ALCOHOLISM

AND

ADULT CHILDREN OF ALCOHOLICS :

A WORKSHOP

By

Douglas A. Cooper

A Practicum
Submitted to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree of

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PREFACE

INTRODUCTION

In April 1989, there were eight Adult Children of Alcoholics self-help groups in Manitoba (five in Winnipeg) with a membership of around 70 people. Interested people become aware of these self-help groups by word of mouth.

Treatment facilities in Winnipeg may mention the effects of alcoholism on the family and children but they do not send their clients to Adult Children of Alcoholics self-help meetings nor do they go into detail about how alcoholism has affected their families or their children. The only adults these treatment facilities educate are their clients and mostly on alcoholism. The focus of education is on chemical dependency. At the present time, educational prevention programs developed by the Alcoholism Foundation of Manitoba are focused on educating children in the schools. The Foundation does mention and describes the effects of alcoholism on the family and on the children raised in the alcoholic home in appropirate training courses. In addition, in 1989 two individuals were hired to assist the family members of those who are using the Foundations' treatment services. These individuals will also take referrals from community resources and their speciality is dealing with Adult Children of Alcoholics.

Some Alcoholism Foundation of Manitoba employees make presentations in the community, on request, on the topic of Adult children of Alcoholics.

This practicum is an attempt to overcome this shortfall by providing an educational workshop to a community based group. It is hoped that as the group members pick up information they will talk to their friends who will talk to their friends. People who attend the sessions will have:

1. A factual basis for their attitudes on alcoholism:
2. An awareness of alcoholism;
3. The effect of alcohol on families;
4. The effects of alcohol in the community; and
5. There is help available for those who want help.

Expected Education Benefits to the Student

Central to any expectation of possible or probable benefits to be gained by "studying" the alcoholic family, is the opportunity to expand upon and assimilate knowledge and practical experience in working with adults in a variety of settings. Specific anticipated benefits included the opportunity:

1. To synthesize and begin to use general theories in developing new ways of working and creating specific strategies to aid families effected by alcohol.

2. To increase my ability in the role of Social Worker as educator, specifically in providing an educational forum, to help community members to modify their attitudes about alcohol and its effects on the family.
3. To increase self-supervision abilities in becoming more accountable to agencies and participant populations involved.
4. To validate my own counselling experience by transferring information from a treatment setting and applying it to a community based educational setting.

CHAPTER ONE

LITERATURE REVIEW

1-1 Introduction

The aim of this literature review is to provide the reader with a broad overview of the literature on alcoholism, its effects on the family and the children of alcoholics. The material reviewed was mostly written by clinicians. Materials presented on alcoholism, humanistic theories, Social Learning and Adult Education Models were gathered from reports, research papers and scholarly books. The literature review is given in the order the material was presented in the workshop.

1-2 Historical Perspective

Alcoholism is a condition the average person knows very little about and yet everyone knows someone who has been affected by it. The condition of alcoholism has been noted for thousands of years. Early in the 20th century we have seen the failure of the Temperance Movement and Prohibition which were attempts to curtail the use of alcohol. Laws have been changed to make it easier purchase and consume alcohol.

"Governments in Canada derive substantial revenues from the sale of alcoholic beverages in fiscal year 1985-86, provincial and federal government revenues specifically related to alcoholic beverages amounted to $3,787,000,000" (Eliany, 1989, p. 1). The estimated "... health care cost due to alcohol abuse was $2 billion " (Eliany, 1989, p. 27). The revenues that are returned to the agencies that provide primary, secondary to tiruary prevention programs for individuals who have trouble controlling their intake and behaviour when under the influence of this drug is relatively small. Other costs (Social Welfare, Law Enforcement and Reduced Productivity) related to alcohol abuse in Canada is $3.25 billion for a total cost of approximately $215.75 per person (Elany, 1989, p. 27). These cost figures may be a little misleading because they are not all the liability of governments. Reduced productivity is also a liability of private organizations and this accounts for over $1.2 billion. The annual government budget for medical services in Manitoba is approximately $220 million. Of this, $10 million is dedicated for the treatment of chemical dependency. This figure does not include the costs associated with law enforcment and social welfare or lost productivity. However, it is not consistent with the figures given above for Canada. In addition, there is no breakdown for the costs of medical care for those admitted for chemical

dependency or alcohol abuse. I also think that if the Canadian figures are to be considered as accurate, it is necessary to separate alcohol abuse from those who abuse other chemicals.

The medical community has recognized the dangers of alcohol misuse. At first they treated alcoholism as a mental condition while some thought it was a moral problem. It was not until 1949 that the American Psychiatric Association recognized Alcoholics Anonymous (A.A. World Service, 1980, p. 245). In 1955 the American Medical Association considered alcoholism to be a disease. This acknowledgement paved the way for the financing of treatment of alcoholism by third party insurance and the creation of treatment centres. The treatment of alcoholism in almost all these centers is based on the Alcoholics Anonymous 12-Step program. Only recently and in only a few centers has alcoholism been considered something other than a disease. As a result, alternative methods are being explored to find other ways of treating those who have problems with alcohol misuse but who do not fit into the classification of "alcoholics." As far as we know, Alcoholics Anonymous has been the most effective structured intervention method for alcohol misusers to maintain sobriety. At this time we do not yet know whether or not natural recovery in of itself may occur more often than recovery due to Alcoholics Anonymous.

1-3 Alcoholics Anonymous

"Bill Wilson, a co-founder of Alcoholics Anonymous was classified an incurable alcoholic in 1934 by Dr. William D. Silkworth" (A.A. World Service, 1980, p. 52). He attempted a number of ways of becoming and staying sober and was unsuccessful. In May, 1935, he went to Akron, Ohio and met with Dr. Bob where they started talking about their drinking and problems they had with sobriety. Dr. Bob had his last drink in June, 1935 and with that event, Alcoholics Anonymous was born (A.A. World Service, 1980, p. 71). Table 9 outlines the significant events in the evolution of Alcoholics Anonymous.

Bill's wife, Lois and Dr. Bob's wife, Annie started involving the wives and significant others of those attending Alcoholics Anonymous in a self-help program in the 1940's. In 1950 they started a clearing house for information about the problems associated with living, working with or dealing with an alcoholic. They called their organization Al-Anon. It was officially recognized at the Alcoholics Anonymous convention in Cleveland in 1950 (A.A. World Service, 1980, p. 23).

Al-Anon was designed to help those spouses and friends understand what the alcoholics had gone through, how they were affected and what helped bring some normality back into their lives. In their wisdom, Al-Anon started and

supervised a self-help group for the children of alcoholics (Alateen) for the age group 12-18.

In 1974, The National Association for Children of Alcoholics was founded in the United States with the goal of providing guidance and assistance to self-help groups throughout the United States. Approximately three years ago a Canadian Chapter was formed in Toronto to service the Adult Children of Alcoholics self-help groups in Canada.

Unfortunately, Alcoholics Anonymous only reaches approximately 5% of the alcoholic population (Jager, 1984). We can assume the membership of Al-Anon is somewhat less than 5% and Alateen membership is somewhat lower than Al-Anon.

Alcoholics Anonymous claims to have a membership of a little over one million world wide. This means there are about 20 million practising alcoholics drinking and adversely affecting about five others each or around 100 million people. Most of these 100 million people are the children of alcoholics, ranging from a few minutes old to 90+ years old. The Children of Alcoholics Foundation of New York claims there are 28 million children of alcoholic parents in the United States (Blume, 1984). This suggests the widespread need for awareness and understanding.

Table 1

Historical Development of Alcoholics Anonymous

Year	Event
1935	June 10. Dr. Bob has last drink. Alcoholics Anonymous founded.
1937	New York A.A.'s separate from Oxford Groups
1938	May. Beginning of writing of the book, Alcoholics Anonymous
1938	December. Twelve Steps written
1939	April. Alcoholics Anonymous published
1940	Religious leaders approve Alcoholics Anonymous
1946	The Twelve Traditions of Alcoholics Anonymous formulated and published
1949	American Psychiatric Association recognizes A.A.
1953	Twelve Steps and Twelve Traditions published
1976	Worldwide estimates: more than 1,000,000 members almost 28,000 groups.

(Complied from A.A World Service, 1980, vii -xi)

1-4 Theoretical Base

Educational theories are based upon behaviourial, cognitive and humanistic psychology. A brief description of each theoretical group follows.

a. "Behaviourist Theories. This group of theories suggest that we learn by receiving stimulus from our environment, stimulus that pushes a response

... and it relies on reinforcement" (Rogers, 1986, p. 46).

b. "Cognitive Theories are the active engagement of the mind in relation to the matter under consideration ... understanding is necessary, the material must be marshalled step by step and then mastered ... and feedback is an essential element" (Rogers, 1986, p. 47).

c. "Humanist Theories emphasize the urges and drives of the personality - movements towards ... increased autonomy and competence, the compulsion towards development and growth, the active search for meaning, the goals that individuals set for themselves - and the social setting within which they operate" (Rogers, 1986, p. 48).

The Humanistic theories will be considered for this practicum because:

a. "Human beings are naturally beneficent, altruistic and good. It is the task of those determining the form of society to create environments which allow and encourage the expression of this innate goodness; and

b. Human beings are truly free in the sense accepted by philosophers of free will. Humanists reject the thesis of determinism in which choices and individuals acts are the inevitable and

> predictable result of antecedent causes (such as family upbringing or genetic inheritance). Human beings are faced with the moral necessity to make free choices in the conduct of their lives" (Brookfield, 1983, p. 150).

If these propositions are accepted, it is not necessary to be the "authoritarian" educator but one who "goes" with the wishes of those learning. This does not mean that an educator does not have to plan or develop lesson plans but once the interaction commences, the educator has to be flexible enough to respond to the questions and queries of the individuals in the learning group. The educator must understand that although he has developed his program from experience and research, it might not meet the needs or connect with the experiences of the adult students in the group.

> "Carl Rogers[1] (1969) has explored the connections between the humanistic practice of psychotherapy and the facilitation role of the educator. Rogers placed primary importance on the presence of independence in learning declaring that 'the only learning which significantly influences behaviour is self-discovered, self-appropriated learning' (Rogers 1986, p. 153)".

1-5 Adult Learning Model

The learning of adults is different from the learning of children. Adult learning requires a different approach,

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[1] Cited in Brookfield, 1983, p. 150.

style and process by the educator. This "concept ... is premised on four assumptions regarding adult psychology ... as follows:

1) their self-concept moves from one of being a dependent personality toward being a self-directed human being;
2) they accumulate a growing reservoir of experience that becomes an increasingly rich resource for learning;
3) their readiness to learn becomes oriented increasingly to the developmental tasks of their social roles; and
4) their prime perspective changes from one of postponed application of knowledge to immediacy of application, and accordingly, their orientation toward learning shifts from one of subject-centredness to one of performance-centredness" (Brookfield, 1983, p. 151).

Humanistic theories allow the educator more flexibility and use of experiments in presenting material to adult learners. Adults can adapt to different scenarios and techniques. Because of their experiences, adults are able to take the new information in and assimilate it with little difficulty. "... the more the teacher of adults can base teaching upon the previous experiences of the learner, the better and faster the adult will learn" (Rossman, et al.,

1984, p. 30). Implications of the aforementioned assumptions for the educator in preparing an educational package are;

"1. It is important to grant to the learner a degree of self-diagnosis about learning needs.

2. The learner assumes partial responsibility for planning learning.

3. The teaching-learning transaction becomes the mutual responsibility of learners and teachers.

4. Evaluative procedures and criteria to judge successful performance become the partial responsibility of the learners.

5. Experiential techniques of teaching are particularly suited to work with adult learners" (Brookfield, 1983, p. 151).

The Social Work value of client self-determination parallels the humanistic theoretical base discussed above.

1-6 Social Learning Model

A facilitator has two choices when presenting a learning program. It can be presented to an individual or a group. Considering the Social Learning Model, the group is the preferred method of providing an educational program to adults. The rewards and reinforcements required for learning can be gained from other group members. Role

modelling or symbolic modelling can also occur between group members and/or the facilitator. Also, "Observational learning, or learning through imitation, is assumed to account for a great deal of significant social learning. The assumption is based on the idea that one can explain the effects of imitation with the principles of operant conditioning" (Lefrancois, 1977, p. 99). Therefore, an attempt to educate on an individual basis would not be as effective as educating a group.

Educating on an individual basis provides only one role model whereas educating a group provides a number of role models which may be imitated by group members. Rewards and reinforcements received by the individual learner come from the facilitator and not from peers.

1-7 Group

> "A group is more than a collection of individuals. It is an entity, something whole in itself. There is a continuum of groups: at one end, the tightly knit team, the integrated group where all the members have submerged their individuality; at the other, the loose-knit group" (Rogers, 1986, p. 100).

It makes little difference where the group falls on the continuum as to the type of group one will encounter. For example there are the following types of groups:

a. Formal Groups where the structure is set before any member joins. Formal groups are normally set up for a specific purpose and the group is seldom

changed in any way. Examples would be task orientated groups or treatment groups.

b. Informal Groups are those where each member can be influenced by other members. In addition, the loyalty to the group is strong. Examples include a family, a church, a committee or an education groups. Most forms of adult education groups, being voluntary and participatory, are informal groups.

c. Reference Groups are groups of people from whom we draw the range of values, standards, aims and goals. Examples include socialists, farmers, teachers, clergymen, etc. (Rogers, 1986).

The group that comprised the workshop would be considered an informal group. Each member had the opportunity to influence other members and most group members took advantage of their opportunities. Open discussions took place in every session which meant the group member benefited from each other's experiences.

1-8 Group Dynamics

An educator planning to use the Education Group method of intervention must be aware of the dynamics of groups. Toseland and Revis (1984) have suggested four types of

dynamics which affect or may affect the group process. They are:

1. Communication and interaction patterns.
2. The attraction of the group for its members.
3. Social controls such as norms, roles and status.
4. The groups culture (p. 57).

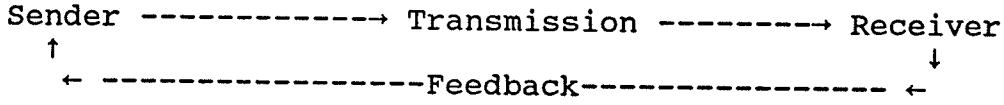
These four dynamics will be discussed separately.

1-8-1 Communications

The communication process begins with a person communicating a message, by voice or in writing or in a nonverbal way to another person. The receiver, through his experience, training and interpretation, decodes the message. The receiver provides the sender feedback through verbal or nonverbal means to indicate either an understanding of the message or simply an acknowledgement. The communication process depicted in Figure One is an adaptation of Hamilton and Parker's (1987) "basic model of communication."

Figure One

The Communication Process



(Hamilton & Parker, 1987, p. 5)

The facilitator, who is aware of the various methods of communicating, can assess by watching for verbal and nonverbal clues, whether or not the message has been received and understood. For example, if the facilitator passes some highly technical data to the group and the group responds nonverbally with blank stares, the facilitator is aware the group may not have understood the message. To confirm this nonverbal message, the facilitator asks some open ended questions to determine if group members did or did not receive the right message.

The facilitator should also be aware that the group members may be interpreting another message from the data given. For example, a group member may only hear selected things or only hear a portion of the message because he has a hearing problem. Another group member may interpret or give the message a different meaning because of language barriers or past experiences. The message may be distorted which can cause it to be skewed or misinterpreted (Rossman, 1984, p. 15).

When dealing with adults, the facilitator must consider some physiological factors, that is, the vision, hearing, reaction time, and emotional reactions of the participants. It has been suggested "... 85 percent of all learning occurs through vision" (Rossman, 1984, p. 15). Rossman also notes "... older individuals find it difficult to follow rapid speech despite little or no hearing loss" (p. 17). It is

therefore paramount for the facilitator to speak slowly and distinctly, ensure good lighting, use visual aides (films, video tapes, overhead projections, 35mm slides, chalkboard, etc.), and use conversational speech (Rossman, 1984). Each one of these factors will have an effect on an educational program. Being aware of these factors, the facilitator had the main points of each session on overhead slides that were visible to all participants.

1-8-2 Group Attraction

The Group Attraction dynamic is "... defined as the result of all forces acting on the members to remain in the group" (Toseland & Revis, 1984, p. 65). Some of these forces include:

1. "Needs for affiliation, recognition and security.
2. Incentives and resources of the groups such as the prestige of its members, the groups goals, its program activities, and style of operation.
3. The subjective expectation of members about the beneficial or detrimental consequences of the group.
4. A comparison of the group to other group experiences" (Toseland & Revis, 1984, p. 65).

Adults will join a group to meet or satisfy a psychological need. For example, if a person notices a

living problem and they learn there is a group that is helping others learn about that problem, they will join the group looking for an understanding or a confirmation of their attitudes, beliefs, and behaviours. This is one of the reasons why educational programs geared towards current "living problems" are becoming more and more in demand.

1-8-3 Social Control

Social control "... is a term to describe the process by which the group as a whole gains sufficient compliance and conformity from its members to enable it to function in an orderly manner" (Toseland & Revis, 1984, p. 67). This dynamic varies from group to group and results from the "... norms that develop in the group and the roles and status of individual group members" (Toseland & Revis, 1984, p. 67).

The norms are the shared expectations and beliefs of the group members which determine acceptable behaviour of each member. The norms stabilize and regulate behaviour and become clear as the group develops.

Roles allow for the division of labour and appropriate use of power and serve as a means of social control by prescribing how members should behave in certain situations. Roles are also closely related to status which is the ranking of each members position in the group relative to all other members. Roles can and do change over time. For

example, at the onset of a group a member may be given an elevated role because of his knowledge or experience. As the group progresses and other members increase their knowledge, the original roles change to reflect the new informal leaders.

Status is determined by the person's prestige, position and recognized expertise. For example, a person who has formal education in the area the group is formed for, will have a higher status in the group than another member who has no education (Toseland & Revis, 1984).

Similar to the initial roles, status can and does change as group members gain knowledge and experience. In a sense, the assumption can be made that education can be an equalizer. It can lower the status of some and raise the status of others.

1-8-4 Group Culture

The fourth dynamic, Group Culture, "... refers to the values, beliefs, customs and traditions that are held in common by group members: (Toseland & Revis, 1984, ,p. 71). Group culture emerges as the group develops and is the result of group members background, ethnic, cultural and racial heritages. It is a common set of values and is influenced by environmental factors. These values have a direct impact on the material presented. If the material or

the method of presentation is not accepted, the group will let the facilitator know and either demand change or the members will stop coming.

In addition to the dynamics described above, "Individuals tend to realize the most personal benefit from learning in groups to the extent that the following four conditions are present:

1. Everyone shares in the program development and evaluation.
2. Freedom of expression is allowed.
3. Group members possess the skills of joint inquiry and problem-solving.
4. A diagnostic attitude towards progress is encouraged" (Smith, 1982, p. 106).

1-9 Advantages of Group

The advantages of the group process in an educational setting are based on certain assumptions:

1. Each person has the ability to make appropriate use of the available resources to meet needs. Some persons may use this ability more fully than others, but it is present in everyone.
2. All group members together know more than any one member. Everyone has value and has something to add to the group process.

3. Each person is the ultimate authority on what he or she needs and on what will work for him or her.
4. Open and honest communication is important to a positive group experience.
5. Group members can explore their style of relating to others and can use the group to learn better social skills.
6. The group setting can offer support for new behaviours and encourages experimentation.
7. A group is often a reincarnation of the everyday world where members recreate problems existing for them in that world. Members can then get helpful feedback and can participate in reality testing.
8. Group work can do almost anything individual work can do.
9. Groups help members know that they are not alone with their problems.
10. Groups give members the chance to help others.
11. Group members can learn through the experience of others.
12. It can be beneficial for those who are socially isolated.
13. Groups provide a supportive environment which is seen through a sense of solidarity. The

individual will be supported by the group and the group will reward success.

14. A group often provides stimulus to change.
15. By drawing upon the increased variety of experience possessed by its members, can build larger and more complex cognitive structures.
16. The group has a life of its own, a momentum that carries the participant along, helps to create and maintain motivation, and sets a pace of learning that is satisfying to most of its members. (Toseland & Revis, 1984; Malleroy, 1984; Corey & Corey, 1977; & Brookfield, 1983).

1-10 Disadvantages of Group

There are disadvantages of educational groups as well. Some of the disadvantages noted by Brookfield (1984), Cermak (1985), Curtin (1985) and Johnson (1984) are:

1. There may be a tendency for the facilitator to run time-limited groups or to be overly active in guiding the group.
2. In the learning environment there may be pressure to conform or promote imitation.
3. There may be conflict between learners re prejudices and expectations

4. It may be difficult to cope with the experiences of others.
5. The pace set by the group may create pressure.

The advantages do outweigh the disadvantages and educational groups are the preferred method of teaching adults. "Adults usually learn more effectively and quickly in a non-competitive atmosphere where they can collaborate with others and foster their own learning" (Rossman, 1984, p. 31).

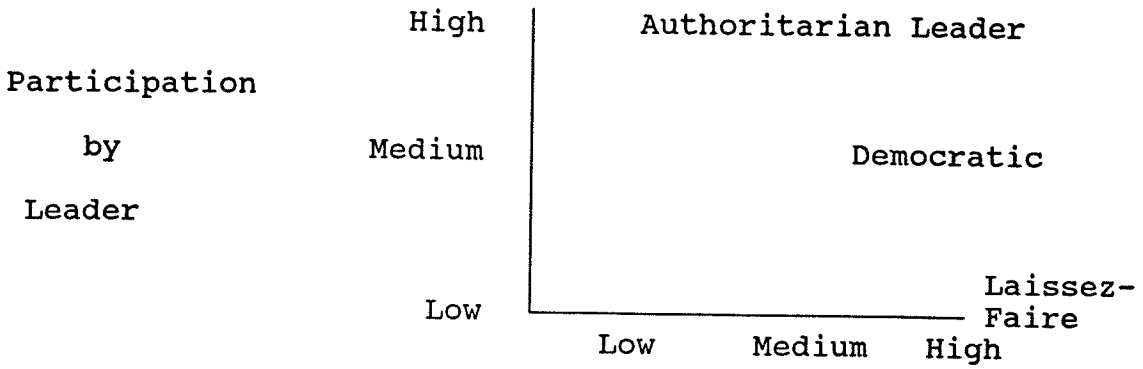
1-11 Leadership

Leadership in an adult educational group is an important factor which must be considered. "... leadership should vary depending on the purpose of the group and the groups' membership" (Toseland & Revis, 1984, p. 85). When dealing with an adult learning group, using an inappropriate leadership style can have disastrous effect on the group process and outcomes. For example, an authoritarian facilitator will get very little participation from members while a laissez-faire facilitator may get a lot of participation from members but will not participate in the process. In both cases very little learning will take place. A democratic style of leadership is the style which provides an equal amount of participation by group members

and the leader as shown in Figure Two. Maximum learning takes place when participants are allowed to express their

Figure Two

Leadership and Participation



(Toseland & Revis, 1984, p. 81)

ideas, opinions or beliefs. To ensure paricipants were given the opportunity to receive maximum learning, the principles of democratic leadership were used throughout the workshop. Participants were given the opportunity to voice their opinions, ideas and beliefs with minimal guidance from the leader.

