

1990

Relationships Between Gender and Activity Involvement and the Incidence of Behavioral Disorders in Children of Alcoholics

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RELATIONSHIPS BETWEEN GENDER AND ACTIVITY
INVOLVEMENT AND THE INCIDENCE OF BEHAVIORAL DISORDERS
IN CHILDREN OF ALCOHOLICS

By

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A THESIS

Submitted to

Grand Valley State University

in partial fulfillment of the requirements

for the degree of

MASTER OF SCIENCE IN NURSING

Kirkhof School of Nursing

1990

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ABSTRACT

RELATIONSHIPS BETWEEN GENDER AND ACTIVITY
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The purpose of this study was to identify relationships between behavioral disorders and gender of the child and gender of the alcoholic parent(s) and to investigate if positive involvement in activities outside the home decreases the number of behavioral disorders in children of alcoholics. This descriptive retrospective study used data collected from eighty-three questionnaires filled out by the parents. The data was analyzed with a two-way analysis of variance. No significance relationships were found regarding gender of the child and gender of the alcoholic parent(s). Children who were involved in outside activities had significantly fewer behavior disorders than those who were not ($t = -2.99$, $df = 81$, $p = .004$). Children who were involved in activities other than school had significantly more behavioral disorders compared to children involved in school activities or children involved in both ($F = 9.938$, $df = 2$, $p = .000$).

Dedication

To my loving husband, Michael.

Acknowledgments

This research project could not have been completed without the support and assistance of many people.

My sincere appreciation is extended to Mary Horan, Ph.D., R.N., for her expertise, guidance, and patience in assisting me through this study.

My thanks to Patricia Underwood, Ph.D., R.N. and Virginia Stamler, Ph.D. for their invaluable contributions.

My thanks to Cindy Coviak, M.S.N., R.N. for her unlimited assistance during the data analysis process.

My colleagues at Kirtland Community College with a special thanks to Katherine Grosser who provided an immense amount of support throughout this project.

My mother and my sister, Joan, for their endless words of encouragement.

My husband, Michael, for always supporting me in my educational endeavors.

Finally, to Amanda and Tommy, for understanding when this project demanded so much of my time.

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CHAPTER 1

INTRODUCTION

Introduction

Although accurate figures are unavailable, there are indications that children of alcoholics in the United States are an enormous group. According to the 1985 report (the most recent data) to the Children of Alcoholics Foundation, extrapolated from data from the National Drinking Practices Study (Clark and Midanik, 1982), there are 28,600,000 children of alcoholics in the United States (National Institute on Alcohol and Alcoholism, 1984). This figure represents one out of every eight Americans. Six and a half million are youngsters under the age of 18 years who daily face the fear, uncertainties and problems which result from parental alcohol abuse. Twenty-two million are adults who may well continue to suffer the long-lasting negative consequences caused by life in an alcoholic family.

Alcoholism is a family disease. Children of alcoholics are considered at high risk for developing alcohol-related problems (Bargar and Bingham, 1985). O'Gorman and Ross (1984), conducted a survey which

indicated a high correlation between involvement in the juvenile system and alcoholism in the families of those involved in that system. Bennett, Wolin, and Reiss (1988) examined three aspects of childhood functioning; cognitive, emotional, and behavioral. The families were, in general, moderately or well-educated professional and white-collar workers with above-average incomes. Sixty-four children from 37 families with an alcoholic parent were compared with 80 children from 45 families that did not have an alcoholic parent. Measures of intelligence, cognitive achievement, psychological and physical disorders, impulsivity-hyperactivity, social competence, learning problems, behavior problems, and self-esteem were compared. On nine of 17 tests, the children of alcoholic parents scored less well than did the children of nonalcoholic parents, although both were within normal ranges. The authors reported significant differences between the two samples in emotional functioning ($F = 5.79$, $df = 1, 126$, $p < 0.02$) and cognitive abilities ($F = 4.01$, $df = 1, 126$, $p < 0.05$). Marginally significant differences were found with respect to behavior problem ($F = 3.51$, $df = 1, 126$, $p < 0.07$).

Extensive interviews with 50 children of alcoholics uncovered a variety of family problems, feelings, and outcomes (National Institute on Alcohol and Alcoholism 1984). Some of these problems were child abuse and

neglect, hyperactivity, enuresis, behavior problems, suicide, and chemical dependency. There is adequate data to support the theory that presence of parental alcoholism introduces a serious deterrent to healthy child development.

Alcoholism is a family disease, and children of alcoholics are considered at high risk for developing behavioral disorders. The present study examined the relationship between gender and positive involvement in activities outside the home and the occurrence of behavioral disorders in children of alcoholics in treatment.

The primary purpose of this research was to determine if positive involvement in activities outside the home was associated with differences in the number of behavioral disorders. This information will assist nurses in assessment of protective factors that may affect a child's vulnerability to familial alcoholism and its related problems. A greater understanding of the variables that can have an impact on the child's psychosocial development will provide nurses with data they can utilize for early intervention and prevention programs to promote positive outcomes in children of alcoholics. Secondly, this data will provide nurses with information that will be valuable in providing care by identifying relationships between behavioral disorders and gender that will identify childhood risk factors for adult disorders.

CHAPTER 2 REVIEW OF THE LITERATURE AND THEORETICAL FRAMEWORK

Review of the Literature

Children of alcoholics are vulnerable to becoming alcoholics. Sons of alcoholic fathers are at four times greater risk of alcoholism than the general population. Daughters of alcoholic mothers are three times more likely to become future alcoholics than the general population, and more often marry alcoholic men. Women alcoholics are twice as likely as men alcoholics to have been reared by two alcoholic parents, and there is usually a higher rate of alcoholism in families of female alcoholics. All told, children of alcoholics are an immense but hidden group in the nation's population (Woodside, 1988).

While not all children of alcoholics grow up to become alcoholic, they are likely to have more physical, mental, and emotional problems than others. As youngsters, children of alcoholics usually feel guilty and responsible for their parents' alcoholism (Woodside, 1986). They do not know or believe that alcoholism is a disease which they cannot cause, control, or cure. Instead they assume responsibility for the parents' drinking. Children also

often feel invisible and unloved because all attention is focused on the alcoholic parent and the child's needs are neglected or ignored. Youngsters feel anxious and insecure due to the consistent inconsistencies in parental behavior, attitudes and rules which change according to the level of intoxication.

According to Bargar and Bingham (1985), in most well-functioning families, one finds affection, trust, and emotional expressions accepted and integrated along with understanding and support. Family members feel free to ask for attention, and give attention to others in return. In alcoholic homes, trust, affection, and sharing are scarce commodities, and emotions are often repressed and twisted.

Hindman (1977), studied 51 abused children. Thirty-five (69 percent) had a history of alcoholism or alcohol abuse in at least one parent. Of the 26 parents of these children, 24 (92 percent) reported that they had been abused by a parent who was alcoholic or abused alcohol. Black (1981) reported that 66 percent of children raised in alcoholic families have been physically abused, or have witnessed abuse of another family member. In more than one-third of these families, such abuse occurred on a regular basis. She stated both spouses and children of alcoholics and abusers tend to minimize the impact of the drinking and violence on the family. This is the family's denial process. Family members accept the blame because they believe that had they been better in their roles, (a

better wife, or a better child) the batterer/alcoholic would have no reason to get so upset, fly into rages and drink. The denial processes of not feeling, not trusting, and not talking permeate the family. Alcoholism, when coupled with violence, doubles the need for denial and creates an even greater sense of helplessness in the lives of family members.

