from lack of self-esteem from significant others, namely, their parents, as a result of inconsistent attention and affection from the parents. Secondly, children of alcoholics often suffer in self-esteem as a result of heightened feelings of incompetence and experiences of failure rather than success. Third, these children tend to hold inappropriate self-standards which negatively effect their self-esteem. Because of inconsistency in the home, among other factors, the child either sets unrealistically high expectations for him/herself, or just the opposite, reject all values and standards. Finally, adolescent children of alcoholics may

learn inappropriate coping mechanisms from their parents, such as denial and projection. These means of handling devaluation, however, do not adequately protect the ego from confrontations from others or the self and lead to a diminishing of the self-esteem. Further, for adolescents, who are already experiencing challenges to their self-esteem due to their stage of development, the deficiency in appropriate parenting as a result of living in an alcoholic home results in even lower self-esteem.

While the need for treatment for this population is clearly evident, especially in terms of poor self-esteem, it is estimated that only five percent of all children of alcoholics receive any structured help (Deutsch, 1982). The literature suggests that because of the importance of peer relationships the most effective mode of treating adolescent children of alcoholics is group treatment rather than individual therapy.

Deutsch (1982) suggests that any group treatment program should consist of five stages of systematic intervention. These stages are: pre-identification, identification, referral and intake, the group experience, and reinforcement and follow up. Any treatment program depends upon the financial and personal support of the community.

Several group treatment programs were reviewed. Alateen, the most popular and accessible, is based upon the

Twelve Steps, Twelve Traditions, and Slogans developed by Alcoholics Anonymous. The goals of Alateen are to educate, enlighten and foster change in the adolescent's life. Reviews differ, however, on the effectiveness of Alateen on the improvement of self-esteem in the participants.

Three other group treatment programs for children of alcoholics besides Alateen were also reviewed. The first, Peitler's (1980) group counseling was reported to be more effective than Alateen in ameliorating adjustment problems. The second program, the Cambridge and Sommerville Program for Alcohol Rehabilitation (CASPAR) follows Deutsch's stages of systematic intervention with the goal of breaking the pattern of passing alcoholism from one generation to the next. Davis' (1983) study of the CASPAR program found that no significant differences in levels of self-esteem existed after the participants had completed the program. Finally, Hawley and Brown's (1981) model of group treatment for children of alcoholics included groups for both children and parents, regardless of the alcoholic's participation. No studies exist which examine the effectiveness of Hawley and Brown's group treatment model, particularly in relation to the improvement in self-esteem in the adolescent children.

One model of family therapy reviewed, the Children from Alcoholic Families, is similar to Hawley and Brown's model, yet expands the model by including a component of family

therapy. Although family therapy may be the ideal mode of treating children of alcoholics, only a few families are in a situation in which to receive this help. No studies exist which assess the effectiveness of the Children from Alcoholic Families program in regards to the improvement of self-esteem in adolescent children.

Recommendations for Practicioners

There are several recommendations for group treatment of adolescent children of alcoholics that can be made as a result of this review of the literature. First, the importance of peer relationships during the developmental stage of adolescence strongly suggests that group treatment, with peer leaders, is to be preferred over individual therapy. Second, this review of the literature has established that the self-esteem in this population is significantly lower than most adolescents who are not from alcoholic homes. Therefore, group treatment programs should have, as one of their primary goals, activities which promote the improvement of self-esteem in their participants. Third, since adolescent children of alcoholics take on rigid, inflexible roles as a means of coping with their unpredictable home environment, group treatment programs should address the disadvantages of the participants' role behaviors and assist them in developing a variety of responses to life situations. Fourth, it is recommended that a network of youth professionals be

established in communities to help in the identification,
education, and treatment of this population.

Recommendations for Future Research

Further research questions evolve from this review of
the literature. First, Huber (1984) found that a great
majority of children of alcoholics are from single-parent
families as well. Do children of alcoholics from single-
parent families have lower self-esteem than children of
alcoholics from intact families? Particular problems for
these children resulting from living with only one parent
should be addressed in research and group treatment
programs.

Second, Peitler (1980) studied the impact on the self-
esteem of adolescent sons of alcoholic fathers. A
comparison study is warranted that would examine any
differences in self-esteem between those children of
alcoholics whose father is alcoholic versus those whose
mother is the alcoholic. Also, the differences between male
and female children of alcoholics in terms of self-esteem
could be examined. Another related research question should
involve the differences in self-esteem between those
children who have one alcoholic parent versus those whose
parents are both alcoholic.

A third area of research to be investigated concerns
the roles of children of alcoholics. Is any one of the
roles assumed by children of alcoholics, as described by

Wegscheider (1981), more likely than the others to lead the adolescent to become alcoholic? Group treatment programs should pay particular attention to the differing problems and needs resulting from the different roles of children of alcoholics.

Fourth, Woititz (1976) has outlined twenty-six common characteristics found among adult children of alcoholics (See Appendix D). Researchers should investigate the similarities and differences between adult children of alcoholics and adolescent children of alcoholics.

And finally, further research is needed to establish which treatment programs are the most effective in improving the self-esteem of their participants. Longitudinal studies are recommended in order to establish long-term influences of treatment.

Conclusion

It has been established that positive self-esteem is necessary for normal, healthy personality development and psychological well-being. The experience of children growing up in an alcoholic home, however, differs from that of children from non-alcoholic homes. The experience often disrupts and severely interferes with a child's normal development, impeding the positive development of self-esteem. The developmental stage of adolescence is a time of many changes which challenge the self-esteem of children from alcoholic and non-alcoholic families alike. But for

adolescent children of alcoholics self-esteem may be critically low, effecting the child's schoolwork, peer and parent relationships, health, and future development.