1-11-1 The Interactional Model of Group Leadership

The Interactional Model of Group Leadership incorporates the empirical findings of others who have developed comprehensive models of group leadership. It

views leadership as being derived from the interactions of the group, its members, the leader and the environment. This model is closely related to the ecological systems perspective of social casework. There are six separate but interrelated factors which were considered in developing this model. These six factors are:

1. The purpose of the group. This factor includes reasons for bringing the group members together and the problem to be worked on or considered. It helps to determine the extent to which the facilitator uses power and influence to affect how work will be accomplished.
2. The type of problem. This factor considers whether the problem is of concern to the group as a whole, some subgroup or an individual. The facilitator must be aware of where their legitimate influence ends.
3. The environment. This factor includes the physical setting, agency or organization, social systems and the social environment. An attempt should be made to match the groups' needs and preferences to a setting that facilitates the groups needs.

Table 2

An Interactional Model of Group Leadership

Purpose of the Group	Type of Problem
THE ENVIRONMENT 1. Physical Setting 2. Agency or Organization 3. Social systems and the social environment	THE GROUP SIZE AS A WHOLE 1. Size 2. Time Limits 3. Group Dynamics 4. Stages of Group Development
THE GROUP MEMBERS 1. Members' Characteristics a. interpersonal skills b. information c. motivation d. expectations 2. Extent of Participation a. amount of time worked together b. extent to which decision is implemented by the members c. reaction of participants	THE GROUP LEADER 1. Power base 2. Skill level 3. Personality 4. Service technology

(Toseland & Revis, 1984)

4. The Group as a whole. This factor consists of four properties. These are:

   a. Group size.

   b. Time limit versus no time limit.

   c. Group dynamics.

   d. The stage of group development.

   The size of educational groups ranges from two to a large audience. An education group of around ten learners is optimal. For example, as a group size grows, participation by individuals decreases and subgroups may

form. Smaller groups usually have greater cohesion, member participation and intimacy (Wickham & Cowan, 1986). The time limit versus no time limit property allows for greater structuring of interactions and increased task-focused behaviour. Group dynamics and stage of group development have been discussed earlier.

5. The group members. This factor influences how leadership emerges in the group. Members characteristics such as interpersonal skills, education, experience, amount of information they have access to, motivation and expectation has a direct impact on leadership styles and techniques. Also considered in this factor is the extent to which members participate, the amount of decision making by members and the extent to which leadership is shared between the worker and group members.

6. The group leader. This factor considers the qualities of the designated leader by looking at the power base of the leader, level of skill, personality and particular theories or method of intervention used by the worker (Toseland & Revis, 1984).

1-11-2 Leadership Role

Rogers (1984) says that the role of the facilitator is to set the tone of the group. Therefore the success of the group is dependent upon that tone. To ensure success there are four parts to the facilitator's role in setting the tone:

1. "First, as leader of the group, whose purpose is to keep the group together, to keep things going.
2. Second, as educator (and social worker), an agent of change ... we aim to use the group to help to bring about changes in skills, knowledge, understanding and behaviour.
3. Third, as member of the group, subject to the pressure it exerts.
4. Fourth, as audience, outside of the group, the person before whom the group members will perform their newly acquired learning in search of evaluation and reinforcement" (Rogers, 1986, p. 118).

Being aware of the facilitators role will assist the facilitator in setting the tone he/she wishes for the program. Coupled with a democratic leadership style, the facilitator can made the educational experience of learning new material a worthwhile and exciting event.

1-12 Summary

So far, this section has looked at the purpose, types and parts of groups, some basic principles of group leadership and what should be considered in a group leader. The next section will consider the group as it applies to providing a educational experience for adult children of alcoholics, some of the factors considered and the rationale which some facilitators used for educating this population.

As noted earlier, an informal education group is the intervention method that will be used in this practicum.

Group takes place when relationships based on honesty, vulnerability and need are developed. It is "... a laboratory where a member can learn how to have relationships. It is a place where risks can be taken safely. It is a place where old, self-defeating ways of relating can be pointed out, acknowledged, mourned, and disregarded. It is a place where healthy ways of interacting can be developed" (Curtin, 1985, p. 20).

It was an aim of this student to have maximum participation by group members. With an open exchange of ideas, beliefs and thoughts, participants will gain a better understanding of each other. In addition, the participants will be in an environment where they can freely express their thoughts without fear that they are wrong, out of

place or criticized for their opinions. Risk taking will be encouraged.

CHAPTER TWO

Alcohol

The potable form of alcohol is ethanol. It is one of several types of alcohol that exist including methyl (wood alcohol), butyl and isopropyl (rubbing alcohol). Ethyl, or beverage alcohol or ethanol is clear, colourless, highly flammable and has a slight sweet smell. Alcohol is an anaesthetic drug. Misuse can be hazardous (Pattison & Kaufman, 1982).

Alcoholic beverages are divided into three categories: wines, beers and distilled spirits. Table 3 provides some basic data on these categories.

2-1 Safe and Healthy Drinking

Is there a safe and healthy way of drinking or should a person drink alcohol at all? The answer to these questions

Table 3

ALCOHOLIC BEVERAGES

Beer	Wine	Spirits
Fermentation for brewing of cereals yeast and hops	Fermentation of yeast and the natural sugars of fruits	Distillation of water and alcohol from corn, rye, malt, berries, and molasses
Alcohol Content 3 - 6 %	Alcohol Content 12 - 14 % Fortified with distilled spirits up to 20% (muscatel, vermouth sherry)	Alcohol Content 40 - 50 % Plus 100 Proof = 50% 80 Proof = 40%

(Compiled from Finn & O'Gorman, 1981)

depends upon a persons ethnic, cultural and religious beliefs as well as how society views the drinking of alcohol. However, from a scientific viewpoint, a safe level "As was reported in the Second Report to the Congress on Alcohol and Health, the equivalent of 1.5 oz of absolute alcohol a day was determined as the safe or moderate use of alcohol" (Pattison & Kaufman, 1982, p. 484). Before deciding to drink, the physical, psychological and social factors should be considered. These factors are outlined in Table 4.

Table 4

SAFE AND HEALTHY DRINKING FACTORS

PART 1 - PHYSICAL

Factor	Consideration
The Drug	- alcohol is an anaesthetic - moderate amount - sedates brain centres that control behaviours and feelings - heavy amounts - adversely affect judgment and motor functions - causes pseudoeffects
Time, Place & Circumstance	- Will this activity be impaired by a given dose of an anaesthetic drug?
Amount	- 1.5 oz of absolute alcohol per day is considered safe for some - Anstie's Law[2]: For some people, one drop of alcohol is a drop too much. Furthermore, one day's unused ration cannot be added onto that for the next day
The Manner	- alcohol should always be sipped slowly - 20% of alcohol is absorbed directly from the stomach - gulping causes an exaggerated response - the body metabolises .75 oz of absolute alcohol per hour - food in the stomach will slow the rate of absorption

PART 2 - PSYCHOLOGICAL FACTORS

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[2] Anstie's law. The safe limit supported by recent scientific corroboration as reported to the Congress of the United States was the reaffirmation of *Anstie's Law of Safe Drinking*, published in 1862 by Sir Francis Anstie, a British pathologist. Anstie's limit is an upper limit, a statistical average not applicable to all individuals. "He concluded that 1½ ounces of pure ethanol, the equivalent of around three ordinary drinks a day, was the upper limit which an adult in otherwise good health could ingest on a regular daily basis without running the risk of developing pathologic organ changes" (Herrington & Jacobson, 1987, p. 198)

Expectation	-	what is expected from alcohol is what results
Loneliness & Solace	-	alcohol solves no problems
	-	alcohol is not a substitute for another person
Setting	-	setting of relaxation is desirable
	-	do not drink in a dark, secluded place
	-	sip rather than gulp drinks
	-	have and eat food with drinks
	-	people who cannot manage their work without this anaesthetic agent are courting addiction and its potential dangers
PART 3 - SOCIAL FACTORS		
Expectation	-	society's expectations and tolerance determine the response
	-	irrespective of dose
	-	requires the willingness of individuals who share the immediate environment to take responsibility for setting expectations that are socially useful and not destructive
Limits & Images	-	behave in a socially acceptable fashion
	-	know your hosts' limits
	-	do not push drinks on others
	-	do not let others push drinks on you
	-	getting drunk means one has overdosed
	-	avoid circumstances conducive to excessive or irresponsible use of alcohol by drinking companions

(Compiled from Pattison & Kaufman, 1981, 484-488)

2-2 Types of Drinkers

In reading the literature on adult children of alcoholics there is reference to three main types of drinkers - abstainers, social drinkers and alcoholics.

These terms are restrictive and do not really reveal the types of drinkers we see in our society. The following descriptions outlined by Finn and O'Gorman (1981) help broaden the concept of the types of drinkers and aid in developing a better understanding of the subject.

1. "Abstainers - drink less than once a year or not at all;
2. Infrequent drinkers - drink at least once a year, but less than once a month;
3. Light drinkers - drink at least once a month but typically only one or two drinks on a single occasion;
4. Moderate drinkers - drink at least once a month, typically several times, but usually with no more than three or four drinks per occasion;
5. Heavy drinkers - drink nearly every day with five or more per occasion at least once in a while, or about once weekly with usually five or more per occasion" (pp. 13-14).

Herrington and Jacobson (1987) defined social drinkers as "Normal drinkers, true social drinkers, have no consistent or compelling need to drink, and are free to choose when, where, and how much alcohol they will consume" (p. 185). They go on to say, "While most individuals remain in the normal drinking category, there are significant numbers, estimated to be as large as 20% of all drinkers,

who fall into the heavy-drinking category. A significant number of these individuals may consume an average of five to ten alcoholic drinks on each drinking occasion and suffer little or no disability in their lives as a result" (p. 185).

Figures Three, Four and Five breakdown the Canadian adult population by number of drinks in the week before the survey, the prevalence of alcohol use and current drinkers in Canada by sex. These Figures portray broad categories and do not break down the current drinkers into the categories of moderate, heavy, problem drinker or alcoholic drinkers. These figures do provide an overview of the drinking patterns of the two countries.

The fifth type of drinker, "Heavy Drinkers" refers not only to alcoholic drinking but also problem drinking which are both considered alcohol abuse. There are some differences between the two categories. For example "a problem drinker is anyone for whom the use of alcohol creates a problem" (Finn & O'Gorman, 1981, p. 23) while alcoholics " ... are individuals who once they begin to drink cannot normally predict or control how long or how much they will drink because they are dependent on alcohol" (Finn & O'Gorman, 1981, p. 23).

The difference between problem and alcoholic drinkers has been refined by the "controlled drinking" advocates. An

accepted definition of problem drinker by these individuals is "... persons who have identifiable problems related to their use of alcohol but who have not experienced major alcohol withdrawal symptoms" (Sobell & Sobell, 1987, p. 7). One can assume from this definition that an alcoholic is one who has experienced alcohol withdrawal symptoms, i.e. seizures, hallucinations, delirium tremens, etc. It must be noted that this definition is not accepted by all researchers or people in the alcoholism field. One example of a definition of alcoholism used by some and adopted by the American Medical Society on Alcoholism is:

> "Alcoholism is a chronic, progressive and potentially fatal disease. It is characterized by tolerance, physical dependency or dangerous changes to body organs, all of which are the direct or indirect consequences of the alcohol ingested" (Finn & O'Gorman, 1981, p. 24).

Other definitions include references to work, health, family, legal and social functioning being adversely affected. One of the major problems with these definitions is they are too broad and do not recognize a distinct difference between a problem drinker and an alcoholic nor does it allow for consideration of natural recovery. For those involved in the treatment or prevention fields, the definition of problem drinker by Sobell & Sobell (noted above) opens up a whole new area of study and work. For example, the treatment of an alcoholic and a problem drinker differ in content and outcome expectations. This means

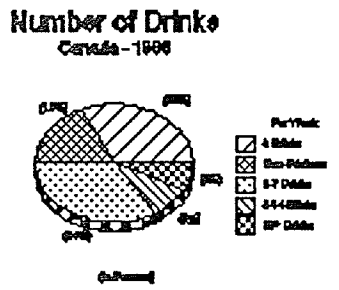

Figure Three

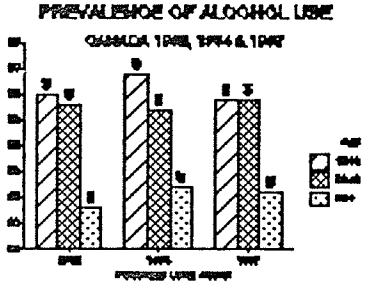

Figure Four

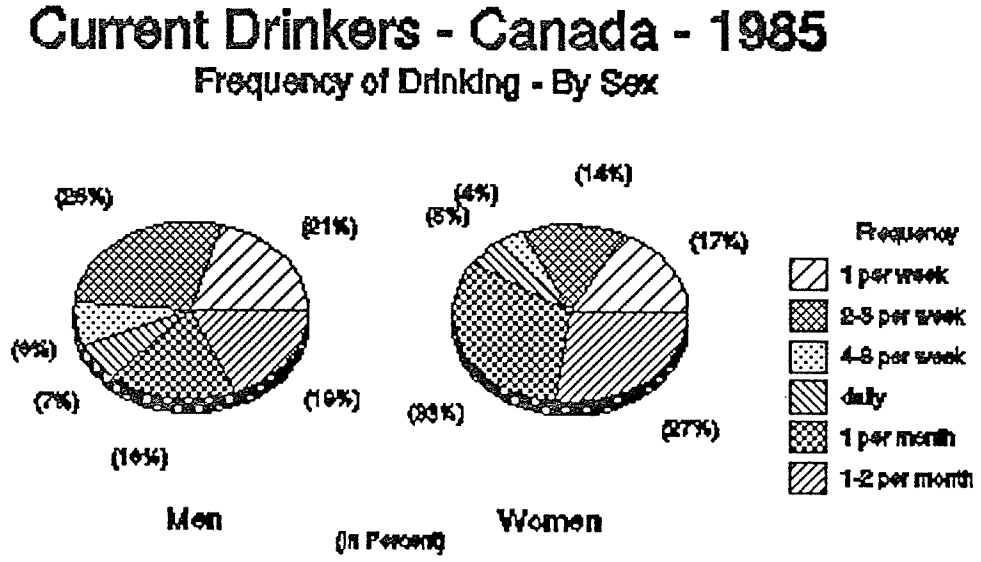

Figure Five

revamping present treatment programs to include those who are not alcoholic and do not have to abstain from drinking.

They will, however, have to learn a more acceptable way of drinking. The next section may aid in the understanding of the causal factors and problems associated with attempting to identify and define alcoholism.

2-3 Etiology of Alcoholism

The "cause" of alcoholism is an area of study that has had many suggested possibilities. There has not been a single concrete cause that satisfies all conditions or covers all circumstances. In this section, we will look at some of the most popular suggestions.

2-3-1 Gender

There is some evidence that the possibility of the children of an alcoholic becoming alcoholic is gender related. If the mother is an alcoholic then it is more likely that the daughter will become an alcoholic (Pickens, 1984; Deutsch, 1983; Wolking, 1978; & Goodwin, 1983) as is the son of the father who is alcoholic (Barnes, 1984; Forney, et al. 1984; Kleinmann; Seixas & Youcha, 1985; & Goodwin, 1983).

The gender suggestion does not consider the influence of environmental, genetic (hereditary), cultural or factors. Each one of these factors will be considered separately.

2-3-2 Genetic

"Dr. Henri Begleiter, Professor of Psychiatry at the State University of New York Downstate Medical Center in Brooklyn, believes that heredity plays a major, though not the only role in determining who becomes an alcoholic" (Kleinmann, p. 1). Other researchers agree. There are studies which do indicate there may be a genetic link in certain people (Barnes, 1984). The possibility that heredity is a factor in the development of alcoholism has recently been explored and supported by several studies (Bahmen et al., 1981; Cloninger et al., 1981; & Goodwin, 1979). Wolin et al. (1980) cite evidence from animal and human studies that there may be a genetic influence on the transmission of alcoholism. Waite & Ludwig, (1985) suggests that both culture and genes contribute to the cause of alcohol abuse (Vaillant, 1983).

None of these studies say conclusively that alcoholism is caused by a genetic deficiency or that it is passed on from either mother or father (hereditary). Before we leave the genetic suggestion, it is important to look at work done by researchers looking at "twin" and "adoption" studies. Their findings are summarized as follows:

1. Goodwin, 1979. Danish Twin and Adoption study.
    a. Children of Alcoholics are particularly vulnerable to alcoholism whether raised by

the alcoholic parents or by non-alcoholic foster parents which suggests that vulnerability is not necessarily an environmental factor but one of genetic background.

b. This vulnerability is specific for alcoholism and does not involve increased risk for other psychopathology, including abuse of other substances; and

c. This was the first study in which the researchers looked at females as well as males. The findings raise the possibility that alcoholism in women has a partially genetic link (Goodwin, 1983).

2. Schuckit et al. (1972)[3] also studied a group of adopted out individuals whose parents - either biological or surrogate had a drinking problem. Subjects whose biological parent were alcoholic were significantly more likely to have a drinking problem than were those raised by an alcoholic surrogate parent (Goodwin, 1983).

3. In 1970, Bahman et al[4]. studied 2,000 adoptees born between 1930 and 1949. There was a significant correlation between subjects for abuse

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[3] Cited in Goodwin, 1983

[4] Cited in Goodwin, 1983

of alcohol among biological parents and their adopted-out sons. These results support a genetic hypothesis for the development of alcoholism and closely parallel those found in the Goodwin et al. (1973) study of adopted sons of alcoholics (Goodwin, 1983).

4. More recently, researchers working at the National Alcohol Research Centre at Washington University in St. Louis, Missouri, and the Umea University School of Medicine in Umea, Sweden, examined the medical and social records of the same 862 males and 913 females. They identified two different forms of inherited alcohol problems that have distinct genetic and environmental causes. For the first time they demonstrated the genetic transmission of alcohol abuse in women (Goodwin, 1983). This study provided additional confirmation of the Goodwin study noted in sub-para 1(c) above.

Again, these studies indicate there may be a genetic factor in the transmission of alcoholism to the children of alcoholic parents. However, it is not conclusive. Further, it is not clear what role is played by heredity (Hennecke, 1984). The Cloninger et al.[5] study concluded "... through a "cross fostering" analysis of adopted men, it appears that

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[5] Cited in Bennett, 1987

susceptibility to becoming alcoholic is due to specific combinations of predisposing genetic factors and environmental stressors that interact together, rather than to either environmental or genetic factors alone" (Bennett, et al., 1987).

2-3-3 Other Possible Causal Factors

From the genetic studies, lets look at a few of the physiological studies that attempt to discover the causal factors of alcoholism.

1. In a biological study of alcoholics, "a marker gene, the HL-A antigen B-8 has been found to be present ... in patients with cirrhosis of the liver" (Murray & Stabenau, 1982).
2. In another biological study, "a minority of those drinking heavily may be especially at risk for the Wernike-Korsakoff syndrome because of a defect in transkelolase" (Murray & Stabenau, 1982).
3. "Research studies of deceased alcoholics identified a brain-specific protein, relatively greater alpha activity after alcohol ingestion, and reduced leucine-enkephalin-like immunoreactive substances" in the brain which were suggested as predisposition factors of alcoholism (Woodside, 1983).

4. In a physiological study, "The data showed that zinc levels ... were significantly lower for children of alcoholic parents" (Woodside, 1983, & Kern, et al. 1981) than children of nonalcoholic parents.
5. "Scientists at Harvard Medical School found a little-known chemical -2,3 Butanediol- in the blood of chronic alcoholics" (Seixas & Youcha, 1985) that was not found in a control group of nonalcoholics; and
6. In another study, "Levels of acetaldehyde were higher after drinking in both alcoholic and non-alcoholic sons of alcoholic fathers" (Seixas & Youcha, 1985) which suggests that there is a difference in how alcohol breaks down in the body of sons of alcoholics.

None of the findings of these studies can be said to be true for all alcoholics. For this reason there has not been a single biological explanation for alcoholism and why it appears in some and not in others. In all the studies to date, it has been found that not all alcoholic parents have alcoholic children, and not all alcoholic children have alcoholic parents, only a minority in both cases (Pickens, 1984).

2-4 Cultural Factors

A commonly held misconception that cultural factors alone play a leading part in the cause of alcoholism is just that - a misconception. "... cultures that teach children to drink responsibly, cultures that have ritualized when and where to drink, tend to have lower rates of alcohol abuse than cultures that forbid children to drink" (Bratter & Forrest, 1985, p. 58). This statement, while true, must also be considered with other factors. For example, if society condones public drunkenness the rates of alcoholism are much higher than in a society that frowns on or forbids public drunkenness. Italy provides education in moderate alcohol use, condones using low-proof alcohol and drinking alcohol with food and their alcoholism rate is relatively low. France, on the other hand, teaches the children to drink, but condones public drunkenness and France has the highest rate of alcoholism in the world. In Ireland it is forbidden for children and adolescents to drink but "... they tolerate - and covertly praise - the capacity of men to drink large amounts of alcohol" (Bratter & Forrest, 1985, p. 62). The message for the children is to be accepted as a man they must be able to drink large quantities of alcohol. Although there is a high rate of alcoholism in men in Ireland, the alcoholism rate in children and adolescents is low when compared to Italy (Vaillant, 1983).

When considering cultural factors, one must also consider societies attitudes about alcohol education, and alcohol use, for example, moderation and drunkenness.

2-5 Environmental Factors.

The three variables that will be discussed under this heading are the Social Learning Theory variables of conditioning, learning and life events.

It has been suggested that operant conditioning may be a causal variable in the development of alcoholism. If a person takes a drink of alcohol and it does something positive for that person then the person will drink again and again for that positive effect. "In substance abuse, reinforcing factors [Natlan, 1983][6] may be described as those which become associated with a favourable outcome of drinking or drug use, such that the event is more likely to be repeated on future occasions" (Bratter & Forrest, 1985, p. 10). This statement assumes that the intake of alcohol will result in a "favourable outcome". If that is true then a person would only drink until they experienced a negative event such as a fight, a charge and/or conviction for a drinking related offence. This is not so. "Those who have researched the question 'Why do people drink?' report that alcohol is taken both for the pleasurable psychological

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[6] Cited in Bratter & Forrest, 1985, p. 10

change it induces in one and for the removal of discomfort [Conger, 1956][7]" (Bratter & Forrest, 1985, p. 12). This indicates alcohol may also be used to remove a discomfort which suggests that people may drink to relieve psychological pain, both real or imagined.