Children of alcoholics may have cognitive and behavioral problems in school. According to Ackerman (1983), children of alcoholics need to be able to see themselves apart from alcoholism. Self-realization is closely associated with the idea of self-concept, the amount of belief in one's own abilities. Obviously, developing a positive self-concept can facilitate a child's achieving self-realization. Often a child may be so absorbed in his or her situation that little or no self-realization is developed. Individual family roles and achievements have been overshadowed by the presence of alcoholism.

Kandell (1990) examined young adults with a detailed drug history in a longitudinal cohort study which focused on childrearing practices. The results indicated poorer parenting with increasing drug involvement. Increasing lifetime or current drug involvement and heavy drinking in the last year were related to less supervision of the child, more punitive forms of discipline, less closeness,

less discussion, and less positive involvement with the child, as well as greater disagreement with the spouse about disciplining the child. Family disorganization, lack of parental monitoring and discipline, and the absence of well-defined rules are related to antisocial behavior in children.

An examination of the relationship between alcoholic fathering and youngsters' intellectual development revealed that children raised in alcoholic families had a mean IQ score seven points lower than youngsters raised by non-alcoholic fathers (Ervin, Little, Streissguth, & Beck, 1984). Marcus (1986) compared the academic achievement of 40 elementary school age children who had alcoholic mothers with a group of similar children who had nonalcoholic mothers. Unlike previous research, mothers of both groups were generally middle class and well educated. Furthermore, children were selected without any prior knowledge of emotional, behavioral, or academic disability. The results indicated that the elementary school aged children of predominantly middle-class alcoholic mothers performed less well on measures of academic achievement than did children not exposed to maternal alcoholism. The children were more often placed in special education classes.

Fine (1976) studied 39 children identified as a result of a parent being in treatment for alcoholism. The influence of parental alcoholism on the personalities of

the children was investigated by use of the Devereux Rating Scales which delineates problem behavior patterns. The findings suggest that the presence of parental alcoholism acts as a serious deterrent to healthy personality development in the children. It was suggested that the degree of disturbance in these individuals might be greater than previously suspected.

Plant, Orford, and Grant (1989), examined relevant epidemiologic evidence from several countries and found significant points of agreement. Problem drinking by a parent markedly increases health risks to children and adolescents. Such risks include diminished intellectual capacity and development, increased neuroticism, and a wide range of psychological and behavioral disorders.

Because the children are consumed by guilt and feel responsible for all their families' problems, yet are powerless to handle them, depression and suicide are common (Whitfield, 1979). Berkowitz and Perkins (1988), in a survey of 860 college freshmen and sophomores, late adolescents and young adults, compared those whose parents were alcoholic with peers whose families were not alcoholic. They found greater tension and need for social support in the offspring of alcoholic parents.

Tishler and McKenry (1982) studied the parents of 46 adolescent suicide attempters compared with adolescent nonattempters to determine differences in factors

descriptive of self image. Results indicated that the fathers of the attempters were significantly more depressed, had significantly lower self-esteem, and consumed significantly more alcohol than did fathers of nonattempters. Mothers of the adolescent attempters were significantly more anxious, experienced significantly greater suicidal ideation, and consumed significantly more alcohol than mothers of nonattempters.

Puig-Antich, Goetz, Davies, Kaplan, Ostrow, Asnis, Twomey, Iyengar, and Ryan (1989), examined prevalence rates of prepubertal major depressive disorder with controlled family histories and found that prepubertal onset of major depression may be especially likely in families with a high aggregation of affective disorders when these families have a high prevalence of alcoholism. A proportion of children without affective disorders but with separation anxiety disorder in this study were at high risk for the development of affective illness later in life. Major depressive disorders and other diagnoses (mostly anxiety) were found more commonly among female relatives, while antisocial personality, alcoholism, and substance abuse were more common in male relatives. All diagnoses were found to be more prevalent among first-degree than among second-degree relatives, independent of diagnostic category, even with the families of normal control probands. A conclusion of the study was that it is possible that the effects of living with an alcoholic

parent may precipitate very early depression in children with loaded familial tendencies for affective disorders.

Earls, Reich, Jung, and Cloniger (1988) studied the frequency of psychiatric disorders in children of alcoholic and antisocial parents. The sample for the study was drawn from three groups: hospitalized alcoholics, convicted felons, and hospitalized medical controls. The children of alcoholic parents were found to have a higher frequency of psychiatric disorders than children of nonalcoholic parents. The rate in children of two alcoholic parents was distinctly higher than in those of one alcoholic parent. Comparison were also made between children of antisocial parents (usually coexisting with alcoholism) and children of parents with alcoholism only. No significant differences in the rates of childhood disorder were found between these two groups. Burk and Sher (1990) investigated the possibility of negative stereotypes toward children of alcoholics emanating from peers. Five hundred and seventy high school students were asked to rate six separate roles (typical teenagers-male and female; teenagers with an alcoholic parent-male and female; and mentally ill teenagers -male and female) using 11 bipolar adjective pairs. Subjects rated children of alcoholics as significantly different overall from both "typical teenagers" and "mentally ill teenagers". When individual

nonsignificant differences occurred, children of alcoholics were more often grouped with mentally ill teenagers.

A study of 34 bulimia patients revealed there was a high incidence of alcoholism and weight problems. Seventeen (50%) indicated alcoholism in at least one first degree family member and seven reported that their fathers were alcoholic (Pyle, Mitchell, & Eckert, 1981). McGann (1989) explored the association between familial alcoholism and presence of certain conditions in nonalcoholic family members. Depression, obesity, functional bowel syndrome, asthma, trauma, and genitourinary problems were analyzed. The prevalence rates of the conditions of interest in the two groups were calculated and compared using the chi-square test for statistical significance. Significant differences in prevalence rates of depression and obesity were found. Trends were found for differing rates of functional bowel syndrome and asthma. No differences were found for trauma and genitourinary problems.

Only three published longitudinal studies have followed the offspring of alcoholics as well as control children coming from the same (low) socioeconomic background from childhood into young adulthood (Werner, 1986). Miller and Jang (1977) reported the findings of a long-term study of 259 children reared in lower class multiproblem families in Oakland, California. The sample consisted of 147 children who had an alcoholic parent and

112 who did not. The children were first seen in 1956 and followed up in 1976. Although parental alcoholism increased the problems of these already troubled children and the likelihood that they would grow up to have drinking problems themselves, it was not possible to predict the child's future adjustment solely on the basis of parental alcoholism. Among variables that moderated adult outcome were the gender of the child and of the alcoholic parent, the severity of family crises in (early) childhood, and the subject's own rating of self-esteem and psychological well being in young adulthood.