Varying group treatments for this population are available. No conclusions can be made at this point as to which treatment program is to be preferred over another. However, it is recommended that any treatment program include a systematic approach to improving the self-esteem of the participants. Finally, it is hoped that the professional community, as well as the general public, will take an even greater interest in these still "forgotten children" and move to provide more effective and easily accessible treatment.

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APPENDIX A

APPENDIX A

THE TWELVE STEPS[1]

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong, promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to others and to practice these principles in all our affairs.

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[1] Al-Anon Family Group Headquarters, Inc. 1969.

APPENDIX B

APPENDIX B

THE TWELVE TRADITIONS OF ALATEEN[1]

1. Our common welfare should come first; personal progress
    for the greatest number depends upon unity.

2. For our group purposes there is but one authority--a
    loving God as He may express Himself in our group
    conscience. Our leaders are but trusted servants; they
    do not govern.

3. The only requirement for membership is that there be a
    problem of alcoholism in a relative or friend. The
    teenage relatives of alcoholics when gathered together
    for mutual aid, may call themselves an Alateen Group
    provided that, as a group, they have no other
    affiliation.

4. Each group should be autonomous, except in matters
    affecting other Alateen and Al-Anon Family Groups or AA
    as a whole.

5. Each Alateen Group has but one purpose: to help other
    teenagers of alcoholics. We do this by practicing the
    Twelve Steps of AA ourselves and by encouraging and
    understanding the members of our immediate families.

6. Alateens, being part of Al-Anon Family Groups, ought
    never endorse, finance or lend our name to any outside
    enterprise, lest problems of money, property and
    prestige divert us from our primary spiritual aim.
    Although a separate entity, we should always cooperate
    with Alcoholics Anonymous.

7. Every group ought to be fully self-supporting, declining
    outside contributions.

8. Alateen 12th-Step work should remain forever
    nonprofessional, but our service centers may employ
    special workers.

9. Our groups, as such, ought never be organinzed; but we

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[1] Al-Anon Family Group Headquarters, Inc. 1969.

may create service boards or committees directly
responsible to those they serve.

10. The Alateen Groups have no opinion on outside issues;
    hence our name ought never be drawn into public
    controversy.

11. Our public relations policy is based on attraction
    rather than promotion; we need always maintain personal
    anonymity at the level of press, radio, TV, and films.
    We need guard with special care the anonymity of all AA
    members.

12. Anonymity is the spiritual foundation of all our
    Traditions, ever reminding us to place principles above
    personalities.

APPENDIX C

APPENDIX C

ALATEEN SLOGANS[1]

1. Easy Does It.

2. First Things First.

3. Let Go and Let God.

4. Live and Let Live.

5. Think.

6. One Day at a Time.

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[1] Al-Anon Family Group Headquarters, Inc. 1969.

APPENDIX D

APPENDIX D

COMMON CHARACTERISTICS OF

ADULT CHILDREN OF ALCOHOLICS[1]

1. We become isolated and afraid of people and authority
    figures.

2. We become approval seekers and lose our identity in the
    process.

3. We are frightened by angry people and any personal
    criticism.

4. We either become alcoholics, marry them, or both or find
    another compulsive personality to fulfill our sick
    abandonment needs.

5. We live life from the viewpoint of victims and are
    attracted by that weakness in our love, friendship and
    career relationships.

6. We have an overdeveloped sense of responsibility and it
    is easier for us to be concerned with others rather than
    ourselves; this enables us not to look too closely at
    our faults or our responsibility to ourselves.

7. We get guilt feelings when we stand up for ourselves
    instead of giving in to others.

8. We are addicted to excitement.

9. We confuse love and pity and tend to "love" people we
    can pity and rescue.

10. We have stuffed our feelings from our traumatic
    childhoods and have lost the ability to feel or express
    our feelings because it hurts so much. This includes
    our good feelings such as joy and happiness. Our being
    out of touch with our feelings is one of our basic

[1]Wegscheider, S. (1981). Another Chance. Palo Alto, CA.
ience and Behavrion Books, Inc.

denials.

11. We judge ourselves harshly and have a very low sense of self-esteem.

12. We are dependent personalities who are terrified of abandonment and will do anything to hold onto a relationship in order not to experience painful abandonment feelings which we received from living with sick people who were never there emotionally for us.

13. Alcoholism is a family disease and we became para-alcoholics and took on the characteristics of that disease even though we did not pick up the drink.

14. We are reactors rather than actors.

15. We guess at what normal is.

16. We have difficulty following a project through from beginning to end.

17. We have difficulty having fun.

18. We have difficulty with intimate relationships.

19. We take ourselves very seriously.

20. We over react to changes over which we have no control.

21. We usually feel different from other people.

22. We are extremely loyal even in the face of evidence that the loyalty is undeserved.

23. We tend to lock ourselves in a course of action without giving serious consideration to alternative behaviors or possible consequences. This impulsivity leads to confusion, self-loathing, and loss of control of our environment. As a result, we spend more energy cleaning up the mess than we would have spent had the alternatives and consequences been examined in the first place.

24. We tend to look for immediate rather than deferred gratification.

25. We generally over-react out of fear.

26. We are either super responsible or super irresponsible.

This thesis submitted by Daniel T. Reim, S.J. has been read and approved by the following committee:

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

_____4/20/88_____   _Manuel S. Silverman____ Ph.D.
Date   Director's Signature