People with low self-esteem or feelings of low self-worth may also drink to hide those feelings i.e. the feeling of discomfort with themselves. People drink for many reasons. For some the reasons change every time they drink. Therefore, operant conditioning may be true for some, but not all the causal factors for alcoholic drinking.

The second variable discussed under the heading Environmental Factors is learning. "Surveys demonstrate that the majority of men and women learn to drink by the time they reach eighteen years of age, and some by then have already established drinking patterns [Albrecht, 1973; Liban & Smart, 1980][8]" (Bratter & Forrest, 1985, p. 13). From the writers experience in two alcoholism rehabilitation clinics, the majority of the participants remember their first drunk around the age of 12, with a few as young as nine and one at the age of four. Most of these participants had an alcoholic parent. In some cases, both parents were alcoholic. "A person who later develops drinking problems is likely to have started using alcohol at an earlier age

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[7] Cited in Bratter & Forrest, 1985, p. 12

[8] Cited in Bratter & Forrest, 1985, p. 13

than is typical for the general population [Cahalan, 1970][9] (Bratter & Forrest, 1985, p. 14). It was also common to have one parent addicted to alcohol and the other to a prescription drug, usually valium. From the learning perspective, these people may have learned how to use alcohol by watching their parent or parents.

People move from learning to use alcohol from their role models to learning from their peers or co-workers. "For alcohol consumption the presence of a heavy drinking partner (peer, co-worker, spouse, friends, etc.) has been found to increase the amount and rate at which alcohol is consumed [Lied & Marlatt, 1979][10]" (Bratter & Forrest, 1985, p. 14). Some also select an occupation or a specific job that will provide them the opportunity or freedom to drink on the job. For example, "...[Casper, 1979][11] has found that the incidence of drinking is increased in occupations where:

1. plenty of leisure time with coworkers is provided;
2. drinking is highly valued as part of the occupations subculture; and
3. drinking can be used to express solidarity or group identity" (Bratter & Forrest, 1985, p. 14).

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[9] Cited in Bratter & Forrest, 1985, p. 14.

[10] Cited in Bratter & Forrest, 1985, p. 14.

[11] Cited in Bratter & Forrest, 1985, p. 14.

Under the learning variable it has been suggested that alcohol abusers usually:

1. start drinking at an earlier age than normal or social drinkers.
2. their heavy drinking may be the result of influences from role models, peers or coworkers; and
3. heavy drinkers may select occupations which provides the time and opportunity to drink.

However, "For the majority of people ... drinking does not develop into excessive use ..." (Bratter & Forrest, 1985, p. 14).

The last variable to be discussed under Environmental Factors is life events. Considered under this variable are events such as marriage, separation, divorce, a jail term, a change in work status, illness, or a death. People may drink more during one of these situations. Some will continue with heavy drinking while others will return to moderate, light or normal social drinking after the effects of the event are over or have been worked through. One study suggests that alcoholics "also appear to be less perceptive of the impact that significant changes have in their life [Dudley et al., 1974][12] and experience proportionately less control over both internal and external pressures when compared with nonalcoholics" (Bratter &

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[12]Cited in Bratter & Forrest, 1985, p. 15.

Forrest, 1985, p. 15). Therefore, these life events may not play a significant role in the development of alcoholism.

Environmental factors appear to play a role in the amount a person drinks, how often they drink and where they drink. However, there does not appear to be any evidence to suggest that environment factors alone can indicate who will suffer from alcoholism nor when a social drinker becomes a problem drinker or drinks alcoholically.

Looking at the factors discussed under the heading of "Etiology," there are none that explain why some individuals become alcoholic and why others, in similar circumstances, do not. Combining factors may help in understanding causality but the reason remains unsolved.

2-6 Other Related Information

It is estimated that one in ten Americans who drink become alcoholic (Seixas & Levitan, 1984) and that a third of the people in this country drink 90% of all the alcohol sold (Porterfield, 1985). Who are these drinkers? They "are, in reality, our neighbours, our friends and the parents of children" (Ackerman, 1983a, p. 4). Of the estimated 5% of people who enter treatment facilities about 70% are typically the middle-class family man (Wegscheider-Cruse, 1981). Most of these alcoholics have children whose

plight has come to light in the schools, hospitals, prisons and alcohol and other drug treatment centres.

Despite the consensus among clinicians that many children of alcoholics are severely affected by alcoholism, relatively few empirical studies have examined this issue (Barnes et al., 1979. El-Guebaly & Offord, 1977. & Jacob et al., 1978). In addition, conclusions which are tentative and ambiguous are the result of methodological problems, that is the studies are not comparable. The absence of reliable and valid instruments for the assessment of key independent and dependent variables results in a possibility of error variance and confounding influences which yield differences which are neither interpretable nor replicable. Furthermore, most investigations have included multiproblem families in which alcoholism is but one of a number of psychopathological and psychosocial problems being experienced by the subjects, the spouse and the family in general (Jacob & Leonard, 1986).

It is also important to note that the lack of empirical studies that have truly isolated alcoholic families will limit the information used in this project to clinical observations and clinical experiences.

CHAPTER THREE

Alcoholism - A Family Problem

The literature suggests that alcoholism is a family problem in several ways:

1. Marital instability, separation and divorce are common (Chafetz et al., 1971. Seixas & Youcha, 1985. McKenna & Pickens, 1981. Chafetz, 1979. Porterfield, 1985).
2. Parents are often not available to meet the needs of their children (Callan & Jackson, 1986. Barnes, 1984. Deutsch, 1982, Seixas & Youcha, 1985). and
3. Physical, emotional, sexual and psychological abuse are the results of this neglect (Deutsch, 1982; Hawley & Brown, 1981; Chafetz, 1979; Woodside, 1983; Seixas & Youcha, 1985; Ackerman, 1983a)

The rate of the alcohol or chemical abuse in the children of alcoholics is higher than those brought up in a family where alcohol is not a problem (Seixas & Youcha, 1985. Porterfield, 1985; Waite & Ludwig, 1985; Kleinmann. Hibsch & Gage; Morehouse, 1979; Cotton, 1979; McKenna & Pickens, 1981; Wegscheider-Cruse, 1981; Hill et al., 1977; Orenstein; Woodside, 1983; Pickens, 1984; Deutsch, 1982; Forney, et al. 1984; Gravitz & Bowden, 1984). Studies have also shown that most alcoholics have relatives who were

alcoholic (Cotton, 1979; Deutsch, 1982; Pickens, 1984; Woodside, 1983; Seixas & Youcha, 1985; Porterfield, 1985; Murray & Stabenau, 1982) which means it is not necessary for parents to be alcoholic for the children to be adversely affected by alcoholism in the family system. For example, if the parents were raised by an alcoholic, then their behaviour, attitudes and ways of living were influenced by that alcoholic parent (role model). If untreated, they in turn pass these factors on to the next generation, that is, to their children. Therefore, many children raised in a home that is dysfunctional, with or without, alcohol abuse (either by a parent, or parents who are actively drinking or were raised by an alcoholic) become alcoholic or dysfunctional themselves (Hindman, 1975; Waite & Ludwig, 1985; Cotton, 1979; Barnes, 1984; McKenna & Pickens, 1983; Deutsch, 1982; Forney, et al., 1984). Another commonality is that they are most likely to marry an alcoholic (estimates run as high as 60%) than a nonalcoholic (Hibsch & Gage. Seixas & Youcha, 1985. Gottieb, 1981. Wolking, 1987). Some differences are shown in Table 5.

3-1 Family Structure & Stability

In a study of 100 children aged 2 to 19 of alcoholics and a comparison group of 100 children of nonalcoholics,

Chafetz, Blane & Hill (1971), it was found that marital instability was also higher in alcoholic families than in

Table 5

Differences Between Dysfunctional Families

Where Abuse May Or May Not Be Present

No Abuse	Abuse Likely
Family willing to talk about problems when help is offered	Because of denial, family unlikely to be willing to discuss alcoholism
Family members communicate with each other	Intrafamily communications is often poor
Children usually manifest negative action or behaviour	Children may adopt super responsible role
Children and parents can identify and relate to feelings	Children and parents cannot identify and relate to feelings
Trust relationship easily established with family after initial anger, hostility, or fears are aired.	Difficult to establish trust with family
Family at least will attempt to accept referrals to appropriate agencies or community group	Family often do not follow through with referrals

(Riddell, 1988, p. 113).

nonalcoholic families (41% vs 11%) and most of the children of alcoholics were living with one parent (p. 690). Table 6 summarizes the Chafetz et al. study.

The authors state "it is abundantly clear that a child in a family with an alcoholic parent is much more likely than a child from a family without an alcoholic parent, to have suffered a prolonged separation from one of his parents by the time he reaches mid-adolescence" (p. 692) and "... adolescence seems to be the critical period for occurrence of school and police or court problems" (p. 693).

This study brought to light other factors which indicate that children of alcoholics are different than children of nonalcoholics in the following ways:

1. "... there are distinct and deleterious social consequences to being the child of an alcoholic parent (p. 696).
2. "The relatively high incidence of school problems and of involvement with police and courts shown by children of alcoholics ... suggests that children of alcoholics have a difficult time becoming socially mature and responsible adults" (p. 696).
3. "... children of alcoholics may behave differently with regard to the things that society worries about ... " or "children of alcoholics learn socially disapproving ways of behaving from parental models" (p. 697).

The structure and stability in the home are important

Table 6

Indicators of Structure & Stability in Families With and Without Alcoholic Parents
(in Per Cent)

	Alcoholic Families	Nonalcoholic Families
A. Presence of Parent in Home	(N=100)	(N=100)
Both present	38.0	77.0***
One present	55.0	20.0
One natural, one step	6.0	3.0
Other	1.0	0.0
B. Relationship between parents	(N-38)	(N=77)
Good	10.5	40.3**
Fair	18.4	23.4
Poor	60.5	18.2
No rating	10.5	18.2
C. Source of Income	(N=100)	(N=100)
Husband only	32.0	55.0*
Other	59.0	43.0
Unknown	9.0	2.0
D. Employment of Mother		
Employed	60.0	63.0
Not employed	31.0	34.0
Unknown	9.0	3.0
E. Extended Separation from Parent		
Lifetime	57.0	27.0***
Infancy	21.0	9.0*
Childhood	41.7	20.4**
Adolescence	26.5	8.8*
F. Child's Serious Illness or Accident		
Lifetime	38.0	13.0***
Infancy	19.0	4.0**
Childhood	21.9	10.2
Adolescence	16.3	8.8
G. School Problems		
Lifetime	60.2	37.0**
Childhood	37.6	27.2
Adolescence	51.0	23.5*
H. Problem with Police/Courts		
Lifetime	17.7	5.1**
Childhood	2.1	4.1
Adolescence	30.6	2.9**

* = $p < .05$ ** = $p < .01$ *** = $p < .001$—

(Bernard & Spoentgen, 1986, p. 54)

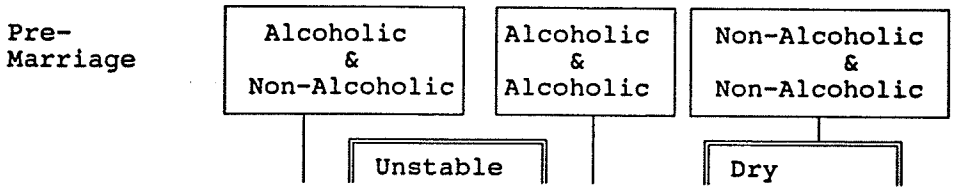
factors in understanding adult children of alcoholics. Without these factors being present, their upbringing was one of chaos. Learning how to cope with the problems was a means to survival.

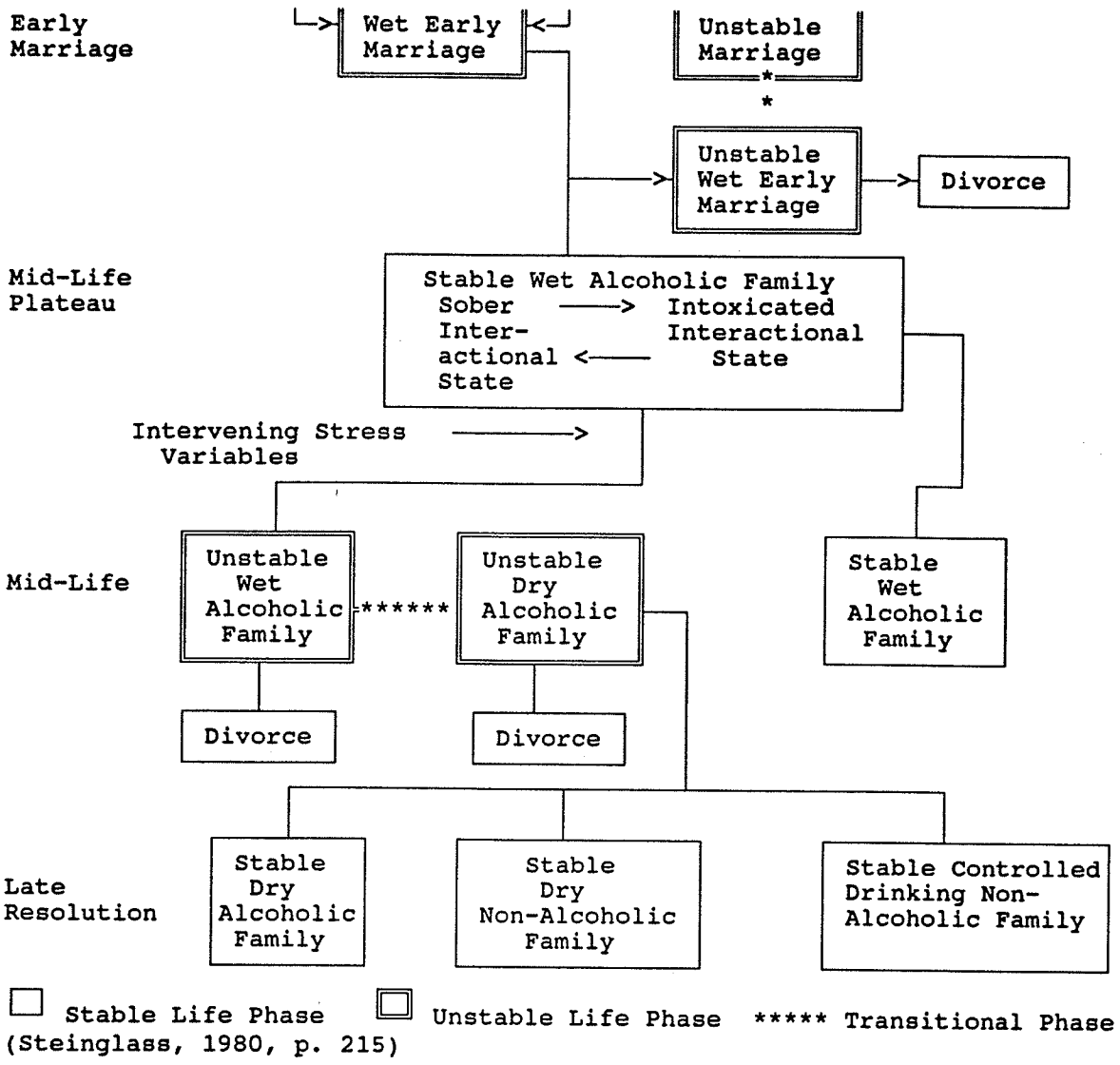
In Figure Six, Steinglass (1980) provides a diagrammatic representation of the developmental life history of alcoholic families. Shown are the various combinations of alcohol and non-alcoholic people entering marriage and the possible outcomes.

3-2 Coping

The families of alcoholics learn to cope with the alcoholism in several ways. They quickly learn to conceal what happens in the home (Brooks, 1981 l& Seixas & Youcha, 1985) and to adapt their behaviour to lessen the effects of the alcoholism (Ackerman, 1983a. Deutsch, 1982. & Steinglass, 1980). In some cases, role-reversal when the children took over the roles of the parents, occurred (Johnson, 1985. & Seixas & Youcha, 1985). However, "we must remember that the alcoholism syndrome produces particular kinds of behaviours, not particular kinds of people" (Greenleaf, 1981, p. 16).

An alcoholic family stresses a child well beyond such normal events as the birth of a sibling, beginning school, or even the death of a parent. Alcoholic families generate a daily environment of inconsistency, chaos, fear, abandonment, rejection, denial, symbolic death, and real or potential violence (Cermak, 1985). No one in the family escapes the detrimental





(Steinglass, 1980, p. 215)

Figure Six
A diagrammatic representation of the developmental life history of alcoholic families.

effects of an alcoholic family member. Some of those detrimental effects include:

1. A higher risk of developing alcoholism.
2. Gravitation toward alcoholic marital partners.
3. Incest.
4. Learning disabilities.

5. Suicide.
6. Eating disorders.
7. Confused sexual identity or promiscuity.
8. Inability to form healthy relationships.
9. Physical and emotional abuse. and
10. Separation and divorce (Wegscheider-Cruse, 1985a. Ackerman, 1983a. Jaworski, 1986. & Woititz, 1985)

Are these detrimental effects partly due to the lack of parental nurturance? Grace M. Barnes, (1984), conducted a study designed to explore the relationship between nurturance and problem behaviours. The sample included 379 individual family members - 120 mothers, 85 fathers, 124 adolescents and 50 adolescent siblings. Barnes found there is a direct correlation between parental nurturance and adolescent drinking and that "there is a significant positive relationship between adolescent drinking and frequency of deviance for various individual problem behaviours ..." (p. 335). Adolescents who have highly

Table 7

Adolescent Problem-Drinking Classification by Relative Degree of Mother and Father Nurturance

Adolescent Drinking	Mother Nurturance– Low (N=35)	Medium (N-50)	High N=37)
Problem Drinkers	26	24	8
Nonproblem Drinkers & Abstainers	74	76	92
TOTAL	100	100	100
	Father Nurturance Low (N=51)	Medium (N=40)	High N=19)
Problem Drinkers	26	18	5
Nonproblem Drinkers & Abstainers	74	83	95
TOTAL	100	101*	100

* = Rounding Error

(Barnes, 1985, p. 344)

supportive, nurturing relationships with their mothers and fathers have a significantly lower prevalence of problem behaviours as shown in Table 7. Nurturance is almost nonexistent in a family where alcohol is abused.

3-3 Survival

This data shows that without proper or a reasonable amount of nurturance, a child will use other techniques or behaviours to receive acknowledgement as a person. Unfortunately, these anti-social or dysfunctional behaviour patterns do not stop at a certain age and continue into adulthood. Some of the survival behaviour patterns that are brought into adulthood because of the lack of nurturance include:

1. Disassociation. Adult Children of Alcoholics have mastered the ability to disassociate themselves with their upbringing which may result in the dysfunctional behaviours being taught to their children.
2. Relationships. Due to the lack of proper role modelling and the inability to bring friends home or the fear of developing close relationships during childhood, Adult Children of Alcoholics do not know how to develop and maintain intimate relationships.
3. Responsibility. Adult Children of Alcoholics have developed a sense of super-responsibility. They are allowed to take over the responsibility for what goes on in the family which includes being responsible for the problems that are caused by the drinking or drug using, the lack of personal comforts, the fighting and conflict within the family and normal household tasks and duties. This is especially true for the child who is selected as the one responsible for the raising of the siblings and for taking care of the afflicted one. The other children in the family may become super-irresponsible and take responsibility for nothing that happens in the family. These children leave the family feeling a

sense of guilt because they are the cause of all the problems in the family. They did nothing to resolve them.

3-4 Rituals

It has been proposed by several authors that rituals play an important part in the behaviour of children. The lack of rituals of children raised in an alcoholic home has had serious consequences for some of these children. Family rituals, such as eating dinner together, spending weekends, holidays and vacations with each other, visitors in the home and planned evenings, are taken for granted in a functional family. Rituals bind a family together and their goal is to promote self-worth and harmony in the family (Wegscheider-Cruse, 1981. Wolin, et al., 1980. & Steinglass, et al. 1987). In an alcoholic family the opposite occurs. The rituals that usually bond family members become a source of their most painful battles. The traditions of the family become lost and the family's roots become blurred. Holidays are a particularly stressful time because this is a time when the alcoholic is usually intoxicated, hopes are smashed and expected events do not materialize.

3-5 Roles[13]

> "The roles within alcoholic families resemble those which have been linked to the birth order and gender of siblings in healthy families. The difference lies not in the broad outlines of the roles, but in the reactive and rigid nature of the roles in alcoholic families" (Deutsch, 1982, p. 57).

The roles adopted by children of alcoholics resemble, and sometimes are identical to the roles adopted by children in other dysfunctional families who do not have an alcohol problem (Black, 1985, Woititz, 1983a, Wegscheider-Cruse, 1981, Ackerman, 1983a, Barnes, 1984, & Seixas & Youcha, 1985). Some of the reasons these roles are adopted include:

1. "... it buys them (the children) a place in the family system" (Cermak, 1985, p. 20).
2. "... these roles ... serve not only to make up the deficiencies in the system which are necessary to maintain family functioning and stability, but they also serve as ways of disqualifying self or other, thereby maintaining the family game" (Creighton, 1986, p. 69).
3. "... personality traits develop early and are part of the pattern of survival that helps children in alcoholic families adjust ..." to the chaos (Siexas & Youcha, 1985, p. 48).

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[13] Nathan Ackerman originally identified the roles used in this paper in his book, Treating the Troubled Family (1966) p. 77

4. "Family systems theory explains the development of these roles, since every member adapts to the chemically dependent person by assuming a role that will create the least amount of stress" (Scavnicky-Mylant, 1984, p. 60).

5. "They form narrow and extremely rigid role structures, patterns of behaviour consistent with their unconscious and unarticulated view of who they are, what they must do to contribute to the family, and win the family's love and protection in return" (Deutsch, 1983, p. 4).

6. "In family systems, the roles and behaviours each member of the family adopts is designed not only to reduce their own stress but also to reduce the stress of the whole family system by maintaining homostatis of the family system" (Creighton, 1986, p. 69).

7. "... the children are forced to adapt to a chaotic reality, and, very often, to nurture and support their parents when they are drunk or despairing or otherwise broken down. Thus, the children adopt false selves ... which represent an attempt to deal with the parents' failure to parent ..." (Wood, 1984, p. C3. Also see Deutsch, 1982 & Duby & Schuckit, 1981).

The roles a child initially adopts may not remain the one(s) he/she uses forever. Often the children move from one role to another or they may utilize more than one role depending upon the situation and/or events occurring at any specific time. Furthermore, the roles are not left behind at a certain age or when the person leaves home. People carry their roles into adulthood and often pass them on to the next generation (Black, 1979, Crieghton, 1986, Gravitz & Bowden, 1985, Deutsch, 1983, & Gravitz, 1985).