A Swedish study by Rydelius (1981) focused on the health and social adjustment of 229 children of alcoholic fathers and 163 control children in Stockholm. The offspring of alcoholic fathers already had a high incidence of health, learning and social problems when they were first studied at ages 4-12 in 1958. Twenty years later, in 1978, they continued to exhibit more physical illnesses, social problems and, among the males, both alcoholism and antisocial behavior. Sons of alcoholic fathers were found to be more vulnerable in young adulthood than daughters. Although both the boys and the girls showed symptoms of insecurity and learning problems in childhood, fewer of the girls developed serious mental health problems and asocial behavior in young adulthood, or misused drugs or alcohol.

Both the studies by Miller and Jang (1977) and Rydellius (1981), focused on the "cause and effect" associated with being reared by an alcoholic parent. An evaluation of the sources of strengths is also important. Werner (1986) focused on childhood characteristics and on the qualities of the caregiving environment that differentiated between offspring of alcoholics who did and those who did not develop serious coping problems by age 18. The 49 subjects were members of a multiracial cohort of 698 children born in 1955 on the island of Kauai, Hawaii, who were followed at ages 1,2,10 and 18. By age 10, nearly a third of the children were in need of long-term remedial education. The proportion of those in need of long-term mental health care was more than twice that of the offspring of nonalcoholic parents. By age 18, 30 percent of the youth had records of repeated or serious delinquencies. Twenty-five percent had serious mental health problems, a proportion nearly three times as high as that of the offspring of parents who were not alcoholics. Some 41 percent of the 49 offspring of the alcoholic parents had serious coping problems by age 18 that caused problems at home, in school, at work or in the community. While the risk of developing serious learning and behavior problems was considerably higher, approximately 59 percent of the 49 offspring of alcoholics had not developed such problems. Information from interviews with them and from their records in the community, indicated that this

"resilient" group managed to do well in school, at work and in their social life, and had realistic goals and expectations for the future. Nearly three-fourths of the resilient offspring of alcoholics were females; more than two-thirds of the group which developed psychosocial problems were males. More of the resilient children had received a great deal of attention from their primary caretakers during the first year of life (as judged by public health nurses and social workers who observed in the home) than did the children of alcoholic parents who later developed serious coping problems. Thus it was not solely the risk of parental alcoholism, but the balance between the risk factors, the accumulation of stressful life events and protective factors within the child and his caregiving environment that accounted for the range of adaptive and maladaptive outcomes observed among the offspring of alcoholics in this study. The study concluded that interventions on behalf of children of alcoholics may thus be conceived as an attempt to restore this balance, either by decreasing the exposure to the risk of parental alcoholism and associated problems (through family based treatment) or by increasing the number of protective factors (competencies, sources of support) that the children can draw upon in themselves and their caregiving environments (Werner, 1986).

These three longitudinal studies have the greatest impact on the proposed research questions. However, the three studies do have several limitations. Most of the studies are descriptive in nature. In the studies that had control groups, there was no acknowledgment of how the groups were constructed to control for contamination of children of alcoholics. Alcoholism is socially stigmatized and permeated by a family denial of the problem making it highly probable that children of alcoholics exist in the control group. All three studies were conducted utilizing a specific ethnic group, so the results can not be generalized to other populations. Families in all three studies experienced additional severe stressors imposed on the families due to chronic intense poverty. One study had a high attrition rate (Miller & Jang, 1977). There were problems in all the studies in controlling extraneous variables. For example, findings could be attributed to genetic factors, environmental factors or a combination of these, or to other unknown factors. Measurements were inadequate when considering the degree of alcoholism, identifying if the affected parent was the primary caretaker, and the degree to which the unaffected parent was impaired due to the spouse's alcohol misuse.

There was no documentation as to the degree of social support that was received by the children, which could dramatically affect the outcomes. Subjects in all of the studies had demonstrated other asocial behavior in addition

to the alcoholism which could account for the results obtained. In one of the studies (Rydellius, 1981) a tremendous amount of data may have been missed because of the way the dependent variable was measured (the measurement was obtained by checking the names of the sample against the Swedish Social Assistance Register, Criminal Offenses Register, and the Temperance Register).

When examining the effects of parental alcoholism on the child trapped in the environment, the researcher is faced with many obstacles. There are numerous ethical considerations in protecting the rights of the child and the family. It is difficult to identify children of alcoholics and to assure a control group not contaminated with children of alcoholics. Some researchers have not included control groups; others have selected control groups from clinical or potentially biased populations. The majority of the studies did not adequately define the concept alcoholism. Research has rarely controlled for size of family, spacing of children, or gender of siblings. Jacob, Seilhamer, and Rushe (1989) reported that the vast majority of work in this area has been based upon psychodynamic, individually oriented conceptual frameworks despite the repeatedly implied interest in interpersonal relationships. These obstacles may account for why there is such limited empirical evidence related to the incidence of behavioral disorders in children of alcoholics.

Theoretical Framework

Family

"Family" is defined here as a system of interacting individuals which differs from other social groups through its modes of communication, living, interaction, and cultural experiences. As a unit of society, the family influences social and moral values, and contributes to the emotional and psychological make-up of the individual (Mosser, 1971). Satir (1972) defined healthy families as untroubled and nurturing, with the following characteristics: "self-worth is high; communications are direct, clear, specific, and honest; rules are flexible, humane, appropriate, and subject to change; and the linkage to society is open and hopeful" (Satir, 1972, p. 8).

Families with dysfunctional communications are severely troubled. Friedman (1986) defines dysfunctional communication as "unclearly transmitted or received messages and/or messages with incongruent content and command aspects" (Friedman, 1986, p. 4). Conflicts are painful for the dysfunctional family. These families avoid direct communication. Self-centeredness, lack of empathy, and need for total agreement are family values that perpetuate the low esteem in members.

For the child raised in an alcoholic environment, dysfunctional communication predominates. Emotions are often not shared, and, unfortunately when they are

expressed, it is done in a judgmental manner placing blame on one another. While constructive alliances are part of the healthy family, adult members of an alcoholic family often lack alliance.. If alliances are demonstrated, they are destructive and usually consist of one parent and a child (or children) against the other parent (Black, 1981).

Alcoholic and co-alcoholic parenting consists of poor communication, permissiveness, undersocialization, broken promises and neglect. To compound these parenting patterns, alcoholic families frequently experience social alienation, divorce, separation, parental fighting, spouse abuse and economic setbacks (Scheitlin, 1990). Preli, Protinsky, and Cross (1990) explored the structural variables of boundaries (cohesion) and adaptability as manifested in families with an adult male alcoholic member and nonalcoholic families. The investigation revealed disturbed interactional boundaries and rigid or chaotic patterns of adaptability.

Developmental Tasks

The family is a system of interacting individuals, experiencing different tasks and resource needs according to its developmental stages. The developmental stages identified by Evelyn Duvall (1977) are used in this theoretical framework because they represent the physical, psychological, emotional, and interactional changes that occur in the family unit. Duvall described an eight stage

model that allows for greater differentiation of family changes over time and a closer analysis of the relationship between the family and the individual's developmental tasks. The theory delineates developmental tasks for the family much like the individual developmental tasks of Erikson (1980). Family developmental tasks differ from those of the individual family members. The family's tasks are met when the family works together as a unit to assist individual members in their developmental task accomplishments. These tasks include: 1) establishing an independent home; 2) establishing satisfactory ways of getting and spending money; 3) establishing mutually acceptable patterns in the division of labor; 4) establishing continuity of mutually satisfying sex relationships; 5) establishing an open system of intellectual and emotional communication; 6) establishing workable relationships with relatives; 7) establishing ways of interacting with associates and community organizations; 8) establishing competency in bearing and rearing children; and 9) establishing a workable philosophy of life. The tasks are defined as the growth responsibilities that arise at a specific stage in the life of the family. If they are successfully achieved, it will lead to satisfaction and success with later tasks, while failure leads to unhappiness (Friedman, 1986).

Although the family system as a whole is important, the family depends on the behavior of each individual

member. Achievement of family developmental tasks at each family life cycle is interrelated with the simultaneous accomplishment of the individual developmental task of each member (Duvall, 1977). A child's developmental task mastery, though dependent on biological potential and maturation, occurs due to characteristics of the child's primary care givers and his ability to meet Duvall's developmental tasks (Duvall, 1977). An assumption can be made that alcohol abuse by the child's primary care givers, can seriously impair the ability to meet Duvall's family developmental tasks; and thereby, impair the child's ability to meet individual tasks for healthy personality development.

Gender

The development of gender identity occurs through the socialization process. In addition to conscious efforts, the process includes role modeling, imitation of same-sex adults, and the influence of biologic differences (Losh-Hesslebart, 1987). Ackerman (1987) explored the relationship of gender implications and differences of effects in adult children of alcoholics. Five hundred adult children of alcoholics, and five hundred adults raised by non-alcoholic parents responded to a twenty-item Likert scale which measured attitudes of the most commonly agreed upon personality characteristics found in adult children of alcoholics. Daughters of alcoholics, with two

alcoholic parents scored highest on negative personality characteristics. The group demonstrating the next highest were daughters of alcoholic fathers, followed by those of alcoholic mothers. For sons of alcoholic parents, the negative characteristic scores were highest when the child had an alcoholic mother, second highest was two alcoholic parents, and the lowest scores were for sons who had an alcoholic father. It is interesting to note that both adult sons and daughters scored lowest on the negative personality characteristics when the alcoholic parent was the mother.

A study by Williams (1983) of 100 families examined the gender of the alcoholic parent and effects on children by describing the quality of child care, the level of family stability, incidence of child abuse, and child neglect. In the case of two alcoholic parents the quality of child care was the lowest and the level of child abuse the highest. Families in which mothers were alcoholic resulted in the lowest family stability and families in which fathers were alcoholic resulted in the highest family stability.

Berkowitz and Perkins (1988) compared the personality characteristics of late adolescent and young adult children of alcoholics with those of their peers, examining gender specificity in personality differences. Children of alcoholics, particularly women, and especially women with alcoholic fathers, were more likely to report greater self-

depreciation. Male children of alcoholics rated themselves significantly higher on autonomy regardless of gender of alcoholic parent. Based on this data, the relationship of gender of the child and gender of the alcoholic parent(s) seems an important factor to integrate into a conceptual framework to explore the relationship of gender to the development of behavioral disorders. An assumption can be made that alcohol consumption by the child's primary caregiver can affect the ability to role model the appropriate gender behavior, thereby, impairing the child's ability to imitate appropriate gender behavior necessary to meet individual tasks for healthy personality development.

Child's Roles

Roles are the dynamic part of a position defined by the norms of the culture. Each position contains a number of dominant and recessive roles related reciprocally to at least one role in each of the other family-member positions (Hill & Rogers, 1964). Wegscheider (1979) found that children of alcoholics seldom learn the combinations of roles which mold healthy personalities. Instead, they become locked into roles based on their perception of what they need to do to "survive" and to bring some stability to their lives. These are the childhood roles of being the family hero, scapegoat, lost child, or mascot.

Children who assume the role of Family Hero are usually the oldest children and display behaviors that are

extremely mature for them. The children are considered highly competent on the exterior, but suffer internally with feelings of guilt, inadequacy and hurt. They provide self-worth for the family unit.

Children who assume the role of the Scapegoat are traditionally the target of family frustrations, anger, and confusion. Often these feelings are internalized by the Scapegoat, but may be outwardly displayed by negative behavior (behavioral disorders). Behavioral disorders are defined as any of a group of antisocial behavior patterns occurring primarily in children and adolescents, overaggressiveness, overactivity, destructiveness, cruelty, truancy, lying, disobedience, perverse sexual activity, criminality, alcoholism, and drug addiction (Glanze, 1986). The children provide a focus for the family.

Children who assume the role of the Lost Child, usually the middle children, are probably the children suffering the most role inconsistency. Unlike the other siblings' roles which are specifically defined, the Lost Child's identity is uncertain and they feel rage, confusion, fear and hurt. They are literally lost regarding where they fit in the family and they provide relief for the family.

Children who assume the role of the Mascot are often identified as the youngest children. These children may be overly protected from the family problems resulting in them becoming overly dependent, insecure and confused. They

provide distraction for the family by being charming, clowning, and working hard and fast to be the center of attention, often doubting their own self-worth unless the whole world notices and approves.

The spouse is also locked into the role of enabling the chemically dependent member and provides responsibility for the family, but feels anger, guilt, pain, and fear. These negative feelings experienced by the spouse can be expected to affect the quality of the parenting role by interfering with the closeness dimension. The closeness dimension examines affection, nurturance, and acceptance of the children by the parent; and control or monitoring of the children, which emphasizes setting controls and limits (Kandel, 1990).

The scapegoats may be the only children recognized as being dysfunctional because of their outward display of negative behavior. This may be the only dysfunctional role identified in the institutional setting because the focus is on socially unacceptable behaviors. Although the other "survival" roles adopted by these children may be socially successful, "none" are emotionally successful! No one living in an alcoholic home can fail to be touched by it. None of these roles are "healthy", they all center on suppressing the children's feelings which results in emotional problems by early adulthood (Woodside, 1988).

In addition to the above roles, there may be another category of children from troubled families. These children have been called "invulnerables" (Garmezy, 1976). These are the children, that despite all the family problems, have not only survived, but also have grown into healthy adults. It has been estimated that approximately ten percent of children in troubled homes are "invulnerables".

Positive Involvement in Activities Outside of Home

Ackerman (1987) described "offsetting factors" that may have a positive impact on the children's lives. School may be an offsetting factor by providing a physical break from family involvement, an emotional recess from thinking about family problems. The instructor may act as a positive role model who fosters a sense of self worth in the children. Activities outside the home that foster a sense of accomplishment are offsetting factors that provide a positive self-concept not offered in the home. Outside activities give children opportunities to have meaningful interactions during their day with an adult role model. These children can be divided into two broad categories, the "haves" and the "have nots." What they have or do not have is an ability within themselves to establish positive relationships outside the home (a positive relationship is defined as a positive influence on the children that promotes self growth) that assists them in meeting Duvall's individual developmental tasks. The assumption is made

that children who are involved in positive activities outside the home will exhibit a fewer number of behavioral disorder. This study does recognize that causality can exists in both directions. Children who have fewer behavioral problems may have an increased tendency to involve themselves in activities outside the home when compared to children who have a greater number of behavioral disorders.