The roles are necessary for survival. "In alcoholic families, these roles are not temporary or partial suits of clothing. Like spacesuits, they are crucial for survival" (Deutsch, 1983, p. 4) to enable the child to feel he/she has a position and function in the family system.

What are these roles? The terms used to describe the roles and the number of roles identified vary by author. They are usually identifiable by birth order. The terms commonly used are:

1. First born - Hero, The Family Hero, Responsible One, Introjector, Superkid, Manager, Caretaker, Controller and Alerts.
2. Second born - Scapegoat, Acting Out Child, Projector, and Middle Children.
3. Middle children - The Lost Child, The Placator and the Retroflector.

4. Last born - The Mascot, The Clown, The Adjuster, The Deflector, or simply The Last Born (Black, 1971, 1981, 1981a, 1981b, 1985, Bresnahan & Bresnahan, 1985, Gottieb, 1981, Gravitz & Bowden, 1984, Deutsch, 1982, Gravitz, 1985, Jaworski, 1986, Klemesrud, 1982, Waite & Ludwig, 1985, Wegscheider-Cruse, 1981, 1985a, Wood, 1984 & Yip, 1984).

The roles used in this paper from this point on will be The Hero, The Scapegoat, The Lost Child and The Mascot. A brief description of the four roles follows.

3-5-1 The Hero

The Hero is usually the first born, however, if the first born is male and the second born is female, the female may end up sharing this role to taking it over. In this case, the male first born usually reverts to the Scapegoat role.

The Hero is especially sensitive to the family's problems. Feeling responsible for the pain of family members, the hero tries to improve the situation. This may be accomplished by trying to be a great success in an environment outside the home - work or school - to provide self-worth or positive recognition for the family. The Hero usually does very well in school, is a team leader, holds positions such as class president, team captain and other "prestigious" positions. At home he/she takes

responsibility for siblings. The Hero ensures that siblings eat, are properly washed and dressed, and attempts to maintain order. The Hero often takes over other parental tasks such as grocery shopping, paying bills and maintaining the household. At work the Hero is a perfectionist, workaholic, people pleaser and sycophant. Heros are always willing to please, cannot tolerate being wrong and have a difficult time accepting criticism. To the Hero, work is an escape from intimacy and from the need to trust others.

The Hero feels like a failure because personal successes do not change the alcoholics behaviour. This sense of failure brings on feelings of inadequacy, low self-esteem, low self-worth, and guilt. The Hero ends up resenting the family for the parents' lack of support and constant criticism. Heroes resent others for not stepping in and stopping the chaos.

Heroes are prone to stomach ulcers,migraines, recurring colds, heart attacks and strokes. They may turn to alcohol or tranquillizers for relief and often become chemically addicted. Heroes often marry people whom they can care for and manage such as another chemically dependent individual, a Lost Child or a Mascot (Black, 1979, 1981a, Deutsch, 1982, Gravitz & Bowden, 1984, Waite l& Ludwig, 1985, & Wegscheider-Cruse, 1981).

3-5-2 The Scapegoat

The Scapegoat is usually the second born who contributes to the family by embracing and expressing each members' anger, disappointment, and frustration. If the Hero abdicates his/her role, it is more likely the scapegoat will take over.

The characteristic attitudes and behaviours of the Scapegoat include acting out, rationalization, irresponsibility, giving up easily, defiance, withdrawal and sullenness. In school their grades are poor, they cut classes, break school rules, talk back to teachers and many drop out. Scapegoats draw attention to themselves by negative behaviour such as getting into fights, stealing, "goofing off', getting pregnant in mid-teems, vandalism, shop lifting, abusing drugs and exhibiting other socially unacceptable behaviour. They are the most frequent "run aways" from alcoholic homes. At work they are the trouble makers who complain about everything and entice work slowdowns, and general discontent among the workers.

Scapegoats usually start using alcohol and other drugs early in life and often have nutritional problems. They are accident prone, promiscuous and often suicidal.

The characteristic feelings of scapegoats are hurt, guilt, depression, anger, resentment and frustration.

The Scapegoat does not wish to work as hard as the hero to achieve recognition. He chooses to pull away in a destructive manner, bringing negative attention to the family by getting into

trouble, getting hurt, or just withdrawing (Black, 1981a, Deutsch, 1982, Gravitz & Bowden, 1984, Waite & Ludwig, 1985, & Wegscheider-Cruse, 1981).

3-5-3 The Lost Child

The Lost Child is normally a middle child who offers relief for the family by taking care of his/her own personal problems and avoiding trouble. The family ignores the child, who is then left to face problems alone.

The Lost Child may be described as socially "retarded", out of touch, quiet, shy and a loner. Common characteristics include low profile, independence, aloneness, problems with sexual identity and preference, materialistic and overindulgent.

At home this child is usually alone, oblivious to the environment, and seems detached from the family. They are often classified in school as slow learners, quiet, shy and nondescript. They rarely date and remain somewhat detached in the outer parameters of social circles.

The Lost Child does not volunteer and does not outwardly oppose. They avoid leadership roles and rarely express a strong opinion. Passive resistance is their mode of assertion.

The Lost Child suffers from numerous medical and psychological problems. Hearing difficulties, stuttering, learning disabilities, accidents, obesity, bed wetting, allergies, asthma, and in extreme cases, schizophrenia, are found

in this group. The Lost Child has feelings of low self-worth and self-esteem, guilt, anger, isolation, fear, unimportance, insecurity and unwanted. They often become alcohol and drug abusers and many marry a chemical dependent person or a Hero (Black, 1981a, Deutsch, 1982, Gravitz & Bowden, 1984, Waite & Ludwig, 1985, & Wegscheider-Cruse, 1981).

3-5-4 The Mascot

The Mascot is usually the youngest child and is often referred to as the Clown. The Mascot provides relief and humour for the family by being charming and funny during stressful times. Mascots are perceived as the most sensitive and will spend their early and adolescent years trying to "fix" the sadness, fears, anger and problems of their parents and siblings. The Mascot is often described as immature, hyperactive, fragile, nervous, high-strung, and sensitive. They spend their time trying to please others by diffusing tension, stress and conflict and turning these situations into ones which are light and humorous. The Mascot is the life of the party and is well liked by peers. Mascots do well in school and in later life they have a tendency to become social workers, psychologists and psychiatrists.

Fear is the most prominent feeling of the Mascot but they also display confusion, insecurity and an inability to deal with stress. Mascots are incessant talkers, people with annoying nervous mannerisms and manipulators. The Mascot is highly

susceptible to abuse of alcohol and other drugs and usually marry strong, silent Heroes (Black, 1981a, Deutsch, 1982, Gravitz & Bowden, 1984, Waite & Ludwig, 1985, & Wegscheider-Cruse, 1981).

3-6 Summary

In summary, the information above is not necessarily true for all the children raised in an alcoholic home. Some of the children grow into normal adults without any lingering problems from their childhood. However, there are a significant number who are seriously affected.

"What do children of alcoholics learn? From the alcoholic they can learn dependency, irresponsibility, unpredictability, immaturity and self-centredness. Control, rigidity, fear, anger and focusing on others are learned from the co-alcoholic. Together, both parents teach the children to distrust and ignore what their eyes and ears tell them" (Gravitz, 1985, p. 9).

What a facilitator might see when watching or talking to an Adult Child of an Alcoholic are such things as: low self-esteem; low self-worth; hypervigalence; guardedness; mistrust; chronic fear; anxiety; controlling; lying; clowning; limited attention span; and other behaviours.

A study that compared the children of 71 alcoholics, 20 depressive subjects and 51 not well subjects was designed to explore the relationship between parental alcoholism and

problems in their children. The children were 17 years and younger and living at home. The mean age of the alcoholic's children was 11.2 years and the other two groups 8.7 years (t=3.78. p=.01) (Rimmer, 1982). The selected behaviour problems are shown in Table 8.

A major conclusion from Rimmer's study was "... that one should be cautious in generalizing about problems in families of alcoholics" (Rimmer, 1982, p. 372).

3-7 Symptomology

Children raised in families where alcohol was not a problem but the families were considered dysfunctional because of sexual, psychological or physical abuse, often have the same or similar symptomology and/or characteristics as those raised in an alcoholic home. Therefore the generalizability of the data presented must be used with caution. For example, J. Duby and M.A. Schuckit (1981) and N.A. Nielson (1984) noted the following symptomological similarities between chemically dependent and sexually abusive families:

1. Massive denial.
2. Delusional thinking.
3. Role reversal.
4. Rigid defence patterns.
5. Crisis orientation.
6. Chaotic lifestyle.

7. Inappropriate role modelling.
8. Expectations of children.
9. Indirect communication of needs and wants.
10. Excessive secrecy.
11. Inconsistent family rules. and
12. A shame-based system (Neilson, 1984, p. 11).

Black (1981a), Woititz, (1983), Wegscheider-Cruse (1981) and Ackerman, (1983a) also state the characteristics and/or symptomology of children from alcoholic families is similar to that of dysfunctional families. Dysfunctional families are also those families where abuse may not necessarily occur but other problems create the dysfunction. For example, the following problems can create a crisis in a family and cause the family to become dysfunctional:

1. Parental separation.
2. Divorce.
3. Death of a family member or close relative.
4. Terminal illness of a family member or close relative.
5. Remarriage of a parent.
6. Incarceration of a parent.
7. Parent released from incarceration.
8. Job loss.
9. Family entering the welfare system.

Some of the behaviours of children, where one or more of these events occur, are different from those of children raised

in an alcoholic or abusive family setting. A few of the differences are shown in Table 3.

To avoid confusion and misunderstandings, this literature review will be based on children raised in a family where alcoholism is proposed as the major problem area and as written and described by clinicians through their observations and clinical experience.

Researchers and authors have indicated Children of Alcoholics experience and display the same or similar defence mechanisms.

3-8 Characteristics

Children raised in an environment where rituals are not followed or observed end up with low self-esteem, low self-worth, inappropriate social skills and several dysfunctional behaviours.

Woititz, (1983a) & Chafetz et al. (1971) observed these behaviours in their clinical practices, and, although they refer to them as characteristics, they are in fact dysfunctional behaviours. These characteristics are shown in Tables 9, 10 and 11. Also included in Table 9 are the characteristics as described by Ackerman, (1983) and Chafetz, (1979).

Some of the characteristics have been noted previously and others have been implied. It is also necessary to reemphasize that the characteristics presented are not necessarily restricted to children of alcoholics. In

Table 8

Characteristics of Adult Children of Alcoholics

Woititz	Ackerman	Cermak
*Guess at what normal is *Difficulty completing projects *Compulsive liars *Judge themselves without mercy *Have difficulty having fun *Take themselves very seriously *Difficulty with intimate relationships *Overreact to changes *Constantly seek approval and affirmation *Feel that they are different *Super responsible or super irresponsible *Extremely loyal *Impulsive	*Guess at what normal is *Difficulty following projects through to completion *Compulsive liars *Judge myself without mercy *Have difficulty with intimate relationships. *Overreact to changes *Feel different *Constantly seek approval and affirmation *Super responsible or super irresponsible *Extremely loyal *Look for immediate gratification *Do not consider consequences or alternate choices *Avoid conflict *Seek tension & crisis *Fear - rejection - abandonment - failure - criticism - judgment *Poor time manager *Fear of: - losing control - feelings - conflict - abandonment	*Overdeveloped sense of responsibility *Feelings of guilt *Inability to relax, let go, have fun *Harsh, even fierce self-criticism *Live in denial *Difficulties with intimate relationships *Live life from the viewpoint of a victim *Comfortable with chaos *Confuse love & pity *Assume a black and white perspective under pressure *Tendency towards physical complaints *Suffering from delayed grief *React rather than act *A Survivor
Chafetz		
*Overrepresented in juvenile justice system *Disciplinary problems in school *Alcohol & drug users *Do poorly in school *Become workaholics, antisocial and irresponsible.		

Table 9

THE CHARACTERISTICS - TRAITS - FEELINGS - BEHAVIOURS

OF CHILDREN OF ALCOHOLICS

The name of the game of the mode of **survival**	THE FAMILY HERO OR SUPER KID	THE SCAPEGOAT OR PROBLEM KID	THE LOST CHILD	THE MASCOT OR FAMILY CLOWN
What you see of visible traits. Outside behaviour	"The little mother""The little man of the family" Always does what's right, over responsible, needs everyone's approval. Not much fun	Hostility & defiance, withdrawn & sullen. Gets negative attention. Troublemaker	Loner, day dreamer, solitary (alone) rewards, i.e. food, withdrawn, drifts & floats through life, not missed for days, quiet, shy & ignored.	Supercute, immature, and anything for a laugh or attention, fragile and needful of protection, hyperactive, short attention span, learning disabilities anxious
What you don't see or the inside story. **Feelings**	Hurt, inadequate, confusion, guilt, fear, low self-esteem. Progressive disease so never can do enough.	Hurt & abandoned, anger & rejection, feels totally inadequate & no or low self-worth	Unimportant, not allowed to have feelings, loneliness, hurt &* abandoned, defeated.	Low self-esteem, terror, lonely, inadequate & unimportant.
What he/she represents to the family & why they play along.	Provides self-worth to the family, someone to be proud of.	Take the focus, takes the heat, "see what he's done" & "Leave me alone."	Relief, at least one kid no one worries about.	Comic relief, fun & humour.
As an adult, without **help**, this is very possible.	Workalcoholic, never wrong, marry a dependent person, need to control & manipulate, compulsive, can't say no, can't fail.	alcoholic or addict, unplanned pregnancy. Trouble, legal problems.	Indecisive, no zest, little fun, stays the same, alone or promiscuous, dies early, can't say NO.	Compulsive clown, lampshade on head, etc. Can't handle stress, marry a "hero", always on verge of hysterics.

As an adult with help, this is also very possible.	Competent, organized, responsible, make good managers. Becomes successful and healthy.	Recovery, has courage, good under pressure, can see reality, can help others, can take risks.	Independent, talented & creative. Imaginative, assertive & resourceful.	Charming host & person, good with company, quick wit, good sense of humour, independent, helpful.

Wegscheider-Cruse, 1985, p. 40)

different situation these characteristics could also describe a victim of incest, sexual abuse, physical abuse, psychological abuse and other abuses that adversely affect children raised in a dysfunctional environment. It is also important to note that not all children raised in an environment where there was alcohol abuse are affected the same way and these characteristics may not be evident.

Other authors have provided lists of the characteristics of children of alcoholics. Their lists are, in some cases, identical to the four noted above, are reworded, or they have used a selected number for their article or book. These authors include Gravitz, 1985; Morehouse, 1979; Porterfield, 1985; Siexas & Youcha, 1985; and Waite & Ludwig, 1985.

Characteristics developed by some authors are targeted for specific environments or situations. For example, it is suggested that:

Table 10

PERCEPTIONS OF ADULT CHILD'S BEHAVIOUR

SYMPTOMS
Workaholism, caretaker, controlling, chronic, sickly, anorexic, overweight, perfectionistic, relationship problems, peer worship, spouse surrogate, emotional binging, undying loyalty.
SOCIETY'S VIEW
Successful American dream, loving, dependable, strong leaders, fragile, fashionable, scorned, "very" dependable, independent, conforming, cool, close family relationship, over sensitivity, brave, admirable.
PARENTS' PERCEPTION
Proud, success, mature & responsible, organized, helpless, attractive, medical problem, embarrassed, wonderful self-disciplined, very selective high standards, friendly, "Daddy's Girl", "Mommy's Boy", fully honest, traditional.
PATHOLOGY
Driven, unable to get needs met, manipulator, starving feelings, feeding feelings, compulsive, inability to relate, socially inept, emotional incest, blaming, controlling, fearful.
CHILD'S FEELINGS
Lonely, tired, unloved, inadequate, afraid, unsure, angry, inadequate, guilty, hurt, fear, power, righteousness, insecurity.

Wegscheider-Cruse, 1985, p. 102)

1. Children of alcoholics are likely to be overrepresented in the juvenile justice system (Chafitz, Blane & Hill, 1971; & McKenna & Pickens, 1983);

2. Children of alcoholics are disciplinary problems in school (Barnes, 1984; Gottieb, 1981; Hindman, 1975; McKenna & Pickens, 1981; & Regan, 1984);
3. Children of alcoholics are alcohol and other drug users (Barnes, 1984; Moe, 1987; & McKenna & Pickens, 1981);
4. Children of alcoholics do poorly in school (Hindman, 1975; & Barnes, 1984);
5. Children of alcoholics become workaholics, antisocial and irresponsible (Regan, 1984).

All or some of the characteristics noted in Tables 9, 10 and 11 and in the examples given above may apply to some of those raised in a family where alcohol was a problem. For some children, they may identify with only one or two of the characteristics while other children will not identify with any. It could be disastrous to insist all children of alcoholics have to identify with some or all of these characteristics. As noted earlier, some do not display any characteristics for a number of reasons. Some include the ability to completely block the experiences, some did not experience them, some learned how to handle chaos and crisis in a healthy way and some may have been in their teen years or older when the alcoholism became a problem.

Dealing with alcoholism and its effects on the family is an inexact science. There are not concrete theories, studies or research that describe all cases. A number of hypothesis have

been presented that partially explain alcoholism or explain the causes for specific cases. Holes can be found in every study done to date. In addition, researchers cannot agree on a specific set of definitions in which to apply to their research. For example, what is the definition of "an alcoholic" or "alcoholism" or "problem drinker" or "alcohol abuse"? When does problem drinking end and alcoholism start?

The study of alcohol abuse, alcoholism, children of alcoholics and related topics must be done with an "Open Mind." At the present state of knowledge, it is important to consider all aspects and apply those which appear to fit the program being considered. Consider all aspects and do not close the mind against one theory or hypothesis was a theme used throughout the workshop.

CHAPTER FOUR

Outcome & Process

4-1 Aims

The aims of this practicum were:

1. To expand public awareness of the adverse effects of heavy drinking and alcoholism on the individual, family and significant others.
2. To dispel the myths and misconceptions about alcoholism through an educational workshop.
3. To provide indepth exposure of how alcoholism affects the children in an alcoholic family.
4. To help develop an understanding of the resources available in the community to help all members of an alcoholic family overcome difficulties they may be experiencing and begin to lead a "normal" lifestyle.

4-3 Humanistic Theories

In conducting the workshop, the facilitator presented materials according to the hypothesis of Brookfield, (1983), that "human beings are faced with the moral necessity to make free choices in the conduct of their lives" (150). Using the premises of the Humanistic Theories in providing choices, new information

made the workshop a worthwhile experience for the participants and learning experience for the facilitator.

The Social Learning Model's symbolic modelling, observational learning and reinforcement were used in this practicum. In general terms, this was a successful modality for this workshop. Specific facets will be discussed separately.

4-3 Observational Learning

Lafrancois (1977) said "Observational learning, or learning through imitation, is assumed to account for a great deal of significant social learning" (99). This occurred in several ways during the workshop:

1. The facilitator used personal experiences to give the participants "permission" to disclose their own experiences. An illustration of this occurred when the participants were discussing events from childhood. The facilitator, who remembers very little of his childhood, mentioned four events he remembers very clearly.
2. Another example of the advantages of the Social Learning Model format was the individual rewards and reinforcements achieved by the openness of the participants. The participants:
   a. Listened to each other;
   b. Did not cut each other off;

c. Did not become judgmental; and

d. Acknowledged the individuality of the other participants.

Disagreements were made in the form of personal experiences. For example, if a participant made a statement and another participant disagreed, the first one was not told he was wrong. The second participant gave a personal example of a similar experience that pointed out the reason for the disagreement. These actions and reactions made each participant feel a part of the group and reinforced their feelings of being a worthwhile individual. The participants made the workshop a beneficial learning experience for each other. As Rogers (1986) said, "A group is more than a collection of individuals. It is an entity, something whole in itself" (100).

A hypothesis of the Social Learning Model, symbolic modelling, was also shown to be effective in the methodology used. Symbolic modelling was used by the facilitator throughout the workshop to encourage participant participation. Another way symbolic modelling was used was to allow the participants to wander off topic to express concerns or ask questions. This, in effect, allowed the participants to state needs and to have those needs addressed which was a consideration when determining how the workshop would be presented.

The negative comments about going off topic are counter to the Adult Learning Model. For example, Brookfield (1983) said,

> "Adult educators who accept [his] propositions will not seek to impose their will on students in some kind of

> didactic, authoritarian manner: indeed, they may entirely reject the teacher-student division. The student is partially responsible for determining objectives and curricula whilst the educator becomes a facilitator of learning. The end result of such facilitation is the development of a fully realized person" (150).

He goes on to say,

> "Carl Rogers[14](1969) has explored the connections between the humanistic practice of psychotherapy and the facilitation role of the educator. Rogers placed primary importance on the presence of independence in learning declaring that 'the only learning which significantly influences behaviour is self-discovered, self-appropriated learning'. Such learning exhibits personal involvement, it is self-initiated, it pervades the behaviour and personality of the learner, and it is evaluated by the learner" (151).

It is for these reasons the facilitator encouraged the participants to discuss topics of interest, as long as they were within the scope of the workshop. This rationale was explained to the participants at the beginning of Session One and it was commented on during the wrap up in Session Six. Some of the positive comments made by the participants also indicated acceptance and pleasure with the methodology used. Examples of the comments are:

1. "Open forum. The opportunity to discuss openly different perspectives of alcoholism."
2. "General conversation and discussion."
3. "Excellent discussion where the opinions of all were important."
4. "The amount of latitude to discuss our own perspectives."

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[14]. Quoted by Brookfield in referenced material

5. "The comments from personal experience increased my understanding of some of ACOA's problems."
6. "The input by all the participants."
7. "Good interpersonal reactions."
8. "I enjoyed the open discussion. Answers were well informed."

4-3 Student Centered Criteria

The expected benefits I anticipated were partially realized in the development and management of the workshop. The workshop was designed using the Social Learning and Adult Education Models as the basis for developing and presenting the material.

The Adult Education Theory hypothesis that individuals, through expressing their ideas and thoughts in the group setting, will be in control of their learning experiences and will let the facilitator know if their needs are being met or they wish additional information. Most of the participants openly:

1. Discussed the materials presented;
2. Asked numerous questions; and
3. Stated their ideas, thoughts and opinions.

However, there were two participants who did not voluntarily say anything during the whole workshop. Even when asked direct questions, they would respond with a very brief answer. They did not reveal personal information or attempt to state an opinion. They would, on the other hand, readily criticize in writing on

the evaluation tools. Specific examples of their feedback included the following statements:

1. "Group off track. Did not cover intended material"; and
2. "I would prefer to stick to the session material."

Because of the positive feedback on the open forum method, I did not make any major changes.