Ackerman (1978), found that children of alcoholics who were able to establish positive relationships outside the home were not as likely to become alcoholic in their adult lives as children who did not establish these relationships. Anthony (1984) described the characteristics of children who have high levels of invulnerability to stress. These behaviors include: knowing how to attract and use the support of adults; actively trying to master their own environments and have a sense of their own power; developing a high degree of autonomy early in life; getting involved in various activities or projects and doing well in most things they do; being socially at ease and making others feel comfortable around them.

Roosa, Sandler, Gehring, Beals, and Capps (1988), support Ackerman with their conceptual model which considered parental alcoholism as a chronic condition that leads to an increase in stressful events experienced by children. According to the model, childhood psychological

disorders result from the amount of environmental stress caused by the alcoholism, the children's success in coping with these disruptions (in the roles they play) and the assistance in coping that the children receive by establishing positive relationships outside the home. Positive relationships may provide the children with positive role models, emotional support, meaningful activities, a sense of belonging, diversion from family conflict and a positive self-concept that is not offered in the home (Ackerman, 1987). The assumption is that children who are rated as doing well academically and behaviorally in school and/or are involved in positive activities outside the home involving an adult role model have an increased ability to meet their individual developmental tasks.

Alcoholism is a disease process that is characterized by repetitive abusive drinking, personality changes while drinking, and a process that affects the entire family system (Bargar & Bingham, 1985). When a parent is alcoholic, parental roles are also often marked by inconsistency. Inconsistency is exhibited by both the alcoholic and the non-alcoholic parent. The alcoholic parent behaves like several different individuals, with conflicting reactions and unpredictable attitudes. Often their role performance is dictated by successive periods of drunken behavior, remorse, or guilt, followed by high degrees of anxiety, tension, and finally, complete

sobriety. Ackerman (1986) found that children may learn through experience to adapt to such inconsistency in roles, and even to develop some form of predictability, but they develop very little emotional security. What emotional security is attained is usually attained only during periods of sobriety, and then only if other family issues are not producing tension. Alcohol has a direct impact on the family's ability to meet family developmental tasks, and thus impedes the child's ability to complete individual developmental tasks which may result in behavioral disorders in the child.

This conceptualization assumes that alcohol has a direct impact on the family's ability to meet Duvall's family developmental tasks and thus impedes the child's ability to complete individual developmental tasks resulting in behavioral disorders. Variables that may mediate the process are the gender of the child and the alcoholic parent(s), the survival role(s) the child assumes, and positive involvement in activities outside the home (involvement in positive activities are defined as children who are rated as doing well academically and behaviorally in school and/or are involved in positive activities outside the home involving an adult role model). Refer to Figure 1 for a model conceptualizing these concepts and their relationships.

This study was designed to address the following questions: What is the relationship between the gender of the alcoholic parent and/or the gender of the child and the incidence of specific behavioral disorders? Is positive involvement in activities outside the home related to lower levels of behavioral disorder.

Hypotheses

Specifically the following hypotheses will be tested:

1. There is a relationship between the gender of the child and/or the gender of the alcoholic parent and the number of behavioral disorders exhibited by the child.

2. Children who are involved in positive activities outside the home will exhibit fewer behavioral disorder than those that are not involved in positive outside activities.

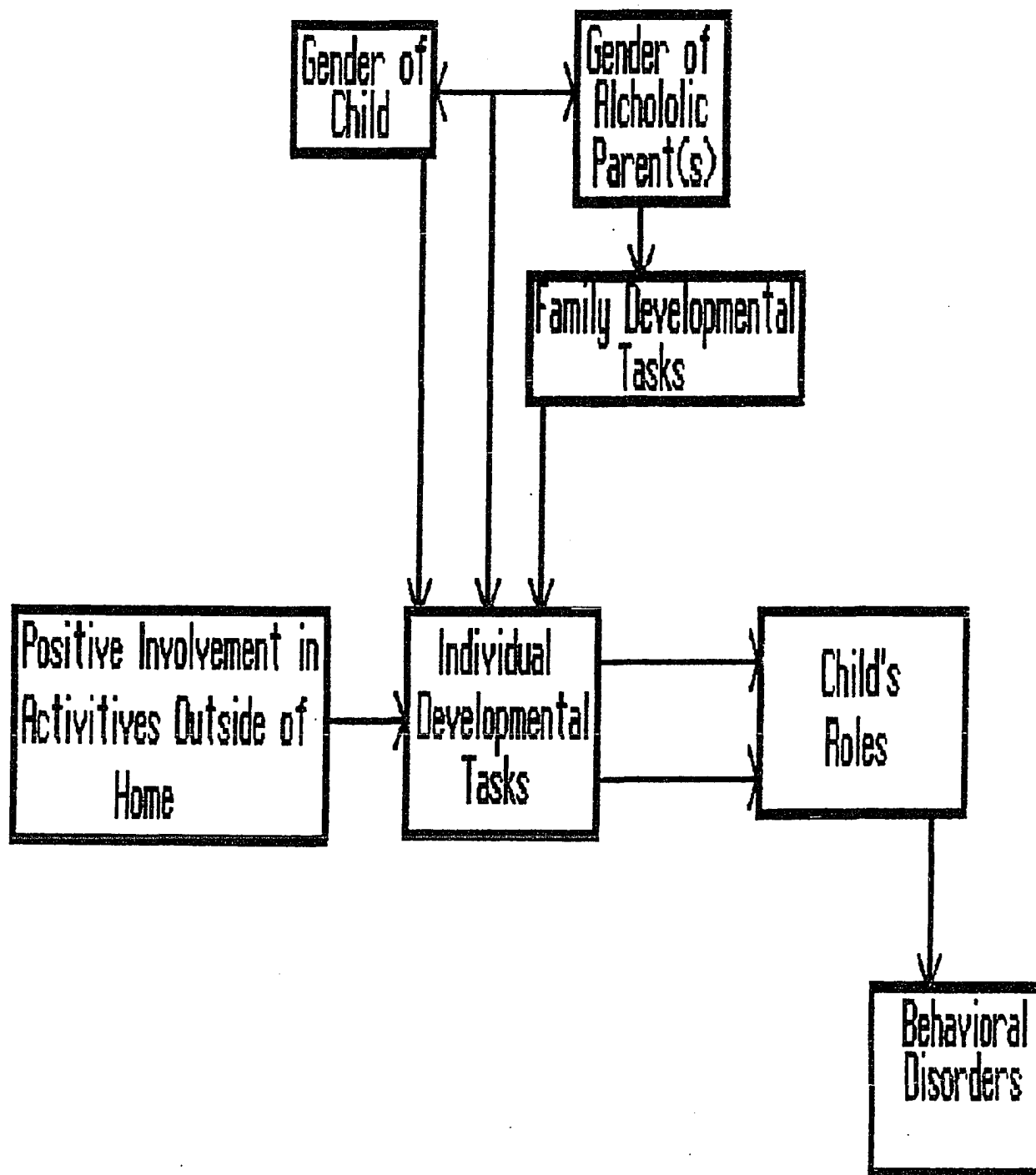


Figure 1 - Conceptual framework of the relationship between parental alcoholism and behavioral disorders in children.

CHAPTER 3

METHODOLOGY

Design

This descriptive retrospective study utilized a data record review of charts of children who were patients in an alcoholic treatment center. The independent variables were gender of the child, gender of the parent, and the involvement in positive activities outside the home. The dependent variable was the occurrence of behavioral disorders. Specifically this study investigated the relationship between gender of the alcoholic parent(s) and/or gender of the child and the number of behavioral disorders. A second focus was the relationship between positive involvement in activities outside the home and the number of behavioral disorders.

Population and Sample

The data for this research study was collected from a questionnaire the parents were required to fill out before the children were admitted into the treatment center. The questionnaire gathered information from the parents regarding the developmental history of the child with a special emphasis on behavioral disorders exhibited by the child.

This was a professional treatment center for chemical dependency and co-dependency located in the southern region of the United States. The facility offered both an intensive day treatment program (40 hrs/week) and a six week evening program for children between the ages of 5-12, whose parents were presently undergoing chemical dependency treatment, or had gone through treatment in the past. Both programs offered individual and group counseling, play therapy, art therapy, multi-family groups, and introduction to support. The philosophy of the agency in regard to alcoholism was that it is a family disease, and until recently, children from alcoholic homes have been untreated, misdiagnosed and ignored. The Children's Program utilized the Children Are People support group model developed by Rokelle Lerner (1982) designed to provide children with the tools they need to become healthy adults.

The facility attracted children from a high socioeconomic level, a primarily White Anglo-Saxon Protestant ethnic group. The records of children were reviewed. The sample consisted of the records of all the children age 5 to 12 years who were clients at the facility between January 1, 1989 and April 25, 1990. Eighty-seven charts were reviewed; four charts were eliminated due to a lack of chemical dependency history (history consisted of abuse and/or incest).

Human Rights Protection

The participants of this study were not required to sign a consent. The staff felt that a consent form indicating that the questionnaire would be utilized in research would inhibit the parents, due to fear of exposure, from indicating all behavioral disorders. Further, the study used a retrospective chart review.

Confidentiality was the greatest risk to the subjects. This was minimized by deleting all references made to the name of the treatment center and to the clients. During the data collection procedure specific precautions were taken by not recording any identifying data. The author of this research project gathered the data at the treatment center. The researcher was not from the area and had no previous knowledge of any of the clients. The instruments were coded for analysis with no identifying information related to the documents. No documents bearing patients' names left the center. The researcher obtained a letter of support from the facility with an indicated desire to utilize the information obtained in the research project to further develop the program (Appendix A).

Data Collection

The Parent's Questionnaire and Developmental History from the children's program at the treatment center were utilized to gather the data for the instrument (Appendix B). The questionnaire contained information regarding the developmental history of the child with a special emphasis

on behavioral disorders that were present, involvement in positive activities outside the home, and the gender of the child and of the alcoholic parent(s). The majority of the data was clear with the exception of documenting positive relationships outside the home. Meaningful activities outside the home were determined by information on the questionnaire which indicated a positive involvement in activities outside the home. Two categories were established, positive involvement in school activities and activities other than school. To qualify for school involvement, the parents' perception that the child's school experience was positive related to academic learning and behavior had to be confirmed by the teacher. To qualify for other activities at least one hobby or activity the child participated in outside the home that would involve interaction with an adult, had to be documented by the parent.

CHAPTER 4

RESULTS

Characteristic of the Subjects

Eighty-three subjects were included in the study. The ages of the subjects ranged from five to thirteen years, $M = 8.7$, $SD = 2.48$. Forty-one subjects were male and forty-two subjects were female. Small families predominated in this study. The subjects' number of siblings ranged from zero to four, $M = 1.193$, $SD = 1.041$. The placement of the children within the family revealed first placement predominating (65.1%) and middle placement rare (6%), $M = 1.639$, $SD = .905$. The number of children presently involved in psychiatric treatment was significant (65.1%). The children with handicaps were rare. Three of the eighty-three subjects had a history of asthma, one had a history of lipoprotein anemia, and two of the subjects had siblings with handicaps (one had cerebral palsy and one had leukemia). The subjects' family units consisted of primarily nuclear families and single parent mothers with active involvement of the natural father (see Table 1).

Table 1 - Frequency and Percent of Types of Family Units

Family Units N=83	Frequency	Percent
Natural mother & father	29	34.9
Natural mother & step-father	10	12.0
Mother without involvement of father	8	9.6
Father without involvement of mother	3	3.6
Mother with active involvement of father	33	39.8

In this study, the chemical history of the parents revealed that fathers were most commonly representative (43.4%), then both parents (33.7%), and the least representative were the mothers (22.9%). Table 2 presents a crosstabulation by gender of the child and gender of the chemically dependent parent(s). Chemically dependent fathers with a male child were most prevalent and chemically dependent mothers with a male child least prevalent.

The total number of behavioral disorders varied greatly from child to child with the lowest number zero and the highest number sixty-four, $M = 21.92$, $SD = 15.199$. The disorders that were present in greater than forty percent of the children are indicated in Table 3.

Table 2 - Crosstabulation of Chemical Dependency History by Gender of Child N=83

Chemical Dependent History	Gender of Child		Total
	Male	Female	
MOTHER	6	13	19
FATHER	20	16	36
BOTH	15	13	28

Table 3 - Prevalent Behavioral Disorders

Behavioral Disorders Occurring in More than 40% of Subjects

Behavior	Number of children	Percent
Excessive demands for attention	38	45.8
Takes path of least resistance	35	42.2
Poor follow through	65	42.2
Argumentative	40	48.2
Always wants his own way	36	43.4
Low self esteem	40	48.2
Very poor toleration for criticism	36	43.4
Feelings easily hurt	52	62.7

Hypothesis

The independent variables in the study were gender of the child, gender of the alcoholic parent(s) and evidence of the existence of positive involvement in activities outside the home. The dependent variable was the number of behavioral disorders exhibited by the child.

Table 4 represents the mean number of behavioral disorders in relation to the gender of the child and the chemically dependent parent(s). A two-way Analysis of Variance was computed to test the hypothesis that the gender of the alcoholic parent(s) and/or the gender of the child was related to the number of behavioral disorders. Neither the main effect of gender of the child nor the interactive effective of child-alcoholic parent(s) gender on the number of behavioral disorders was significant ($F = 1.199$, $p = .318$).

Table 4 - Gender Related to Behavioral Disorders

Chemical Dependency History	Mean Number of Behavioral Disorder	
	Gender of Child N=83	
	Male	Female
MOTHER	28.33	20.23
FATHER	22.40	15.00
BOTH	23.67	26.46

A t-test was computed to determine if children who were involved in activities outside the home experienced fewer behavioral disorders than children who were not involved in outside activities. The difference was statistically significant (see Table 5). The mean number of behavioral disorders was higher for children not involved in activities than for children involved in activities.