I found that my counselling experience enhanced the presentations. Being aware of body language and communication styles I was able to respond appropriately to the concerns of the participants. For example, when a participant indicated in body language (a frown or a confused look) that they did not comprehend what was being presented I would ask them if they understood what I was saying or I would rephrase the material. When rephrasing the material brought a "nod" or some other indication the material was making sense, I felt the participant understood. I would follow this up with a confirmation question. I believe that my counselling experience allowed me to do this and it was an effective utilization of experience to make the workshop a rewarding learning experience for all.

My Social Worker abilities as an educator were expanded by this workshop. The practical experience of having the workshop presented as a group learning model (facilitator and participants on an equal basis) allowed for the free exchange of ideas and the expression and open demonstration of attitudes and behaviours. I learned that letting this happen made the workshop less of an

"we" and "they" scenario and more of an "us" experience. The participants enjoyed the "new" format which made the conduct and delivery a worthwhile learning endeavour.

4-4 Participants Needs

Throughout the workshop, the participants raised and discussed issues about which they either wanted more information or expression of their opinions. Many times the participants did not answer a question asked of them and the asker did repeat the question or make the comment that his/her question was not being answered. The group appeared to be very cognizant of receiving accurate data and ensuring they were understood. In addition, the facilitator asked questions to ensure that information was understood. It was also necessary, at times, to provide answers in varying ways to ensure the message was understood as intended.

4-5 Participants Expectations

Individual group member's stated expectations provided their reasons for taking this workshop. Examples include:

a. "Personal and professional growth and development."

b. "To learn a little more, understand a little more, and perhaps, be a little less perplexed.

c. "For review and new information."

d. "To learn a wide range of information on alcoholism i.e. how to recognize it, why it happens and how to deal with it."

e. "That I will learn more about alcoholics and the cause of their problem."

These expectations must have been met because the participants returned and attended as many sessions as they could. Some participants were unable to attend all the sessions but the reasons they could not attend were beyond their control. For example, one member missed two sessions because he had to attend previously scheduled work related meetings. Another member missed one session because his daughter was performing in a major school event and he had made the commitment to attend before he decided to take the workshop. One participant requested permission to attend only the last three sessions and one had other commitments for the first three sessions. None of the members indicated in any form, that they did not attend because of the material presented.

4-6 Assumpitons

Some of the assumptions used by the author in developing and designing this workshop are described below while others are discussed in the appropriate section.

Assumption: The general populace knows very little about alcohol, alcohol abuse, alcoholism and how it affects the individual, the family and those around the alcohol user.

In addition to comments made during the workshop, recent newspaper articles (See McKinley, 1990 & MacKenzie, 1990) indicate that alcohol education is required in the Winnipeg schools. If these articles are correct, parents know very little about alcoholism or they are not passing the information on to their children. "... three-quarters of students think their school needs a drug/alcohol program" (MacKenzie, 1990, p. 3) and "... 74 per cent of students said information about drugs and alcohol is needed at their schools" (MacKenzie, 1990, p. 3).

In the past, "Attempts to proceed with implementation of the committee's aims were met with denial, from the school principals and the community in general..." (MacKenzie, 1990, p. 3). The results of a survey conducted by the Knowles Centre, Inc. of the River East School division has had an impact on provincial authorities. "The province hopes to introduce mandatory drug and alcohol education program in Manitoba schools next fall" (McKinley, 1990, p. 12). This means that by the end of this decade, the younger population of Manitoba will have a good basic knowledge of the effects of alcohol on the user, their family and on society. A major roadblock may have been overcome.

Assumption: Providing factual data on alcoholism, its effects on the family and on Adult Children of Alcoholics issues will be an empowering process for the participants.

Comments made by some of the participants indicate a better understanding of alcoholism and how it has affected them. For example, one client said, "Answered some questions that I had for sure." Comments from other participants included:

a. "Priceless information for me personally."

b. "The discussion on the definitions helped in my understanding of the complex nature of alcoholism."

c. "A lot of information provided and I think some ideas/myths confronted."

d. "Various personality traits that fit me and ACOA (untreated) friends (extreme traits)."

These statements indicate a gain in knowledge about alcoholism and a better understanding of themselves. This empowers the individual because they are in a better position to discuss the topic and understand how it has affected them.

Assumption: The participants who attend the sessions will be interested in learning more about alcoholism and Adult Children of Alcoholics.

This assumption is upheld by noting some of the comments received on the Post Session Report and Client Satisfaction Questionnaires. For example, the following comments are an indication that the participants were interested in learning new material.

a. "Open forum. The opportunity to discuss openly different perspectives of alcoholism."

b. "Excellent discussion where the opinions of all were important."

Assumption: People want to know good, factual information about alcohol, alcohol abuse and its' effects on family members.

This assumption is one that is difficult to interpret from the participant's direct statements. However, in a general sense, the following statements indicate the participants needs are being met with either new data or data that reinforces the information they have gained in the past.

a. "Answered some questions that I had for sure."
b. "Stimulating interaction which I always appreciate especially when it generates more light than dark."
c. "The discussion of the definitions help in my understanding of the complex nature of alcoholism."
d. "The film helped to fill in the spaces ... A lot of info provided and I think some ideas/myths confronted."
e. "Learned a lot!!"
f. "Continues to be a worthwhile experience.:
g. "Good informative medicine."

Assumption: The way to overcome a lot of the difficulties with alcohol abuse is through education.

There was no measure used that addresses this assumption.

Assumption: The way to provide a good educational session is to meet the needs of the participants.

The open participation of the participants indicates that they were willing to express their concerns and to have their questions answered. The participation occurred in a number of ways.

1. There were direct questions on the material presented. These were answered by other participants or the facilitator.
2. Interaction between participants took the form of discussion and
3. The relating of personal experiences and answering questions.

As with the other assumptions, comments from the participants indicate their thoughts about the sessions and whether or not, the session has satisfied a need. Examples include:

a. "Values are important (Movie) but it is inherent upon an individual to set his own."
b. "Priceless information for me personally."
c. "The discussion of the definitions help in my understanding of the complex nature of alcoholism."
d. "..., the ability to look at how other people view people who drink too much."

e. "The amount of latitude to discuss our own perspectives."

f. "I really enjoyed the video by Father Martin about "Values". Helped to remind me of who I am, what I'm worth. It left me with a positive feeling - nice way to go home."

g. "The video answered some of the questions I had - I'm OK. Just like anyone else I have my own problems but hopefully have some awareness and maybe able to break the cycle."

h. "There is a choice in life."

i. "Very revealing to my personal history - Thank You."

j. "Excellent, carry on."

k. "Informative and interesting."

l. "Well presented, good info."

These statements demonstrate the workshop met the expressed and implied needs of the participants.

CHAPTER FIVE

5-1 Target Group

The River Heights Family Life Education Centre, through their resources, advertised for adults in the Winnipeg Area who are interested in attending this six-week workshop. The workshop is on alcoholism and the effects heavy drinking has on the drinker, the spouse and the children in a family where the use of alcohol is a problem.

5-1-1 Recruitment

The River Heights Family Life Education Centre said they would recruit participants for the workshop. They sent public service announcements to newspapers, television stations, radio stations and community and school newsletters (Appendix 8). The Executive Director also telephoned personal contacts in the Social Service Agencies for possible participants. They recruited one participant for this program who joined the fourth session, came for the fifth session, and did not return for the final session. The results of her questionnaires are not considered in the calculations used throughout this report. The Executive Director of River Height Family Life Education Centre said that all programs are down this year and none of their programs are full. She also said that the programs that had a

waiting list last year are unable to recruit participants for the same or similar programs this year.

With less than a week to go before the workshop was to start, the facilitator contacted several individuals to see if they wish to attend the workshop on alcoholism. Of the nine people contacted, five said they would attend. Another participant was contacted just prior to the start of the workshop but because of prior commitments could not attend until the third session. The last member heard about the workshop through a friend after the workshop had started. He was accepted, came to Session 3 and remained until the end of the workshop.

5-1-2 Group Composition

The composition of the group was as follows:

a. One psychiatric nurse employed in a rehabilitation setting;
b. An engineer with the Provincial Water Works Department;
c. A salesman for a janitorial supplies company.
d. A regional distribution manager and entrepreneur.
e. A purchasing agent for a local company.
f. A worker in a centre for mentally disabled adults who underwent treatment for chemical dependency;
g. An entrepreneur, part time attendant and student; and

h. A Housewife (Only attended two sessions).

5-1-3 Demographic Data

The were six males and one female attending the workshop. Their education ranged from grade 11 to a university graduate as shown on Table 11.

Table 11

Education Levels

Member	Education Level				
	GR11	GR 12	1st Yr Univ	Univ Grad	Community College
1				BEng	
2				BA (Actg)	
3					✓
4			✓		
5		✓			
6		✓			
7	✓				

The marital status, sex and ages of the participants is displayed in Table 12.

Table 12

Marital Status, Sex & Age

Age	Sex	Marital Status
28	F	Single
39	M	Divorced
38	M	Separated
22	M	Single
31	M	Single
40	M	Married
41	M	Married
AGE RANGE = 19 Years MEAN AGE = 34.14 Years		

As shown on Table 14, the ages of the seven participants ranged from 22 to 41 with a Mean age of 34.14 years which collaborates the assumption made that the age of the participants would be between 30 and 35 years of age.

5-2 Schedule

The schedule for the workshop was as follows:

1. Week One:
    a. Children of Alcoholics Screening Test
    b. A description of the six week program
    c. Overview of alcohol and alcoholism
    d Video The Other Guy
    e. Discussion
    f. Definitions Exercise

g. Completion of The Post Session Report

h. Completion of Client Satisfaction Questionnaire

2. Week Two:

a. VHS: Medical Effects of Alcohol Use

b. Discussion - Alcohol - General

c. Safe Drinking

d. Exercise - Safe Drinking

e. Completion of The Post Session Report

f. Completion of Client Satisfaction Questionnaire

3. Week Three:

a. Presentation - Alcohol & Behaviour

b. Alcohol and the Family

c. Video: Values (Alternative - Alcoholism and the Family)

d. Completion of The Post Session Report

e. Completion of Client Satisfaction Questionnaire

4. Week Four:

a. Video Tape - Robert Ackerman Adult Children of Alcoholics

b. Presentation - Characteristics

c. Exercise - Characteristics

d. Completion of The Post Session Report

e. Completion of Client Satisfaction Questionnaire

5. Week Five:

a. VHS - The Family Trap (Alternative - Roles)

b. Exercise - Roles

c. Presentation - Rules

d. Adult Children of Alcoholics in the Workplace

e. Completion of The Post Session Report

f. Completion of Client Satisfaction Questionnaire

6. Week Six:

a. Community Resources

b. Alcoholism and the Elderly

c. Question period

d. Completion of The Post Session Report

e. Completion of The Client Satisfaction Questionnaire.

f. Handout a self-study package on self-help groups.

NOTE: As an alternative, a presentation or panel on Self-Help Groups can be presented in place of Alcoholism and the Elderly.

5-2-1 **Content**

To help the participants make free choices about material they wished to discuss or questions they wanted to ask, they were

provided with a comprehensive set of topical readings. Besides the readings, a film or a video on the subject matter was shown in each session. The facilitator then presented data designed to foster questions and self-disclosure. Two methods of presenting data were used:

1. Factual information, i.e. the amount of ethyl alcohol in 100 proof whisky or the exact wording of quotes; and
2. Asking open-ended questions that would elicit a response or responses from the participants.

An attempt was made to engage all the participants in discussions. The facilitator either took an active part or listened. If it was felt the participants were off track or when discussing information that was not consistent with the data presented the facilitator would bring them back onto the topic.

It was felt that these methods of presenting the data allowed the participants the opportunity to have their needs met as well as a chance to expand their experience base.

Attitudes, behaviours and thoughts about ethyl alcohol, alcoholism, alcoholics, and problem drinkers in most people is based:

1. Partly on accurate facts;
2. Partly on myths;
3. Partly on misconceptions;
4. Partly on fallacies; and
5. Partly on misinformation.

Their knowledge of alcohol was learned from their:

1. Personal experiences with ethyl alcohol;
2. Parents;
3. Friends;
4. Peers; and sometimes
5. Educators.

The workshop was designed to provide information on the factors noted above, because, it was possible to "base [the] teaching upon the previous experiences of the experiences of the learner (Rossman, et al., 1984 p. 30). To help overcome the myths, misconceptions, fallacies and misinformation that may have been learned, the facilitator started from the basics and introduced new data logically, leading up to alcohol problems in the elderly. For example, in Session Two, one topic was on the manufacture of the different types of alcohol, and the alcohol content of various types of drinks (beer, wine and spirits). The next logical topic was "Safe Drinking" where the effects of various amounts of ethyl alcohol on the body were discussed. To show how this happens another topic in Session Two was the "Medical Effects of Alcohol Use" that covered the adverse effects ethyl alcohol has on the brain, liver, esophagus, pancreas, heart, and other body organs. Factual information was the aim of this session.

Session Three concentrated on how ethyl alcohol affects a person's behaviour. At the end of this session, alcoholism and

how it affects the whole family was introduced as preparation for the next session.

Session Four and Session Five discussed the effects of an alcohol abusive parent or parents on the children. Characteristics, or generalized statements as described by clinicians were introduced. The purpose of this session was to empower the participants by developing an understanding of how the alcohol abuse may have affected them or others they are acquainted with. Awareness means a person has an opportunity to decide to change or not to change his/her attitudes and behaviours. The follow-up topic to characteristics was a discussion on the main roles children inappropriately use in a dysfunctional family. These roles are described by several authors (Black, Wegscheider-Cruse, DeCicco, Cermak, Ackerman, and so on) using various terms as noted earlier in this report. The importance of this topic is that these roles are taken into adulthood directly affecting the Adult Child of an Alcoholic's relationships and work. The final theme in this topic was about untreated Adult Children of Alcoholics in the workplace. Described were the behaviours displayed by these in their work and working relationships.

The final session concentrated on alcoholism in the elderly. The emphasis of this session was to combat the attitude that it is okay for elders to drink abusively because they are coming to the end of their lives and should leave be left alone to "enjoy their last days."

Finally, the participants were given a list of agencies and organizations that deal with alcoholism and abuse in Winnipeg. Included on the list were self-help groups and social service agencies that offer services to people affected by mood altering drugs.

CHAPTER SIX

6-1 Evaluation Instruments

The instruments used for evaluating this practicum are shown in Table 14 and described below. **The Post Session Report** was modified to meet the needs of the facilitator and to enable him to evaluate the session. **The Client Satisfaction Questionnaire** was also modified to meet the requirements of this practicum and to provide a better evaluation of each session. The questionnaire **How Much Do You Know About Alcoholism** provided the facilitator with data on the knowledge the participants had about various aspects of alcoholism. These instruments were helpful to both the facilitator and the participants in understanding the workshop.

The River Heights Family Life Information Centre Quick Feedback Sheet provides another evaluative tool that was used to assess the outcome of the workshop. This questionnaire was used as a posttest and provided data that was considered useful for evaluation purposes. It was produced by the River Heights Family Live Information Centre and is used to determine whether the programs they sponsor will be used in the future.

Table 13

Evaluation Instruments

Instruments	Administered		
	Pre-	Each Session	Post
Client Satisfaction Questionnaire		✓	
Post Session Report		✓	
How Much Do You Know About Alcoholism?	✓		✓
River Heights Family Live Education Centre Quick Feedback Sheet			✓

6-2 Evaluation

6-2-1 The Children of Alcoholics Screening Test

The Children of Alcoholics Screening Test was used for three purposes.

1. The first purpose was to provide confirmation of those who indicated on the Demographic Questionnaire that they were Adult Children of Alcoholics.
2. The second purpose is when they read the questions it might bring issues to mind. It could remind them of instances in the past that were alcohol

related and had an adverse affect on them. The benefit of this will be to empower them to take a better look at the material presented and enable them to seek help if it is required.

3. The third purpose is the Children of Alcoholics Screening Test may also assist participants in identifying reasons why things are happening to them today that they are not aware of. It is quite common for children of alcoholics to have living problems and no idea of why or where they came from. If this questionnaire does this for them, they will be in a better position to deal with the identified living problems.

The Children of Alcoholics Screening Test (Jones, 1982), "was developed to identify adult children who have lived with at least one alcoholic parent. It is a 30-item inventory which measures an individuals attitudes, feelings, perceptions and experiences related to parental drinking behaviour. It identified individuals who:

1. Have been psychologically distressed as a result of parental drinking. (For example, Have you ever lost sleep because of parents' drinking?)
2. Perceived drinking related marital discord between their parents (For example, Have you ever heard your parents fight when one of them was drunk?)

3. Have attempted to control the drinking (For example, Did you ever encourage one of your parents to quit drinking?)
4. Have been exposed to drinking-related family violence (For example, Has your parent ever yelled at or hit you or other family members when drinking?)
5. Tend to perceive their parents as alcoholic (For example, Did you ever think that your mother was an alcoholic?).
6. Want to receive help (For example, Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?)

A reliability coefficient of .98 is reported for this instrument, using a Spearman-Brown split-half (odd vs even) procedure. The two sample populations used consisted of 82 adolescent children of clinically diagnosed alcoholics and 133 adolescents, randomly selected from the Chicago school system. The practical convenience of split-half procedures has no doubt led to their extensive use, however some caution should be exercised when interpreting reliabilities derived in this way as they suffer from several limitations. Test scores, for example, represent one individual's response at one time only so day to day variation in the subject can not be reflected in the reliability coefficient. Also, when the test includes items

based on a single element, in this case parental drinking, spurious resemblance between scores on the two halves may emerge. If correlation is to provide an appropriate estimate of reliability, then the two halves should be independent of each other.

To assess its validity, the Children of Alcoholics Screening Test was administered to 82 children of clinically diagnosed alcoholics, 15 self-reported children of alcoholics and 118 randomly selected control group children. All were adolescent age range. Chi square analyses showed that all 30 items significantly discriminated children of alcoholics from control group children ($F(2, 212) = 166.4$ $p < .0001$).

The 'no' 'yes' answers on the Children of Alcoholics Screening Test are scored 0 and 1 respectively so a total score can range from 0 (no experience with parental alcohol misuse), to 30 (multiple experiences with parental alcohol misuse). Jones (1982), found that a cut-off score of 6 or more reliably identified 100% of the children of clinically diagnosed alcoholics and 100% of the self-reported children of alcoholics. Twenty-three percent of the control group had scores of 16 and above. A further validation study was carried out (Jones, 1982), using a sample of 81 adults ranging in age from 18 to 37 years ($M = 26.4$ years). Five subjects reported that at least one parent received treatment for alcoholism. Their Children of Alcoholics Screening Test scores were significantly higher ($M = 122.8$, S.D.

= 9.7) than the scores of the other 76 subjects (M = 4.4, S.D. = 7.2). t (79) -2.5 p less than .01" (Jones & Pilat, 1982).

In a study completed by Bernard & Spoentgen (1986), the Children of Alcoholics Screening Test was used as a support instrument. The Children of Alcoholics Screening Test scores for the three groups of this study were:

a. Group 1 - 0.67 (Control group - non Adult Children of Alcoholics).

b. Group 2 - 13.63 (Adult Children of Alcoholics not seeking treatment).

c. Group 3 - 20.31 (Adult Children of Alcoholics undergoing treatment).

In summary, the Children of Alcoholics Screening Test appears to be a valid and reliable screening instrument which can discriminate children of alcoholics from the general population. It was found to perform equally well with clinical and non-clinical samples.

When designing the workshop I assumed that among the participants there will be some Adult Children of Alcoholics. To assist me in confirming this assumption, I administered the Children of Alcoholics Screening Test to the participants during the first session.

Four of the participants scored higher than 6 Yeses on the Children of Alcoholics Screening Test, which , according to Pilat and Jones (1984), indicates they are Adult Children of

Alcoholics. The scores ranged from 0 to 13 with a mean of 5.14 (SD 4.82). Individual scores are displayed in Table 14.

Table 14

Children of Alcoholics Screening Test Scores

Member	Score
1	0
2	0
3	0
4	7
5	7
6	9
7	13
MEAN SCORE	5.14

Two of the four Adult Children of Alcoholics come from divorced families. Both stated their parents divorced when they were 9 years old. The divorces were due to their fathers' drinking. One said the father was physically abusive to his spouse but cannot remember being abused.

6-2-2 Post Session Report

The Post Session Report used for this project is an adaptation of the Lazarus Patient's Therapy Session Report. It is administered after every session and provides data on:

1. The participant's feelings about the session.
2. Subjects talked about during the session.
3. What the participant hoped to get out of the session.
4. What problems or feelings the participant was concerned about in that session.
5. The participant's feelings during the session.
6. The participant's feelings about coming to the session.
7. The participant's feelings about progress during the session.
8. The participant's perception of how the facilitator felt. and
9. How well the facilitator was understood.

This information can be a particularly helpful source of evaluative feedback to the facilitator by providing data on each session which may be used to change, if necessary, upcoming sessions. It can give both the facilitator and participant additional time to think about and discuss the process, problems they are having and any changes to the session that are being contemplated for the next session (Bloom & Fischer, 1982).

The Post Session Report Mean Scores (Table 15 and Appendix 11) shows the participants level of satisfaction with the workshop. The individual Mean Scores ranged from 6.00 to 8.17

Table 15

Post Session Report Mean Scores

By Session			Participant For All Sessions		
Session	Mean	SD	Participant	Mean	SD
1	7.40	0.49	1(6)	7.33	0.47
2	7.75	0.43	2(4)	7.00	0.00
3	7.75	1.09	3(6)	8.17	0.37
4	7.00	1.07	4(6)	6.50	0.96
5	6.88	0.99	5(5)	7.40	0.47
6	7.43	0.73	6(3)	8.33	0.47
			7(3)	6.00	0.82

Scoring = 1 (Low) to 9 (High)
()= Number of Sessions Attended

with the session Mean Scores ranging from 6.88 to 7.75. Comments made by the participants also show the overall general satisfaction with the workshop. Nearly all participants made a positive comment for each session. The negative incident comments varied from one in Session One to seven in Session Five with all sessions being as follows (Numbers in Brackets = Number of participants at Session):

1. Session One 1(5)
2. Session Two 1(4)
3. Session Three 3(4)
4. Session Four 2(7*)
5. Session Five 7(8*)

6. Session Six 4(7)

* = Includes participant who was not considered in calculations.

The majority of the negative comments were about the videos or films. Examples of these comments are:

1. "The movie was excellent until it came to a point where the speaker asked us to accept his reasoning for no explicable reason."
2. "Video. Perhaps a bit preachy."
3. "The movie was too long."
4. "The speaker talked in too much jargon or technical terms."
5. "Most of the film (dull)."
6. "Tape was a little long."

Four of the six comments came from one participant who would rather discuss a topic with the person presenting than to sit and watch. He has difficulty watching material and not being able to question the speaker on point made in the film or video. Comment 4 was in reference to Robert Ackerman who does have a tendency to speak in jargon. However, the participant did not mention this during the session where it could have been cleared up.