Table 5 - Activity Involvement Related to Behavioral Disorders N=83

	<u>Behavioral Disorders</u>		t Value	df	2-tail prob
	Mean	S.D.			
Activity involvement n=55	18.53	13.31	-2.99	81	.004
No activity involvement n=28	28.61	16.66			

An ANOVA was performed to determine differences in behavioral disorders by type of activity involvement; positive involvement in school activities, positive involvement in activities other than school, or both activities. See Table 6. A Scheffe procedure was performed to determine the differences in the groups. Children who were involved in activities not related to school had significantly more behavioral disorders (M = 26.59) compared to children involved in school activities (M = 15.72) or children involved in both

(M = 10.07). This would indicate that children benefit more from positive involvement in school activities than in other activities outside the home. See Table 7.

Table 6 - Analysis of Variance for Activity Involvement

Source of Variation (n=55)	df	SS	MS	F	p
Type of activity	2	2645.846	1322.923	9.938	.000
Residual	52	6921.863			
Total	54	9567.709			

Table 7 - Mean Number of Behavioral Disorders Related to Groups

Groups	S A	O A	B A
School Activities (SA)			
Other Activities (OA)	*		*
Both Activities (BA)			
*Denotes pairs of groups significantly different at the .05 level.			

CHAPTER 5

DISCUSSIONS/IMPLICATIONS/CONCLUSIONS

This study explored gender variables, activity involvement, and the frequency of specific behavioral disorders in children of alcoholics. The study did not identify a significant relationship between the gender of the child and the alcoholic parent(s) and the number of behavioral disorders. It did support William's study with two alcoholic parents having the lowest quality of care and the highest level of abuse; the lowest family stability in which mothers were alcoholic and the highest family stability when fathers were alcoholic. It also supported Ackerman's (1987) findings with daughters of two alcoholic parents exhibiting the highest mean number of behavioral disorders and sons of alcoholic mothers exhibiting the highest mean number of behavioral disorders.

The remaining data related to gender was not consistent with Ackerman's findings. For this group of children, there may be several intervening variables. As children move out of the home, they are exposed to a number of other stimulations which may decrease, nullify, enhance, or correct what they have experienced at home as infants or preschool children. The age of the children when parental

alcoholism emerges or becomes disruptive may also influence the effects of the parental behavior on the children. The effects of many concurrent critical factors, such as marital discord, disrupted family routine, inadequate parental guidance, modeling maladaptive coping behavior and severity of parental alcoholism, have not been isolated in this study. These and other risk factors cloud the conclusions that can be reached with gender interactions.

The study did support Ackerman's theory that there are "offsetting factors" that may have a positive impact on children from alcoholic backgrounds. Furthermore, the study supports the assumption that children who are rated as doing well academically and behaviorally in school and/or are involved in positive activities outside the home have an increased ability to meet individual developmental tasks (based on the assumption that a decrease in behavioral disorders results in an increased ability to meet individual developmental tasks). This study was able to expand on this assumption by finding that children who were positively involved in school had a significantly lower number of behavioral disorders than those involved in other activities outside the home. The implication of these findings would support nursing interventions directed toward increasing involvement in school activities.

The most prevalent behavioral disorders were focused around issues of low self-esteem. These findings support

Erikson's theory of personality development with school-age children struggling with the task of industry versus inferiority. Because of the family's preoccupation with the alcoholic family member, these children are at high risk for unsuccessful completion of this task. The implications for nurses would be to direct nursing interventions toward improving the children's self-esteem by recognizing and promoting their strengths and abilities.

The parent-child relationship is complex and many variables enter into the interaction of children with parents, alcoholic or nonalcoholic. The literature as a whole supports the view that parental alcoholism is associated with increased childhood symptoms of psychopathology. This study and Williams's (1983) suggests that mothers may play a key role in mediating the effects of a father's alcoholism. This would need to be explored further in future research. The importance of genetic factors in alcoholism and in fetal alcohol syndrome and on children's vulnerability to alcohol's influence must be considered along with the influence of stressful environmental factors in assessing the impact of parental alcoholism on children trapped in the dysfunctional environment.

Limitations

The major threats to the external validity of this study are primarily due to sampling. The facility attracts children from a high socioeconomic level of primarily White

Anglo-Saxon Protestant ethnic groups. Therefore, the results of this study can not be generalized to the general population.

The major threats to internal validity are numerous. First, there may be things in the children's history other than parental alcoholism that may be responsible for the behavioral disorders. Over sixty percent of the subjects were identified as suffering from physical and/or sexual abuse. Second, there were problems in controlling extraneous variables, such as genetic or environmental factors. There were no measurements to determine the degree of alcoholism, if the affected parent was the primary caretaker, or the degree to which the unaffected parent was impaired due to the spouse's alcohol misuse.

Some of the items on the behavioral list may be due to maturational age differences (i.e., bed-wetting) instead of due to parental alcoholism. The questionnaire may not fully represent all behavioral disorders that could be attributed to parental alcoholism. The behavioral disorders were treated as having equal weight in this study when in reality some of the disorders would have a greater impact than others (i.e., "shy" vs "sees visions"). Even after these limitations are taken into account, the findings of the present study provide support for the conceptual framework that directed the study.

Recommendations for Future Research

This study should be repeated with a larger sample from a wide variety of socioeconomic levels and ethnic groups. It would be interesting to separate the variable of physical and/or sexual abuse to determine if the variable threatened the internal validity of this study. The study could examine the differences in effect of alcoholism, abuse, and alcoholism/abuse on the number of behavioral disorders.

There are several items that could improve the instrument used in this study. On the identifying data it would be helpful to include a section on the frequency of drinking, whether the affected parent was the primary caretaker, and the age of the children when the parent(s) perceived that the alcohol was impairing their ability to function as a caregiver. It would also be useful to weight each behavioral disorder according to its potential for impairing the children's ability to meet their developmental needs.

Conclusions

Behavioral disorders in children involve multiple variables, one of which is parental alcoholism. The described investigation represents research aimed at developing new knowledge regarding childhood risk factors related to issues of gender and protective factors that may affect a child's vulnerability to familial alcoholism and its related problems. Nurses come in contact with children

who are affected by the problem of alcoholism every day. Identification of childhood risk factors and assessment of protective factors are an initial step toward the development of early identification and treatment programs for children raised in an alcoholic environment. This may be part of the essential ingredients in preventing the development of future alcoholics and emotionally disadvantaged individuals.

This study identified a statistically significant relationship between activity involvement outside the home with a decrease in number of behavioral disorders. It found that children who were involved in activities not related to school had significantly more behavioral disorders compared to children involved in school activities or children involved in both. Nurses are in a unique position to change the lives of children of alcoholics by utilizing research to identify protective factors that may be incorporated into the plan of care.

Appendix A



AT BOCA RATON, INC.

Processing Treatment for Chemical Dependence and Codependency

April 2, 1990


To Whom It May Concern,


This letter is being written in behalf of MICHELLE WILLIAM'S Master thesis. Michelle communicated a desire to utilize our program to gain statistical data to support her thesis. When the requested was received I petitioned the Quality Assurance Board to acquire clearance for the project. Mrs. Williams had assured us that Anon Anew @ Boca Raton Inc. would not be identified in any manner other then a treatment center in the southern part of the United States. It was agreed by the board that Mrs. Williams would sign a statement of Confidentiality (42CFR) and be granted privilege to the children's pre-existing charts.