Other negative comments included:

1. "Questions which appeared to attempt to prompt only one school of thought (re: disease concept)."
2. "We may have strayed off topic at times, but the information was useful."

3. "Group off track. Did not cover intended material."
4. "I would prefer to stick to the session material."
5. "The discussion was interesting but often got a fair distance away from the topic."
6. "Meeting a lot of nice people that I may not meet again - such a loss but such a blessing to have met them."

In two sessions, the disease concept was brought up by one individual who could not understand why alcoholism was considered a disease. He was openly challenged by the two A.A. members and another member who is involved in the treatment of drug abusers. No definite conclusions were made but many aspects of alcoholism being a disease or not being a disease were discussed. There was no indication that this participant's opinion changed as a result of the discussions. It was apparent by comments made during the discussions, that he was taking the information presented to him and applying it against his own experience. This was made evident by the types of questions he asked the members who challenged his belief.

The general comments from the Post Session Report were all positive and they also reflect acceptance of the methodology used. Examples are:

1. "Explanation was clear without clinical terms - very suitable for the layman."
2. "Well organized presentation consistent to outline. Effective and impacting."

3. "Great way to begin the sessions - everyone starts from the same point of reference."
4. "Continues to be a worthwhile learning experience."
5. "Very revealing to my personal history."
6. "Informative and interesting."
7. "Good program overall. Let us have the opportunity to think and evaluate for ourselves."

In summary, the Post Session Report provides amply examples of the effectiveness of using the Adult Education Model for designing and delivering a workshop. Comments show the participants were satisfied with the way the workshop was presented. The comments also demonstrated that learning took place. For example:

1. "The discussion of the definitions help in my understanding of the complex nature of alcoholism."
2. "Discussion how some individuals, when confronted with their condition, can modify their intake of alcohol, and control safer levels."
3. "Discussion and information regarding the problems of problem drinkers versus alcoholics."
4. "The video answers some of the questions I had - I'm OK."
5. "There is a choice in life."
6. "Learned a lot!!"
7. "Continues to be a worthwhile learning experience."

8. "Good program overall. Let us have the opportunity to think and evaluate for ourselves."

6-2-3 The Client Satisfaction Questionnaire (CSQ)

The original CSQ was developed by C.C. Attkission, G. Pascoe, Maurice LeVois, D.L. Larsen, Wm. A. Hargreaves, T. Nguyen and R. Zwick over a 10-year period at Clifford Attkission's Evaluation Research Laboratory at the University Of California, San Francisco. This questionnaire was modified to provide an accurate evaluation of this workshop.

It is a self-administered questionnaire that will be used at the end of each educational session. The CSQ uses a four-point bipolar scale for nine of the ten questions. The tenth question is a rating scale for the films and video tapes used during the sessions. A major purpose of participant satisfaction research and the CSQ is to broaden the scope of participant participation in the evaluation of human service programs. The CSQ is used for program evaluation purposes as a global scale and presents the facilitator information on process and outcome. It will also provide an evaluation of the handouts provided and the method of presentation of materials.

An assessment of this instrument by Nguyen et al. (1983)[15] concluded that "the CSQ is an efficiently administered instrument that:

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[15] Article not available.

1. Has excellent internal consistency.
2. Is well received by the patients, service providers and administrators.
3. is applicable to a wide range of service settings. and
4. has psychometric properties that are stable across many independent studies" (Lettieri, et al. 1987).

Modifications made to the Client Satisfaction Questionnaire are designed to make it applicable to an educational workshop. Minor changes were made to the individual questions to remove the implication that it is a treatment service questionnaire.

Table 16 is a breakdown of the Client Satisfaction Questionnaire for the questions 1, 2, 3, 5, 6, 7, and 8 (See Table 17). Provided are the mean scores of each participant for each session.

The Mean Scores and comments on the Client Satisfaction Questionnaire from the participants demonstrate a general satisfaction with the workshop. These comments basically parallel those made on the Post Session Report described earlier in this report. The comments are an important measure of the process and some will be reproduced for information, emphasis and to back-up the premise the workshop met the objectives and goals of the practicum. Examples of the comments are:

1. "Very effective presentation, consistent to the outline."
2. "Good info, professionally presented."

Table 16

MEAN SCORES FOR THE CLIENT SATISFACTION QUESTIONNAIRE
(By Session)

Partic-ipant	Session					
	1	2	3	4	5	6
1	4.0	4.0	3.50	3.67	3.36	3.50
2	3.17	*	*	3.17	3.00	3.00
3	3.33	3.83	3.50	3.50	3.67	3.67
4	3.00	3.50	3.50	3.17	3.67	3.50
5	3.50	3.50	3.33	*	3.50	3.50
6	*	*	*	3.83	3.67	4.00
7	*	*	*	3.50	3.33	3.33
Range	1	1	1	2	1	1

Legend * = Did not attend session
Top possible score = 4.00

Questions scored 1, 2, 3, 4 with 1 being low and 4 being high.

3. "Very stimulating workshop tonight."
4. "Good session, discussion important."
5. "Priceless information for me personally."
6. "Excellent information on work place behaviour."
7. "Good course, good info."
8. "Very interesting. Answered some questions that I had for sure."
9. "Good interaction. Good stimulating probes and questions introduced."

10. "Stimulating interaction which I always appreciate especially when it generates more light than heat."

Table 17

Client Satisfaction Questionnaire Questions Used in Table 17

1. How would you rate the quality of the workshop you just finished?
2. Did you get the kind of educational program you wanted?
3. To what extent has our program met you educational needs about alcohol and it's effects?
5. How satisfied are you with the amount of material you have received? For example, handouts.
6. Have the sessions you received helped you to understand more about alcohol and associated problems?
7. In an overall, general sense, how satisfied are you with the workshop?
8. If you were to seek information again, would you come back to our program?
Questions Not Used in Table 17
4. If a friend were in need of similar information, would you recommend our program to him or her?
9. Do you think that the pace of the program was: too fast, just right, too slow or don't know?
10. Please rate the films and video tapes used during the workshop: good, okay or no good.

11. "Information accurate but needs further explanation."

12. "Interesting information on seniors abuse."

NOTE: The above comments were not edited for grammar but the spelling was corrected. They were reproduced directly from the Client Satisfaction Questionnaire.

Participant Number 2 rated all questions, with the exception of one question in Session 1 and 4, with a 3 and in the those two sessions he rated a question a 4. There was one rating of a 2 for Participant Number 3 for question 3 in Session 1.

6-2-4 How Much Do You Know About Alcoholism

This an 80-item questionnaire was created by the facilitator and was designed to discover the baseline knowledge of participants about alcohol and alcoholism. Participants were to respond with either a Yes or No or True or False to the questions. The instructions ask the participants to answer the questions they are sure of. If they do not know the answer to a question they are to leave it blank.

Comparing the results of the Pre- and Post administration of the questionnaire will provide:

a. how much new information the participants received;

b. areas that were not adequately covered; and

c. changes in attitude.

This questionnaire was used as a pre- and posttest to determine if there was any change in knowledge level of alcoholism. There are three ways of making a hypothesis of whether or not the participants gained any new knowledge.

a. The number of unanswered questions.

b. The number of correctly answered questions.

c. The number of incorrectly answered questions.

Table 18 gives a summary of these points and an indication of the changes made by the participants.

Table 18

Results of How Much Do You Know About Alcoholism

	Participants						
	1	2	3	4	5	6	7
	Unanswered Questions						
Pre-	28	45	13	14	5	47	12
Post-	3	1	0	0	16	25	1
Change	25	44	13	14	-11	22	11
	Range (-11 to 44)= 55			Mean 16.86			
	Correctly Answered Questions						
Pre-	38	30	59	53	52	27	59
Post-	59	76	69	68	48	38	68
Change	21	46	10	15	-4	11	9
	Range (-4 to 46) = 50			Mean 15.43			
	Incorrectly Answered Questions						
Pre-	11	11	16	10	23	8	9
Post-	17	3	11	12	14	17	11
Change	6	-8	-5	2	-9	9	2
	Range (-9 to 9) = 18			Mean -0.43			

The participants, with the exception of one, answered more questions (Mean increase = 16.86) on the Posttest than they did in the Pretest. Correctly answered questions (Mean increase = 15.43) also rose, with the exception of one, which shows an increase in knowledge. In analyzing the responses to the questions, four of the questions could be eliminated. For example, questions 15 and 45 were either left blank or only one answered it correctly. Questions 54 and 67 were correctly answered by 2 of the seven participants. If these questions were not considered in the calculations the:

1. Range of the Blanks would be 54 with a Mean Score of 17;
2. The Range of the number of correct answers would decrease to 47 with a Mean Score of change rising to 15.86; and
3. The Range of the number of incorrect answers changing to 17 with a Mean Score change to -2.71.

It is assumed that with an increase in knowledge there would be a change in attitude and the attitude change is also reflected in the number of attempted questions and correctly answered questions.

6-2-5 River Heights Family Life Education Centre Quick Feedback Sheet

This questionnaire was designed by the River Heights Family Life Education Centre to evaluate programs sponsored by them. It was found that this form provided additional evaluative tools that would help in evaluating the workshop.

The first three questions are scored on a Likert type scale with five categories to use as a rating. One was considered low or not acceptable with five being high or indicating a high level of acceptance or accomplishment. The next four questions asked for short written answers. The final question asked the participant to indicate how they heard about the workshop.

This questionnaire is locally designed and has not been validated or tested for reliability.

The results of this questionnaire demonstrate, both numerically and verbally that the workshop met the needs of the participants. Table 19 shows the Mean Scores and Sds for the first three questions by participant and an overall Mean Score and Sds of all the participants for each question. The Raw Scores and answers to the questions are shown at Appendix 12. These mean scores indicate that the material provided in the Sessions was considered significantly useful, effective and the participants gained new knowledge. In analyzing the three questions it becomes evident the participants thought the workshop was effective. In their response to Question 1 (Will

you be able to make use of the ideas provided in these sessions?), the lowest score was a 4 out of 5 which means they have gained new information they will be able to use in the future. Two participants answered Question 2 (Did you gain new knowledge or insight into this topic?) with a 3 out of 5. One of these participants works in the field of chemical dependency and the other went through two chemical dependency treatment programs as a patient within the past year. Question 3 (How well do you think the sessions were organized, presented, and facilitated?) was answered by all participants with either a 4 or 5 out of a possible 5.

Table 19

River Heights Family Life Education Centre

Quick Feedback Sheet Mean Scores

MEAN SCORES FOR QUESTIONS 1, 2 AND 3					
Question	Mean	SD	Participant	Mean	SD
1	4.57	0.49	1	4.00	0.82
2	4.00	0.76	2	4.67	0.47
3	4.29	0.45	3	4.33	0.47
SCORING			4	4.67	0.47
1 (Low) to 5 (High)			5	4.00	0.00
Question 1: Usefulness Question 2: New Knowledge Question 3: Effectiveness			6	4.67	0.47
			7	3.67	0.47

The remaining four questions required written answers. Each question will be presented with the written responses.

Question 4: What was the most valuable aspects of the workshop for you? Responses were:

1. "Clarifying some of the questions I had about ACOA."
2. "The open minded discussion of topics."
3. "The amount of information in the handout material was useful in increasing my understanding."
4. "Insight acquired through the information provided, which dispelled some old myths which I had and gave me new information to ponder."
5. "Interaction."
6. "Good discussion - sharing of experiences."
7. "ACOA issues."

Question 5: What could have made the program more effective? Responses:

1. "I believe it was comprehensive."
2. "Shorter films, assigned topics for discussion which would keep subject matter narrower and cover that material more intensely."
3. "Not being a professional in the area, I don't know."
4. "More group discussion."
5. "More interesting films and more dynamic presentation."

Question 6: What follow-up sessions would you like to have offered in the future? Responses:

1. "Co-dependency."
2. "Action groups to promote changes in society and government which enhances the treatment of alcohol abusers."
3. "An opportunity (confidential) to discuss on personal experience."
4. "More specific focus on abuse issues, cause and effect."

Question 7: Comments: Re size of group:

1. "Good size - confusing to get to know one another."
2. "Close small groups, easier to relate and get to know the other participants."
3. "6 - 10 is a good size."
4. "Just fine. Bigger may not have lent itself as well to open discussion."
5. "Try to keep under 10 people."
6. "About right if all participate."

6-3 Problem Areas and Recommendations

The main problem area encountered was finding a setting and organization to sponsor the Workshop and to assist in the recruitment of participants.

In August, 1989, The South Winnipeg Family Information Centre was contacted and requested to sponsor the workshop. The coordinating committee was briefed and appeared interested and

willing to take the necessary steps to sponsor, advertise and recruit participants. They were to organize and provide the necessary space and equipment. Around December 15, 1989, approximately one week before the advertising deadline, the Board of Directors decided that South Winnipeg Family Information Centre could not sponsor the workshop. They were of the opinion that sponsoring a workshop on alcoholism would create a conflict of interest with their major funding agency and they would loose part of their funding. The Director suggested I contact the River Heights Family Life Information Centre for sponsorship. The River Heights Family Life Information Centre were willing to sponsor the workshop and said they would recruit the participants. Difficulties arose with the timing of the workshop and the lead time needed to recruit candidates. There was no advertising done until early January, 1990 and the workshop was rescheduled in anticipation of successfully recruiting members. One week before the workshop was to start, River Heights Family Life Education Centre had no candidates. They had advertised on television, radio, in the local newspapers, and by telephone.

6-3-1 Recommendation Number One

Before making a firm commitment to do a workshop, ensure the sponsoring agency has the required approval from all levels within the organization. If necessary, get the commitment in

writing and make an offer to make any presentation necessary to the agency to sell the program.

Another problem area in delivering the workshop was the number of topics and quantity of material to be presented in the time allotted. The scheduled topics ended up being greater than the amount of time available to present them. However, with the majority of the didactic presentations backed up with a handout, the participants could read on their own time, thereby filling in the blanks.

There is no way of being able to predict the type of participants that will take the workshop, what their needs are or how much they will express themselves or ask questions. For this particular workshop, five of the seven participants were:

1. Very verbal;
2. Asked a lot of questions;
3. Gave examples from their personal experiences;
4. Challenged other group members; and
5. Ensured their needs were met.

As a result not all of the programmed material was covered and four of the six sessions ran 30-minutes over the scheduled time.

It was not possible to do the exercises scheduled for each session, with the exception of one. This was partly due to the amount of material available and partly due to meeting the needs of the participants. There were sufficient questions and discussion taking place to provide new information and learning

experiences for the participants. Cutting the discussions off to do an exercise would have compromised the participant's needs by taking unnecessary control over the sessions.

6-3-2 Recommendation Number Two

Reduce the number of topics to be covered. However, ensure there is sufficient material available to cover times when there was little discussion or few questions. An alternative would be to have a number of exercises available that could be slipped in to ensure the topics were covered in sufficient detail.

6-4 Continuation

One of the hidden objectives of doing a practicum is to use the experience to enable the student to offer workshops and seminars on the selected topic. This objective is being realized from the results of this practicum. River Heights Family Life Education Centre has arranged for a workshop to be conducted at the Sturgeon Creek Collegiate in the St. James School Division as an evening class. This is scheduled for the period May 1, 1990 to June 5, 1990.

Future plans include the conduct of one-half and one-day workshops for professionals in the social service agencies in Winnipeg. If interest is indicated, the workshop will be extended province wide.

6-5 Follow-up

Four months after the end of the workshop, a follow-up discussion was held with all of the workshop participants to find out if taking part in the workshop had made a difference in their lives. All indicated that the material presented and discussed has made an impact in the way they view the use of alcohol, how they interact with others and how they feel about themselves. One of the ACOA participants said that participating in the workshop made her realize she is "okay". That feeling has not left her. Before the workshop she had some concerns about how seriously her father's drinking had affected her. By reviewing the handouts, viewing the video tapes and reading the material presented she discovered was not adversely affected. To her, the workshop was a beneficial part of self-discovery.

Another Adult Child of an Alcoholic revealed that participating in the workshop helped him to better understand what his parents had gone through in relation to alcohol. He has returned to the Adult Children of Alcoholics Self-help Group meetings with a better understanding of his problems and the alternatives open to him. He stated that this decision was the result of the information he gained in the workshop.

One of the participants was a heavy, daily drinker. Before the workshop he would have two or three drinks after work each day and had a tendency to drink excessively on the weekends. Since participating in the workshop, he no longer drinks on a

daily basis. When he does drink, he drinks less, because he is now conscious of the effects alcohol has on a person.

One of the A.A. participants said that he no longer feels there are only two types of drinkers - social and alcoholic. His participation in the workshop helped him realize that each person is affected differently. He said he looks at drinkers in a different light now and is not so quick to label them.

Another A.A. member who had completed treatment for substance abuse approximately one year before attending the workshop said that the one thing that made the biggest impact on him was how non-alcoholics view alcoholism and alcoholics. The information he learned from the Workshop reinforced some of the information he gained while in treatment and provided additional data. He stated that he feels more confident when discussing the effects of alcohol on a person and especially in the 12-step meetings he attends with others.

Another participant said participating in the workshop helped him understand some of the experiences he has had in the workplace with coworkers and other employees. When the different characteristics and behaviours were described he was able to recall people who had displayed these dysfunctional attitudes and behaviours. He believes he could now be a better supervisor and is developing an empathetic understanding for families that displayed those attributes.

He was the only participant who suggested some changes to the workshop, should it be used in the future. He said that he

found some of the terminology difficult to understand. His recommendation was to either provide a "list of words" or to explain new terminology. He also suggested reducing the amount of material. In that way, the number of topics would be fewer and covered in greater depth.

A participant with teen age and pre-teen age children described how he is able to provide his children with more factual information. He feels he is better able to help his children understand the differences between having a drink and abusing alcohol. The workshop provided him with a better understanding of alcoholism and how it affects the whole family and especially children raised in an alcoholic home. He also related that he is now very conscious about the amount he drinks and the frequency. Workshop participation made him realize how powerful alcohol is and the damage it can do, not only to his health, but also to relationships.

During one of the sessions about adult children of alcoholics, a question was asked about children raised in a home where alcohol was <u>not</u> a factor. The response to that question assisted one of the participants to free himself from guilt, shame and responsibility he has held for a number of years. When he was 14-years old his father died at home. The participant said that he tried to revive his father by using artificial respiration. He was not successful and as a result, he blamed himself for his fathers death. He said he thought he should have been able to save his father's life. The result was that he took

over responsibility for the family's well-being and attempted to look after his mother. The unrealistic sense of responsibility adversely affected his social life because he felt he had to work in the evenings and weekends to help provide for the family. It seriously affected personal relationships with peers and girls because he did not have the time to develop meaningful relationships.

Shortly after the completion of the Workshop an acquaintance told him of the death at work of a co-worker. Within minutes of his collapse, he was attended to by two trained first aiders and by ambulance attendants within ten minutes. They were unsuccessful in reviving him. The participant said that he immediately made the connection between this death and his fathers death. He said he believes he is now free of this guilt from the past because of the information gained in the Workshop. He related that he has learned to reevaluate a number of incidents in his past life and is managing to start again with new beliefs and attitudes about himself and others. This participant asked if the Workshop was going to be run again because he wants to pick up the information he missed and to retake the session on adult children of alcoholics. His final comment was "It is nice to realize that I an not nuts!"

6-6 Conclusion

At the end of the Workshop I felt my goals had been met. Although the size of the group was small, it represented a good cross-section of society. Included in the participants were professionals, businessmen, blue collar workers, A.A. members, ACOA's, heavy drinkers and social drinkers.

The follow-up interviews with each participant indicated learning did take place and that an attitude change was accomplished. It helped some participants find out they are "okay"; others to reevaluate their drinking patterns; some had misunderstandings clarified; one was able to understand some of the dysfunctional behaviours he observed in the past in coworkers and acquaintances; and all said they gained a better perspective of the effects of alcohol on an individual.

The workshop was a successful medium for enhancement of my skill development and abilities to develop and present educational workshops that have a positive outcome for participants. It was challenging working with agencies, recruiting participants, and implementing theoretical methodology into a "real life" situation. As shown by the results of the evaluation tools, my expectations of how and what to present, in what order to present the material and to find materials that would meet the needs of the participants were met. I followed the principles of experience, modelling and imitation from the

social learning theory and applied them to the adult learning model.

I believe that knowledge is power. Knowledge allows a person to make informed choices. Learning accurate, factual and practical information leads to better decision-making which can lead to a better and healthier lifestyle.

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APPENDICIES

Appendix 1

CHILDREN OF ALCOHOLICS SCREENING TEST

First Name _____ Sex Male ___ Female __ Age ____

Please check the answers below that best describe your feelings, behaviour, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "Yes" or "No".

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

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

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

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

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

——|—— 20. Have you ever worried about a parent's health because of his or her alcohol use?

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

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

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

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

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

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

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

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

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

——|—— 30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

TOTAL NUMBER OF YES ANSWERS _____

Appendix 2

POST-SESSION REPORT

First Name _____

Please circle the number that comes closest to describing your feelings about the session you just completed

1	2	3	4	5	6	7	8	9
Not Productive at all				Moderately Productive				Extremely Productive

Please try to describe at least one positive and one negative learning experience or a part of the discussion that occurred during the session that might help explain your rating.

POSITIVE LEARNING EXPERIENCE

****

NEGATIVE LEARNING EXPERIENCE

****

OTHER COMMENTS

(Bloom & Fischer, 1982, p. 228)

Appendix 3

CLIENT SATISFACTION QUESTIONNAIRE

First Name _____

Please help us improve our program by answering some questions about the workshop you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of the workshop you just finished?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of educational program you wanted?

1	2	3	4
No, Definitely Not	No, Not really	Yes Generally	Yes Definitely

3. To what extent has our program met your educational needs about alcohol and it's effects?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar information, would you recommend our program to him or her?

1	2	3	4
No, Definitely Not	No, I don't Think so	Yes, I think So	Yes Definitely

5. How satisfied are you with the amount of material you have received? For example, handouts.

1	2	3	4
Quite Dissatisfied	Indifferent or Mildly Dissatisfied	Mostly Satisfied	Very Satisfied

6. Have the sessions you received helped you to understand more about alcohol and associated problems?

4	3	2	1
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things confusing

7. In an overall, general sense, how satisfied are you with the workshop?

4	3	2	1
Very Satisfied	Mostly Satisfied	Indifferent or Mildly Dissatisfied	Quite Dissatisfied

8. If you were to seek information again, would you come back to our program?

1	2	3	4
No, Definitely not	No, I don't Think so	Yes, I Think so	Yes, Definitely

9. Do you think that the pace of the program was:

1	2	3	4	
Too Fast	Just Right	Too Slow	Don't Know	

10. Please rate the films and video tapes used during the workshop.

	Good	Okay	No Good
1. Chalk Talk on Alcoholism			
2. Medical Effects of Alcohol Use			
3. Alcoholism: The Family			
4. Adult Children of Alcoholics			
5. Roles			

COMMENTS

(Lettieri, Nelson, & Sayers, 1987, p. 40)

Appendix 4

First Name _____

HOW MUCH DO YOU KNOW ABOUT ALCOHOLISM

Circle your response in the column opposite each of the following statements or questions. The responses are either TRUE (T), FALSE (F), YES (Y) or NO (N). Please answer all the questions you are sure of and do not answer the ones you are unsure of.

TRUE	FALSE		
T	F	1.	Alcohol is not a stimulant.
T	F	2.	Alcoholism is found among respectable and productive citizens.
T	F	3.	An alcoholic's excessive drinking is the source of all most of his/her problems.
T	F	4.	A heavy drinker is not an alcoholic if he is able to stop drinking for several weeks at a time.
T	F	5.	Anyone who drinks alcoholic beverages might become an alcoholic.
T	F	6.	Most alcoholics are completely unconcerned about their problem.
T	F	7.	The alcoholic usually intends to get drunk when he drinks.
T	F	8.	The alcoholic is seldom helped by any type of treatment.
T	F	9.	An alcoholic cannot be forced to take treatment.
T	F	10.	The alcoholic deserves the same consideration from his employer as any other sick person.
Y	N	11.	Is this a satisfactory definition of "Under the influence of alcohol?" **A person is under the influence of alcohol when, due to the imbibing of alcohol, he has lost to any extent, some of that clearness of intellect and self-control he would otherwise possess."**
Y	N	12.	Can you diagnose drunkenness by a physical exam?
Y	N	13.	Can you detect pure alcohol on a person's breath?
Y	N	14.	Is drinking alcohol a good remedy for snake bite?
Y	N	15.	Will you get as drunk on beer as by drinking the same amount of wine or spirits (rye, rum, vodka, etc.)?
Y	N	16.	Will you get drunker by switching drinks (for example,

going from beer to hard liquor) than by drinking the same amount of alcohol in one form such as rye?

Y N 17. Does the eating of onions or garlic interfere with the breath test for alcohol?

Y N 18. In a diabetic, would the sugar in the blood produce enough alcohol to interfere with the blood test for alcohol?

Y N 19. Is alcohol a member of the anaesthetic series of drugs?

Y N 20. Should you wait at least 3 hours after drinking 2 highballs to be sure it is safe to drive?

Y N 21. Is alcohol taken as a medicine necessary in the treatment of any disease?

Y N 22. Does alcohol increase the visual acuity or the acuity of any other sense?

Y N 23. Will taking a drink of water the morning after the night before, when considerable wine was drunk, produce intoxication?

Y N 24. Is it a good policy to take a few "shots" of whisky to warm one up just before being exposed to very low temperatures?

Y N 25. Can one accurately prophesy the per cent of alcohol in the blood knowing on the amount of alcohol a person drinks?

Y N 26. Can one state the minimum amount of alcohol consumed from the per cent of alcohol found in the blood?

Y N 27. Does loss of judgment and the ability for self-criticism occur before there are obvious symptoms of intoxication?

Y N 28. Can an exceptional person have 0.15% of alcohol in his blood and still retain all of his faculties?

Y N 29. Is alcoholism hereditary?

T F 30. Some social drinkers consume far more alcohol than even late stage alcoholics.

T F 31. Tranquillizing drugs, such as Librium or Valium, are often valuable in maintaining the recovering alcoholic through his first year or so of sobriety.

T F 32. An alcoholic with over ten years sobriety may safely take an occasional social drink.

T F 33. Alcoholism should be considered a symptom of an underlying personality or mental disorder.

T F 34. The first step in psychotherapy with an alcoholic is determining the underlying reasons for drinking.

T F 35. The spouse of the alcoholic is often a primary cause of the alcoholism.

T F 36. Alcoholics Anonymous (AA) has been more effective than psychiatric treatment in helping alcoholics to recover.

T F 37. The majority of alcoholics who stay sober in AA for two years continue to remain sober indefinitely.

T F 38. The incidence of alcoholism among men is constant among all major social classes.

T F 39. At least one out of fifteen drinkers develops alcoholism.

T F 40. Studies suggest alcoholics usually lack the strength of character (will power) required to give up the excessive drinking.

T F 41. An alcoholic is as blameless for his condition as a diabetic.

T F 42. About one-fourth of all alcoholics are on skid row.

T F 43. Research has failed to establish any definite genetic, biochemical, or personality factor as a basis for alcoholism in all alcoholics.

T F 44. Achieving genuine insight into the dynamic causes of his drinking will usually lead the alcoholic to recovery.

T F 45. Assessment of the frequency and quantity of alcohol intake is of little value in diagnosing alcoholism.

T F 46. Virtually anyone who consumes a large enough quantity of alcohol over a long enough period of time will develop alcoholism.

T F 47. The prognosis for alcoholism is such that professionals should spend their time working with more hopeful categories.

T F 48. The strong resistance among alcoholics to admitting their problem is in large part due to society's attitude toward alcoholism.

T F 49. An alcoholic who has fallen off the wagon (relapsed) more than four times may usually be regarded as a lost cause.

T F 50. Most alcoholics seem to be unusually sensitive to even covert rejecting attitudes of professionals.

T F 51. Becoming unconscious from excess drinking is called a blackout.

T F 52. Involuntary treatment of an unmotivated alcoholic has been shown to be effective in many cases.

T F 53. Professionals are often wise to advise the spouse to consider creating a crisis by separation from the unmotivated alcoholic after lesser measures have failed.

T F 54. Most wives of alcoholics tend to become more emotionally disturbed when their husbands are maintaining sobriety.

T F 55. Optimal treatment (versus no treatment) improves the alcoholic's chances for recovery more than the neurotics's.

T F 56. Alcoholism is a self-inflicted disease.

T F 57. A spouse or other informant should be interviewed, if possible, whenever a drinking problem is suspected.

T F 58. A brief drinking history should be obtained on every new adult client in any kind of helping agency.

T F 59. A person who never consumes anything stronger than beer is probably not an alcoholic.

T F 60. One may be a thoroughly reliable worker on the job and still be alcoholic.

T F 61. The ability to confine drinking to weekends suggests that a person is probably not alcoholic.

T F 62. Al-Anon is the companion group to AA for female alcoholics.

T F 63. Alcoholics often seek help for emotional or family problems without ever mentioning a drinking problem to the interviewer.

T F 64. Probably the best criterion for defining a person as an alcoholic is whether drinking has continuing adverse effects on his/her life.

T F 65. Eighty to ninety percent of those who have alcoholism either go into treatment or attend A.A. meetings.

T F 66. Education about alcoholism often helps the alcoholic reduce his resistance to accepting his/her condition.

T F 67. An alcoholic must hit bottom before he can begin the recovery process.

T F 68. On the average, an alcoholic who is maintaining sobriety has no greater number of serious emotional problems than other people in general.

T F 69. Alcoholics are prone to abuse any other chemical substance given them which produces a sedative effect.

T F 70. It is usually wise to conceal liquor when entertaining a recovering alcoholic in your home.

T F 71. The suicide rate among alcoholics is markedly higher

than for the general population.

T F 72. A person who can abstain from drinking for long intervals is not a true alcoholic.

T F 73. It is best to wait until an alcoholic admits his problem and stops drinking before offering professional help.

T F 74. The professional can best help by adding his pleas to that of the family in urging the alcoholic to quit drinking.

T F 75. A person's real character emerges when under the influence of alcohol.

T F 76. The attitudes of the professional person are more responsible for his frequent hostility toward the alcoholic client than the latter's behaviour.

T F 77. In essence, alcoholic drinking boils down to a simple question of will power.

T F 78. People who say alcoholism is an illness often behave toward the alcoholic as though it were a moral weakness.

T F 79. Alcoholism is an insidious, progressive, and treatable illness.

T F 80. Treatment facilities often do not treat problem drinkers any differently than they do those diagnosed as alcoholics.

ANSWERS TO TEST YOUR A.Q.

1. **True.** Alcohol is a depressant and like other anaesthetics, depresses the central nervous system.

2. **True.** Alcoholism does not favour people by religion, class, economic standing, colour, or any other way. There are differences that can be measured in certain groups but alcoholism affects all societies and all levels. It appears to affect the lower classes more because they are the ones which are seen in the treatment centres and self-help groups. The "upper class" receive more help in denying the problem and the resulting physiological and psychological difficulties associated with alcoholism.

3. **True.** Alcohol is the main cause of the majority of the problems an alcoholic has. Alcohol is a drug and when a person drinks they are under the influence of a mood altering drug. This means their thinking, behaviour, actions, attitudes, etc. are drug affected.

4. **False.** Stopping for a period of time is not an indication a person is not an alcoholic. There are different types of alcoholics. One is called the "Binge" alcoholic who may go on a "binge" once a year. However, when he/she goes on the binge it creates problems - either financial, legal, marital, societal, or work, or all of them. Normally the binge will start off lasting a weekend, and over time the length of the binge will increase and may last a month or more. Time is not the key to determining whether a person is an alcoholic or not. The key is what happens when the person drinks and what effects does it have on his/her life.

5. **True.** No one knows what causes a person to turn from a social drinker to an alcoholic drinker. There are no predictable clues an individual can use to determine without a doubt if they will become an alcoholic later in life. However, there are some studies which say there is a difference in the blood, in the levels of zinc in the body, the way alcohol is metabolized in the body, genetic factors, etc. that a person can have tested to see if they meet the criteria established by the applicable study. Some of the things a person can look at are the drinking attitudes and behaviours of their family, how they drink (gulp or sip), what does alcohol do for them (i.e. does it make them feel good and is it a positive experience?), and the reason(s) they drink.

6. **False.** Most alcoholics hate what they are doing and feel completely frustrated and they feel they have no alternatives. Given a choice, most alcoholics would not behave the way they do but they feel powerless to change. They do not know how. One of the reasons suicide is so high among alcoholics is they see no other way out of their dilemma. Alcoholics know they are hurting their families, friends and peers. Alcohol is a positive experience for them, at the start, and they do not see alcohol as the problem - it is something else - and they are not sure what it is. If you do not know what the problem is, how can you fix it.

7. **False.** Alcoholics do not drink for the same reasons a social drinker does. Alcohol does something positive for an alcoholic - it makes them feel good. Therefore, an alcoholic drinks to feel good. Unfortunately, as the alcoholics' tolerance develops, it takes more and more alcohol to "feel good." As time goes on, the alcoholic does not feel good any more, but drinks to feel

"normal." As the alcoholic drinks more and more, the drunker he/she gets. This is not a planned activity, but the result of drinking to regain those positive feelings he/she experienced when they first started drinking.

8. **False.** Although the "success" rate of most treatment centres is relatively low, treatment does help a large number of alcoholics. The educational part of the treatment programs assists the alcoholic in understanding how alcohol affects him/her and may provide an insight into why the person drinks they way they do. One of the reasons for the low success rate is that the alcoholic is put into treatment too soon. Although the alcohol is completely out of the system within 96 hours, it takes much longer for the "brain" to become drug free. In other words, the "brain" has become conditioned to operating under the influence of the drug and it has to relearn how to function drug free. This process takes three to six months. If the alcoholic could remain abstinent for the three to six months and then take the treatment program the success rates would be higher. Another reason for the low success rates may be that the treatment centres treat all patients the same way. They do not provide individualized treatment programs which would concentrate on the problems of the individual drinker. It seems that success is also dependent upon a good, strong aftercare program where support is offered in the form of understanding and guidance. Many successful alcoholics have used the fellowship of Alcoholics Anonymous, others have returned to the church, and others have found strong support from their peers. Successful treatment is a multi-faceted program which considers the alcoholic/problem drinker, their families and aftercare.

9. **True.** Very few, if any, really volunteer for treatment. There is some kind of pressure behind every person who enters treatment. For example, it may be the court system, the family, the "boss", friends, peers, social service agency, housing authority, financial considerations, and so on. If an alcoholic waits until he/she is ready for treatment, chances are they will never get into treatment. Good treatment programs emphasize a change of attitude in their programs. Most successful alcoholics started changing their attitudes while in a treatment program and continued to do so when they leave treatment.

10. **True.** Studies have indicated it takes from seven to ten years before alcoholism seriously affects an employees job performance. The employer has spent a lot of money and time in training this individual and to get rid of him/her because they have an alcohol problem does not make sense. Employers would be better off supporting the individual by insisting they go into treatment and set up a strong support system. The question is, how many times does the employer support the alcoholic? Alcoholism is a relapse prone condition. Therefore each person has to be treated as an individual with individual circumstances being considered. The employer has to be careful they do not become enablers. Refusing to cover up for the alcoholic and insisting they get help and providing support is the best first step an employer can take.

11. **Yes.**

12. **No.** A person being examined may temporarily pull himself together and give a better account of himself than he would if he were not under scrutiny. Also, ordinary physical examination does not show the deterioration of judgment and the acuity of the senses.

Finally, about 100 pathological conditions cause symptoms which resemble those of alcohol.

13. **No.** We smell the flavouring of the drink but not the alcohol. Pure alcohol, i.e. gin and vodka, leave no telltale breath smell.

14. **No.** A person bitten by a snake may be in shock which is increased by the depressing action of alcohol.

15. **No.** The large amount of water in beer is responsible for slower absorption of the alcohol.

16. **No.** The intoxicating action depends upon the amount of alcohol regardless of the type of drink, assuming that all the drinks contain about the same amount of water.

17. **No.** It has been stated that these substances interfere but the breath test is specific for alcohol.

18. **No.** The sugar in the blood of a diabetic does not change to alcohol.

19. **Yes.** Alcohol is chemically related to ether, chloroform and other anaesthetics.

20. **Yes.** The two highballs contain a total of about two ounces of pure alcohol. It takes approximately 2 hours to fully metabolize one ounce of alcohol. A healthy person metabolizes approximately 2/3 an ounce of pure alcohol per hour.

21. **No.** Alcohol is not a specific or cure for any disease, unless one considers "worry' a disease, and a drugged indifference a cure.

22. **No.** As little as 0.04% of alcohol in the blood may reduce visual acuity as much as the wearing of dark glasses after sundown. The other senses are also less acute.

23. **No.** The person may become sick but he is not intoxicated.

24. **No.** The feeling of warmth after drinking is caused by the dilation of the superficial capillaries. This condition is associated with rapid loss of body heat.

25. No. To even guess at what the concentration might be, one would have to know the amount of alcohol consumed, and also over what period of time this amount was imbibed.

26. **Yes.** When a 150 pound man has 0.15% alcohol in his blood he has accumulated 3 ounces of absolute alcohol which indicates he drank at least that amount of alcohol. This would correspond to the amount of alcohol in 6 ounces of 100 proof whisky or the amount of alcohol in six 12 ounce bottles of 3.2% beer.

27. **Yes.** The person is not aware of his shortcoming although careful psychologic examination may indicate marked loss of efficiency.

28. **No.** The individual may give a good account of himself but he has nevertheless lost enough of the clearness of intellect and self-control he would normally possess to materially interfere with his mental and physical capabilities.

29. **No.** Children of alcoholics brought up in foster homes have

better records regarding alcoholism than the normal population.

30. **True.** Some social drinkers consume remarkable great quantities of alcohol but manage to escape developing alcoholism, as manifested by serious adverse life effects. Also, advanced alcoholics, due to decreased physiological tolerance, may require relatively little alcohol to achieve intoxication.

31. **False.** The commonly prescribed tranquilizers tend to alter the mood state in such a way as to pose a grave risk. Either the chemical dependency will simply be transferred from alcohol to the drug, or else the person will also return to alcohol use, resulting in a dual problem.

32. **False.** Widespread experience shows a very high risk of returning to alcoholic drinking is present regardless of how long a period of sobriety precedes an attempt at social drinking. Occasional reports of individuals successfully doing this, if true, represent exceptions (see question 73). There are studies indicating the diagnosis of alcoholism is not being correctly done and a large number of those diagnosed as alcoholics are in fact problem drinkers. The hypothesis is these problem drinkers can be taught to drink socially, with no serious consequences. If this proves to be true, then the response to this question would be a "qualified" true.

33. **False.** Alcoholism should be considered an illness, not a symptom. While other disorders often coexist, the alcoholism is usually by far the most serious in its impact. It is recognized as a disease by the American Medical Association and other health authorities. Attempts to treat alcoholism simply by treating the presumed underlying disorder have been notably unsuccessful. However, the diagnosis of "alcoholism" must be correct. The same can not be said for problem drinkers.

34. **False.** The first step in psychotherapy is to attempt to arrest the drinking by helping the individual recognize and accept his/her condition, and motivating him/her toward sobriety. Only during sobriety can any persisting emotional problems be identified (as distinct from those resulting from alcoholism) and successfully dealt with.

35. **False.** No person can make anyone an alcoholic (or an epileptic or diabetic). At worst, another person's behaviour may provide a convenient and often accepted alibi for drinking, which the unwary professional may mistakenly reinforce.

36. **False.** Alcoholics Anonymous is not a treatment program of any kind. It is a support network which will assist an individual maintain sobriety.

37. **True.** Available studies of AA show longer periods of sobriety are correlated with increased probability of maintaining further sobriety, even though relapses may occur at any point. The probability of permanent sobriety never reaches 1.0. After two years, the probability is about .7.

38. **True.** The myth which suggests alcoholics are primarily found at the bottom of the social ladder is now known to be false. There is evidence, however, that the incidence of alcoholism among women is distinctly higher in the upper class.

39. **True.** The best available estimates of the number of people who drink and the number who are alcoholic leads to this conclusion. One in fifteen is considered conservative, estimates range as high as one in eight.

40. **False.** Actually, there are no studies which measure "strength of character" and this concept is a gross oversimplification of what is involved in recovery (see questions 45 and 78).

41. **True.** The condition of alcoholism is a condition which was certainly not developed intentionally any more than diabetes. Thus nobody should be blamed for its' occurrence. Once aware of it, both the alcoholic and the diabetic have a responsibility to arrest and control their illnesses.

42. **False.** Estimates of the proportion of alcoholics on skid row generally range from 3% to 8%.

43. **True.** In spite of a considerable body of accumulated research, no specific etiologic factor has been clearly demonstrated. A combination of these factors will probably eventually be found to explain the illness of alcoholism.

44. **False.** Experience has shown that insight, while often of definite value, is not sufficient for recovery. There must also be a positive attitude change, emotional acceptance of the condition, and, usually, a long-term supportive group involvement.

45. **True.** In addition to the problem of verifying the "how often" and "how much" variable, identical answers could be accurately given by an alcoholic and a non-alcoholic. The definition of an alcoholic centres of the issue of adverse life effects, which is not necessarily correlated with amount of alcohol intake per se.

46. **False.** Most authorities agree that some unknown factor or set of factors, whether physiological or psychological or both, must exist in addition to the consumption of alcohol as such, in order for alcoholism to develop.

47. **False.** As a chronic condition subject to relapse, alcoholism does not provide a group with as high a remission rate as some disorders. Alcoholics, however, provide great rewards to the helper by the enormous qualitative improvement in those who do benefit, by the number of other people (and society in general) aided when recovery occurs, and even by cases of partial improvement in those who have been previously rejected as hopeless.

48. **True.** While several other factors undoubtedly contribute sig nificantly to the denial system of the alcoholic, the enormous moral stigma still attached to alcoholism may be regarded as a major component of the resistance one observes.

49. **False.** Even a casual acquaintance with any population of al coholics shows it is very unsafe to classify anybody as a "lost cause" because some of those previously so labelled are now leading sober, productive lives, and others will follow suit. While the probability of recovery may decrease as repeated attempts at treatment fail, one never knows which individual will ultimately make it.

50. **True.** Due perhaps to his vast experience at being rejected in various overt or subtle ways and the consequent expectancy of

rejection, plus his or her own skill in "conning" others, the alcoholic is usually expert at detecting rejection, disguised or not.

51. **False.** Becoming unconscious from alcohol consumption is passing out. A blackout is a period of alcohol-induced amnesia; that is, an inability to later recall one's actions while inebriated, though one is conscious during the period. The amnesia usually involves a time period of hours, but can extend to days or even weeks, i.e. for the duration of a prolonged bender.

52. **True.** Contrary to popular belief, motivation is not essential prior to treatment. There is abundant evidence that many, if not most, alcoholics become motivated during, rather than before treatment. In fact, many so-called voluntary patients only submit to treatment as a way of coping with strong social pressure or other non-legal forms of coercion. Available studies show that treatment results are equal for voluntary and involuntary patients. One may also remember that alcoholism is generally fatal, and all but the most extreme civil libertarians believe in society imposing treatment when the probable alternative is death.

53. **True.** Related to the previous question, some form of pressure or coercion is often necessary to push the alcoholic into treatment after simple confrontation and persuasion have failed repeatedly. depending on individual circumstances, a separation may be the most reasonable avenue of producing the necessary crisis, and the professional is well advised to discuss this alternative with the ambivalent spouse, who, with the rest of the family, is deeply suffering.

54. **False.** One of the prevalent myths is that wives of alcoholics are invariably seriously neurotic and are worse when the husband is sober. While many such women clearly do exist, the majority are normal people who develop emotional problems as a result of the enormous family disorganization in alcoholism, and these problems most often diminish with the period of sobriety. Thus, while the period of initial sobriety may require an extensive readjustment of the whole family, most wives will become notably less disturbed in the process.

55. **True.** The rate of recovery for the average alcoholic can be improved from an estimated 10-20% without treatment to 50-70% with optimal treatment. The comparable estimates for neurotics would be 60-70% without treatment to 70-90% with optimal treatment. Thus, while more neurotics recover, treatment plays a relatively more useful role with alcoholics. NOTE: These percentages are suspect.

56. **False.** While the simple physical act of ingesting alcohol is indeed perpetrated by the individual, his acquiring alcoholism is no more sensibly regarded as self-inflicted than breaking a leg while skiing or developing a serious side effect from using a prescribed drug. In all three cases, the individual voluntarily engages in an activity; he probably has some awareness an element of risk may exist, but has no way of knowing until too late that he will be one of the minority who unintentionally fall unfortunate victim to a generally acceptable activity. Should these be called self-inflicted problems?

57. **True.** First, the denial system of the alcoholic is such that the extent of the alcohol problem may only come to light when informa-

tion is obtained from an intimate. Second, alcoholism deeply involves all family members and it is highly desirable to include the key people from the beginning of treatment. Some times the denial system in family members is as strong as it is in the alcoholic. As a result, they will also deny there is a problem with alcohol and rationalize the problem as something else.

58. **True.** Alcoholism is a central factor in a substantial portion of people who seek help at almost any type of social or health agency, and appropriate service can seldom be rendered successfully unless such critical facts are known. A routine drinking history emphasizing the behavioral results of alcohol use will usually determine if a problem may exist, and further information may be sought as needed (see question 64).