We at Anon Anew are very desirous of the information and data that will be interpreted via Michelle's thesis. Not only will it assist this agency directly, but will shed additional needed light on the area of effective "children of alcoholics" services.

Thank you for your attention, and we look forward to working with Michelle.

Sincerely,


Joan Marineau, B.S.W./C.A.P.
Director of Family Services


Dan Sullivan, M.S.
Executive Director

APPENDIX B

Children of Alcoholics

Instrument

Children of Alcoholics Instrument:

I. Identifying data: (001-100)	1-4
1. Gender of child Male(1) Female(2)	5
2. Age of child (round off to nearest year).	6,7
3. Number of siblings	8,9
4. Placement of child First(1) Middle(2)	
Last(3)	10
5. Family Unit: Natural mother and father(1)	
Natural mother and step father(2)	
Natural father and step mother(3)	
Adoptive mother and father(4)	
Foster mother and father(5)	
Single-parent family-mother(6)	
Single-parent family-father(7)	
Natural mother with involve- ment of father (8)	11
6. Chemical Dependency History: Mother(1)	
Father(2) Both(3)	12
7. Illnesses and/or Handicaps: Yes(1) No(2)	13
8. Child presently under psychiatric treatment:	
Yes(1) No(2)	14
II. Positive Involvement in Activities Outside the Home:	
1. Yes(1) No(2)	15
If yes, School(1) Activities(2) Both(3)	16

III. Behavioral Disorders:	Yes(1)	No(2)
1. Thumbsucking		17
2. Baby talk		18
3. Overly dependent for age		19
4. Frequent temper tantrums		20
5. Excessive silliness and clowning		21
6. Excessive demands for attention		22
7. Cries easily and frequently		23
8. Generally immature		24
9. Eats non-edible substances		25
10. Overeating with overweight		26
11. Undereating with underweight		27
12. Long periods of dieting and food abstinence with underweight		28
13. Preoccupied with food--what to eat and what not to eat		29
14. Preoccupation with bowel movements		30
15. Constipation		31
16. Encopresis		32
17. Insomnia		33
18. Enuresis		34
19. Frequent nightmares		35
20. Night terrors		36
21. Sleepwalking		37
22. Excessive sexual interest & preoccupation		38
23. Freq. sex play with other children		39

24. Excessive masturbation	40
25. Freq. likes to wear clothing of the opposite sex	41
26. Exhibits gestures and intonations of the opposite sex	42
27. Freq. headaches	43
28. Freq. stomach cramps	44
29. Freq. nausea and vomiting	45
30. Often complains of bodily aches and pains	46
31. Worries over bodily illness	47
32. Poor motivation	48
33. Apathy	49
34. Takes path of least resistance	50
35. Ever trying to avoid responsibility	51
36. Poor follow through	52
37. Low curiosity	53
38. Open defiance	54
39. Blatantly uncooperative	55
40. Persistent lying	56
41. Freq. use of profanity to parents, teachers, and other authorities	57
42. Truancy from school	58
43. Runs away from school	59
44. Violent outbursts of rage	60
45. Stealing	61
46. Cruelty to animals, children, and others	62
47. Destruction of dangerous acts	63

48. Trouble with the police	64
49. Violent assault	65
50. Fire setting	66
51. Little, if any, guilt or behavior that cause others pain and discomfort	67
52. Little, if any, response to punishment for anti-social behavior	68
53. Few, if any, friends	69
54. Doesn't seek friendship	70
55. Rarely sought by peers	71
56. Not accepted by peer groups	72
57. Selfish	73
58. Doesn't respect the right of others	74
59. Wants things own way with exaggerated reaction if thwarted	75
60. Trouble putting self in other person position	76
61. Feels others are persecuting him when there is no evidence for such	77
62. Egocentric	78
63. Freq. hits other children	79
64. Argumentative	80
65. Excessively critical of others	81
66. Excessively taunts other children	82
67. Ever complaining	83
68. Is often picked on and easily bullied	84

69. Suspicious, distrustful	85
70. Aloof	86
71. Wise-guy or smart aleck attitude	87
72. Brags or boasts	88
73. Bribes other children	89
74. Excessively competitive	90
75. Often cheats when playing games	91
76. Sore loser	92
77. Doesn't know when to stop	93
78. Poor common sense in social situations	94
79. Often feels cheated or gypped	95
80. Always wants his or her own way	96
81. Very stubborn	97
82. Obstruction	98
83. Negativistic (does just the opposite of what is required)	99
84. Quietly, or often silently, defiant of authority	100
85. Feign or verbalizes compliance or cooperation but doesn't comply with requests	101
86. Drug abuse	102
87. Alcohol abuse	103
88. Very tense	104
89. Nail biting	105
90. Chews on clothes, blankets, etc.	106
91. Head banging	107

92. Hair pulling	108
93. Picks at skin	109
94. Speaks rapidly and under pressure	110
95. Irritability, easily flies off the handle	111
96. Fears dark new situations, strangers, being alone death	112
97. Fears separation from parent	113
98. Fears separation from school	114
99. Fears visiting other children's homes	115
100. Fears going away to camp	116
101. Fears animals	117
102. Other fears	118
103. Anxiety attacks with palpitations, shortness of breath, sweating, etc..	119
104. Disorganized	120
105. Ticks such as eye-blinking, grimacing or other spasmodic repetitious movements	121
106. Involuntary grunts	122
107. Stuttering	123
108. Depression	124
109. Freq. crying spells	125
110. Excessive worrying over minor things	126
111. Suicidal preoccupation or attempts	127
112. Too good	128
113. Often appears insincere or artificial	129
114. Too mature, frequently acts older	130

115.	Excessive guilt over minor indiscretions	131
116.	Asks to be punished	132
117.	Low self esteem	133
118.	Excessive self-criticism	134
119.	Very poor toleration for criticism	135
120.	Feelings easily hurt	136
121.	Dissatisfaction with appearance or body parts	137
122.	Excessive modesty over bodily exposure	138
123.	Perfectionistic, rarely satisfied with performance	139
124.	Freq. blames others as cover-up for own short-comings	140
125.	Little concern for personal appearance or hygiene	141
126.	Little concern or pride in personal property	142
127.	Gets hooked on certain ideas and remains preoccupied	143
128.	Compulsive repetition of seemingly meaningless physical acts	144
129.	Shy	145
130.	Inhibited self-expression in dancing, singing, laughing, etc..	146
131.	Recoils from affectionate physical contact	147
132.	Withdrawn	148

133.	Fears asserting self	149
134.	Inhibits open expression of anger	150
135.	Allows self to be easily taken advantage	151
136.	Freq. pouts and/or sulks	152
137.	Mute (refuses to speak) but can	153
138.	Gullible and/or naive	154
139.	Passive and easily led	155
140.	Excessive fantasizing, lives in his/her own world	156
141.	Flat emotional tone	157
142.	Speech non-communicative or poorly communicative	158
143.	Hears voices	159
144.	Sees visions	160

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