59. **False.** This is a common myth, and one often exploited by beer alcoholics in their denial system. Keep in mind that alcohol is alcohol, and there is more alcohol in a 12 oz bottle of strong (6%) beer than in a 1 1/2 oz shot of 90 proof whisky. A case of beer is equivalent to well over a quart (actually about 38 oz) of such whisky (Case of beer = 12 beer).

60. **True.** While job problems are common to many alcoholics, studies show the majority stay reliably at one job for many years, only being fired (or going bankrupt) at a late stage of the illness. Job longevity is often used as a handy alibi in the denial system and should not be considered a contraindication of diagnosing alcoholism.

61. **False.** This is another myth commonly exploited by the alcoholic. A large number of alcoholics spend all week counting the hours until the closing whistle on Friday, so the weekend bender can officially commence. He/she never fails to assure themselves and others that he has no problem because "I never drink during the week," conveniently ignoring the fearful damage occurring on weekends (often including Monday morning).

62. **False.** Al-Anon is an independent organization parallel in form to AA but exclusively for the family or friends of the alcoholic. The spouse or other family members may receive immense help in Al-Anon, through the information, support, and guiding philosophy, whether or not the alcoholic is involved in helping himself or herself.

63. **True.** Such symptoms are depression, anxiety, insomnia, psychosomatic upsets, and marital or family conflicts, plus almost any other complaints, may be directly related to alcohol problems which are never spontaneously revealed. It is not even uncommon for the spouses of alcoholics to ignore or minimize the role of drinking because they too may shun the moral stigma of alcoholism and prefer to see the drinking behaviour as voluntary and "merely a symptom." In practice, many or all of the problems are the result of the alcoholism process rather than independent psychodynamic factors.

64. **True.** While other elements are usually included in formal definitions of alcoholism, this feature is a common denominator. It is also directly observable; that is, the social, psychological, and/or physical consequences on the individual's life become apparent, and eventually demonstrate both the severity of the problem and the failure of any solution except alcohol abstinence to provide a remedy.

65. **False.** Antabuse is a drug which causes a highly unpleasant physiological reaction when any alcohol is ingested or used. It is a valuable adjunct to a recovery program. It is a benefit to many, because it virtually eliminates the common hazards of reactive or impulsive drinking. The individual only has to make a single decision each day, i.e. take the pill. The drug has some side effects and it takes several days to leave the system after cessation of use. Note: In the safe lower dosage in use today, the reaction to alcohol is much milder than formerly, when the high does led to violent and occasional fatal reactions. Reactions have occurred from shaving lotions, cough medicines, deodorizers, etc. that contain alcohol.

66. **True.** Because of his/her denial system, the alcoholic will believe others are worse off than they are. Objectively presented education showing the facts about the condition - its nature, symptoms, progression, and treatability - will often permit the individual to recognize and accept his/her problem. Personalized statements, e.g. "you are an alcoholic," often serve merely to recharge the defense system.

67. **False.** This is another common myth which has been shown by experience to be false. While it is true that motivation for change usually requires some crisis or other serious consequence of drinking, these will occur many times before any extreme bottom, e.g. skid row or organic psychosis, is reached. The implication of course is that treatment should instigated as early as possible. Success rates are better for those who enter treatment early than for those after gross deterioration is present.

68. **True.** Sober alcoholics reflect the entire spectrum of psychologi cal adjustment from exceptionally healthy to profoundly disturbed. Experience suggests they manage to cope with life's problems about as well as other people, on the average. Clinicians, especially in psychiatric settings, often forget they deal mainly with the more disturbed segment of the population, and the vast majority of recovering alcoholics are invisible to them, i.e. functioning successfully without professional help.

69. **True.** Alcoholism may best be considered a particular form of chemical dependency. This dependency will usually manifest itself whether the sedative is in the form of an alcoholic beverage or a medication. In fact, other chemicals affecting the mood, such as stimulants and pain relievers, pose an equally grave risk of abuse in the chemically dependent person.

70. **False.** Hiding liquor is both a naive and condescending act toward the sober alcoholic. It is naive in its assumption that physical proximity alone causes the alcoholic to drink, and condescending in that it fails to show respect for the fact he/she is constantly exercising his choice to abstain, since liquor is always easily available.

71. **True.** Studies of suicide show alcoholism is one of the most potent factors in predicting high risk of suicidal behaviour. Other major factors in suicide, such as depression and social isolation, are correlated with the progression of alcoholism. It should be noted that intoxication may impair judgment to produce a suicide when the intention to die is not even strong. Many "accidental" deaths, (drug overdoses and auto crashes, etc.) are also related to alcoholism and may have involved some degree of

suicidal intent.

72. **False.** Many alcoholics have stayed sober for 15 to 25 years or more. The only criterion of alcoholism is the effects on the individual when he is drinking. The usual result of resumption of drinking (relapse) after any length of sobriety, is a remarkable rapid return to the stage where the person would be if they continued alcoholic drinking.

73. **False.** Professional help should be offered at any or all points to an alcoholic. Even though motivation appears poor, if the individual is willing to come and talk, the professional should continue to attempt to get him to come to grips with his/her problem. As mention in item 53, even treatment given coercively can be highly effective.

74. **False.** A plea, whether given by a professional or anyone else, is almost always ineffective. Education about alcoholism plus persistent correlation of adverse life effects with the person's drinking, done objectively by the professional, offers a much greater probability of bringing about a desire for sobriety.

75. **False.** What is "real" character? Suppose a man is polite and gentle 362 days a year, but gets sarcastic and aggressive on the 3 days a year when he/she gets drunk; or perhaps a woman who is usually very prim and proper gets to be a sexy seductress when drinking. Which is their "real" character? Are not both kinds of behaviour aspects of their total personality, the atypical behaviour while intoxicated nor more "real" (and perhaps less) than their customary behaviour. Besides, while intoxicated their behaviour is drug affected.

76. **True.** While the alcoholic client sometimes may behave in un desirable ways, (not keeping appointments, coming to them intoxicated, being dishonest, or being difficult to help), most professionals have a negative attitude as soon as the alcoholic label is attached to a client. They expect the worst. Even when the alcoholic's behaviour as a client is reasonably satisfactory, hostility is often apparent. Some behaviour, which would be accepted as part of another disorder by the professional, may well lead to rejection when done by the alcoholic, because it "proves" the poor motivation, untreatability, or moral inferiority.

77. **False.** Due to the very nature of chemical addiction, for the alcoholic to control his/her drinking (that is, drink socially but not to excess) is no more a question of willpower than is stopping one's fall from a high building halfway down. The only known solution, total abstinence, does require strong willpower, but even this is no simple question. Most people with alcoholism require relatively long-term help from outside sources, such as AA, which teach a new way of life to combat the strong pressures, both internal (psychological) and external (social conformity) to drink.

78. **True.** While public education aimed at changing attitudes has led many people to pay lip service to the disease concept of alcoholism, the vast majority, professional people included, show by their rejecting behaviour they really believe the alcoholic lis not sick but simply weak-willed and sinful.

79. **True.** Alcoholism develops insidiously rather than suddenly or obviously. It has a progressive course which has been empirically

charted. It is treatable with demonstrable results considering the chronic nature of the disorder, i.e. subject to control but not cure.

80. **True.** Most treatment centers do not distinguish the difference between problem drinkers and alcoholics. If fact, most treatment centres classify all clients as alcoholics or drug addicts, regardless of the extent of their drinking/using or associated problems. In addition, if a person does not admit they are an alcoholic and does not attend AA, they are considered treatment failures, regardless of their drinking attitude and pattern after treatment.

ANSWER SHEET

1.	T	41.	T
2.	T	42.	F
3.	T	43.	T
4.	F	44.	F
5.	T	45.	T
6.	F	46.	F
7.	F	47.	F
8.	F	48.	T
9.	F	49.	F
10.	T	50.	T
11.	Y	51.	F
12.	N	52.	T
13.	N	53.	T
14.	N	54.	F
15.	N	55.	T
16.	N	56.	F
17.	N	57.	T
18.	N	58.	T
19.	Y	59.	F
20.	Y	60.	T
21.	N	61.	F
22.	N	62.	F
23.	N	63.	T
24.	N	64.	T
25.	N	65.	F
26.	Y	66.	T
27.	Y	67.	F
28.	N	68.	T
29.	N	69.	T
30.	T	70.	T
31.	F	71.	T
32.	F	72.	F
33.	F	73	F
34.	F	74.	F
35.	F	75.	F
36.	F	76.	T
37.	T	77.	F
38.	T	78.	T
39.	T	79.	T
40.	F	80.	T

Appendix 5

RIVER HEIGHTS FAMILY LIFE

EDUCATION CENTRE

ACOA/ALCOHOLISM WORKSHOP

DEMOGRAPHIC DATA

FIRST NAME _____
AGE _____ **MALE** _____ **FEMALE** ___

EDUCATION _____
MARITAL STATUS _____
* * * * * * * * * * * * * * * * * * *
HAVE YOU EVER BEEN TO A SELF-HELP GROUP MEETING? YES _____ NO _____

IF YES, WHAT SELF-HELP GROUP(S) DID YOU ATTEND _____
_____
* * * * * * * * * * * * * * * * * * *
WHAT PROMPTED YOU TO ATTEND THIS WORKSHOP?

_____
_____
_____
_____* * * * * * * * * * * *
* * * * * * **WHAT ARE YOUR EXPECTATIONS?**

_____
_____
_____

* *
(Please turn this form into the facilitator at the first session)

Appendix 6

ADULT CHILDREN OF ALCOHOLICS

WORKSHOP SCHEDULE

	SESSION ONE	
Jan 23	Description	Equipment
7:30	Introductions and Overview Facilitator Participants	Flipchart
7:45	Completion of CAST	Flipchart
8:10	Exercise - Definitions	
8:25	Break	
8:35	Film: Father Martin's Chalk On Alcoholism	Film Projector
9:25	Questions	
9:30	Completion of Post Session Report Client Satisfaction Questionnaire	

Jan 30	SESSION TWO	
7:30	Alcohol - General	Flipchart
8:00	VHS: Medical Effects of Alcohol Use	VCR
8:30	Break	
8:40	Exercise - Safe Drinking	
9:05	Safe Drinking	Flipchart
9:25	Completion of Post Session Report & Client Satisfaction Questionnaire	

Feb 6	SESSION THREE	
7:30	Alcohol & Behaviour	Flipchart
8:00	Alcohol and the Family	Flipchart
8:30	Break	
8:40	Film: Alcoholism: The Family	Film Projector
9:25	Completion of Post Session Report & Client Satisfaction Questionnaire	

Feb 13	SESSION FOUR	
7:30	Video: Robert Ackerman - Adult Children of Alcoholics	VCR
8:05	Characteristics	Flipchart
8:30	Break	
8:40	Characteristics	Flipchart
9:10	Exercise - Characteristics	
9:25	Completion of Post Session Report & Client Satisfaction Questionnaire	

Feb 20	SESSION FIVE	
7:30	VHS: The Family Trap	VCR
8:00	Exercise - Roles	Flipchart
8:30	Break	
8:40	Rules	Flipchart
9:10	ACOAs in the Workplace	Flipchart
9:25	Completion of Post Session Report & Client Satisfaction Questionnaire	

Feb 27	SESSION SIX	
7:30	Community Resources	Flipchart
7:45	Alcoholism and the Elderly	
8:30	Break	
8:40	Alcoholism and the Elderly	
9:15	Completion of Post Session Report & Client Satisfaction Questionnaire	

Appendix 7

RIVER HEIGHTS FAMILY LIFE EDUCATION CENTRE

PROGRAM QUICK FEEDBACK SHEET

COURSE TITLE ALCOHOLISM & ADULT CHILDREN OF ALCOHOLICS

1. **USEFULNESS:** Will you be able to make use of the ideas provided in these sessions?

NO, NOT USEFUL				EXTREMELY USEFUL
1	2	3	4	5

2. **NEW KNOWLEDGE** Did you gain new knowledge or insight into this topic?

NO, NOTHING			GAINED SIGNIFICANTLY	
1	2	3	4	5

3. **EFFECTIVENESS** How well do you think these sessions were organized, presented, and facilitated?

POORLY DONE			EXTREMELY WELL DONE	
1	2	3	4	5

4. What was the most valuable aspect of the workshop for you?

5. What could have made the program more effective?

6. What follow up sessions would you like to have offered in the future?

7. **Comments:** Re size of group:

Other: (Continue on Reverse)

8. How did you hear about this program?

___ Friend ___ TV/Radio ___ Church Bulletin
___ Free Press ___ Winnipeg Sun ___ Leisure Guide
___ River Heights Cardinal ___ Called the Centre
___ Brochure ___ Other (Please Elaborate)_____
_____
_____

Appendix 8

RIVER HEIGHTS FAMILY LIFE EDUCATION CENTRE

ORGANIZATIONS AND AGENCIES USED TO ADVERTISE PROGRAMS

The River Heights Family Life Education Centre advertises their programs through the following organizations and agencies.

TELEVISION STATIONS

1.	Cablevision	Public Service Announcement
2.	VIDEON Cable TV	Public Service Announcement
3.	CKND TV	Community Billboard
4.	CBC TV	Public Service Announcement
5.	CFWFT TV	Communication
6.	CKY TV	Public Service Announcement
7.	Manitoba Television Network	Public Service Announcement

RADIO

1.	CBC Radio	Public Service Announcement
2.	CJOB Radio	Promotions
3.	CKJS Radio	Community Billboard
4.	CKRC/CKWG	Public Service Announcement
5.	CKSB Radio Canada	Communication
6.	CKY/CITI Radio	Promotions - P.S.A.
7.	1290 FOX Radio/CHIQ	News Room
8.	CFRW Radio	Public Service Announcement

NEWSPAPERS/NEWSLETTERS

1.	Winnipeg Free Press	Billboard

2.	Winnipeg Sun	Community Billboard
3.	The Manitoban	Public Service Announcement
4.	The Projector	Editor
5.	The Flyer Force	Public Service Announcement
6.	University of Winnipeg Students Association	Editor
7.	Century 21 Newsletter	Public Service Announcement
8.	The Downtowner	Public Service Announcement
9.	M.S.O.S. Journal	Public Service Announcement
10.	Seniors Today	Public Service Announcement
11.	The Voice	Public Service Announcement
12.	Jewish Post & News	Public Service Announcement
13.	Free Press Weekly	Community Calendar

ORGANIZATIONS/AGENCIES

A.P.I.N Child & Family Support Branch, Community Services
Air Canada, Personal Services Manager
Alcoholism Foundation of Manitoba
Assiniboine Park-Fort Garry Community Parks & Recreation Branch
Augustine Resource Centre
Big Brothers of Winnipeg
Canada Post, EAP Coordinator
Canadian Mental health Association, Manitoba Division
Carter Day Care
Catholic Pastoral Centre
Charleswood Health Unit
Child Guidance Clinic, Seven Oaks Unit, School Division #10
Child & Family Services, Central Winnipeg
Child & Family Services of Central Manitoba
Child & Family Services, Eastern Manitoba
Child & Family Services of Winnipeg West, St. James Area.
Child & Family Services of Winnipeg West, Charleswood Area
Child Guidance Clinic
Child Guidance Clinic of Greater Winnipeg
Children's Home of Winnipeg
Children's House
City of Winnipeg Social Services Department
City of Winnipeg, Public Health Nursing
City of Winnipeg Health Department, South District Nursing

Office
City of Winnipeg, E.A.P. Coordinator
City of Winnipeg Health Department
Clinic Inc.
Community Services and Corrections
Community Action Centre
Contact
Crisis Pregnancy Centre
Deer Lodge Centre, Employee Health & Welfare, Coordinator
Department of Health
Diabetes Education Resource, Community Service
Discovery Children's Centre
Early Childhood Education Council, Manitoba Teacher's Society
Elmwood School
Elmwood Family Resource Centre
Employee Assistance Centre
Family Services of Winnipeg
Family Day Care
Family Conciliation Services
Fort Garry Women's Resource Centre
Great West Life Assce. Co., Medical Rooms
Greater Winnipeg Gas Company, Program Coordinators
Health & Community Services
Health and Welfare Canada
Health Action Centre
Health Sciences Centre, Children's Hospital, Child Development Health Sciences Centre, Children's Hospital, Department of Social Health Sciences Centre, Community Services Centre
Health Sciences Centre, Women's Centre
Home & School Parent/Teacher Federation of Manitoba
Immigrant Women's Association
Jewish Child & Family Services
Keystone Counselling Associates, Director & Counsellor
Kildonan Family Resource Centre
La Leche League
La Leche League, Charleswood Group
Lamaze Prepared Childbirth Classes
M.A.C.F.E.
M.E.L.D. Manitoba
M.G.E.A.
M.S.O.S. Journal
MacDonald Youth Services
Manitoba Department of Health, Education Services
Manitoba Government Employee Assistance Program Coordinators
Manitoba Foster Parents Association
Manitoba Health, Maternal & Child Health
Manitoba Health, West District
Manitoba Health, Health Promotion
Manitoba Hydro, EAP Coordinator
Manitoba Teacher's Society

Manitoba Teachers Society, EAP Coordinator
Margaret Park Elementary School
Misericordia Hospital, Social Service Department
Mount Caramel Clinic
New Facess
Northeast Winnipeg Family & Child Extended Social Services
Northeast Child & Family Services
Northwest Child and Family Services
Parent Support Program
Parents Without Partners
Planned Parenthood
Rockwood School, Educational Resource Centre
Seven Oaks School Division
Social Planning Council
Society for Manitobans with Disabilities
South Winnipeg Family Information Centre
Resource Centre
United Church Resource Centre
United Church of Canada, Winnipeg Presbytery Offices
United Way
University of Winnipeg, Interfaith Pastoral Inst.
University of Manitoba, Continuing Education
University of Manitoba, Faculty of Human Ecology
University of Manitoba, Counselling Services
University of Manitoba, Department of Family Studies
Victoria General Hospital, Social Service Department
Volunteer Centre
West Probation Services
Windsor Park/Southdale Resource Centre

Appendix 9

RESULTS OF PRE- AND POST TEST

HOW MUCH DO YOU KNOW ABOUT ALCOHOLISM

		1	2	3	4	5	6	7	
1.	T	* T	T T	T T	T T	T T	T T	T T	1
2.	T	T T	T T	T T	T T	T T	T T	T T	2
3.	T	* *	T T	* T	* T	* T	* *	F *	3
4.	F	F F	F F	F F	F F	F F	F F	F F	4
5.	T	* T	T T	T T	T T	T T	* *	T T	5
6.	F	F F	* F	F F	F F	* *	F F	F F	6
7.	F	F F	* F	F F	F F	F F	* *	F F	7
8.	F	F F	F F	F F	F F	* F	*	F F	8
9.	T	T T	T T	* T	* *	T T	T T	T T	9
10.	T	T T	T T	T T	T T	T T	F T	T T	10
11.	Y	Y Y	Y Y	Y Y	Y Y	Y Y	Y Y	Y Y	11
12.	N	* *	N N	N	N N	N	* N	N *	12
13.	N	* *	* N	N N	* *	*	N N	* *	13
14.	N	* N	* N	N	N	N N	N	N N	14
15.	N	* N	* N	* *	N *	* *	* *	* *	15
16.	N	N N	N N	N N	N N	N N		N *	16
17.	N	N N	N N	N	N N	N N	N	N N	17
18.	N		N	N	N	N			18
19.	Y	Y Y	Y Y	Y Y	Y Y	Y Y		Y Y	19
20.	Y	Y Y	Y Y	Y	Y	Y	Y Y	Y Y	20
21.	N	N	N *	* N	N N	N N		N N	21
22.	N	N N	N N	N N	N N	N N	N N	N N	22
23.	N	N	N N	N	N	N N		N	23
24.	N	N N	N N	N N	N N	N N	N N	N N	24
25.	N	N N	N	N N	N N	* *	N N	Y Y	25
26.	Y	Y *	Y	*	Y Y	*		Y Y	26
27.	Y	Y Y	Y Y	*	Y Y	Y Y	Y Y	Y Y	27
28.	N	N *	N N	N	N N	N N	Y	N N	28
29.	N	N	N *	*	N	N N		N	29
30.	T	* T	T T	T	*	*	T T		30
31.	F	*	F	F	F F	*		F F	31
32.	F	F F	F F	F F	F F	F F	F F	F F	32
33.	F	F F	F F	F	F	* F		F F	33
34.	F	F *	F F	F	F F	* *	*	* F	34
35.	F	F F	F F	F	F F	F F	F	F F	35
36.	F	* * *	F *	*	* *	* *	* F	* T	36
37.	T	T	T *	*	T	T *	T	T T	37
38.	T	T	T *	T	*	T		T T	38
39.	T	T	T	T	T T	T	T	* T	39
40.	F	F *	F F	F	F	F F		F F	40
41.	T	*	T T	T	T	* *	*	T T	41
42.	F	F	F F	F	F			F F	42
43.	T	T *	* T	T	* T	T T	*	T	43
44.	F	*	F F	F	* F	F F	*	F	44

45. T		*		T	*	*	*	*	*	*	*	*		*	45
46. F		*	F		F	F	*	F	F	F	*	F		F	46
47. F		F		F	F	F	F	F	F				F	F	47
48. T	T	T		T	*	T	T	T	T	T		T	T	T	48
49. F	F	F		F	F	F	F	F	F	F			F	F	49
50. T		T		T	*	*	T	T					T	T	50
51. F	F	F	F	*		F	*	*	*	*		F	*	*	51
52. T	*			T		T		*	*	*			T	T	52
53. T	T	T		T	*	*	T	T	T	*			T	T	53
54. F	F	*		F	F	F		*	*			*	*	*	54
55. T		T		T		T		T	T	T				T	55
56. F	F		*	F	F	F		F	*	*		F		*	56
57. T		T		T	T	T	T	T	T			T	*	T	57
58. T		T		T	T	T	T	T	T	T	T	T	T	T	58
59. F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	59
60. T	T	T		T	T	T	T	T	*	*	T		T	T	60
61. F	F	F	F	F	F	F	F	F	F	F	F	F	F	F	61
62. F		*	F	F	F	F	F	F	*	F	F	F	F	F	62
63. T	T	T		T		T	T	T	T	T	T	T	T	T	63
64. T	T	T		T	T	T	T	T	T	T		T	T	T	64
65. F		F	F	F	F	F	F	F					F	F	65
66. T	T	T		T	*	T	T	T	T	T		T	T	T	66
67. F	*	*		*	F	F	F	F	*	*		*	*	*	67
68. T	T	*		T	T	T	*	T	*	F		T	T	T	68
69. T		T		T		T	T	T				*	T	T	69
70. F	F	F	F	F	F	F	F	F	F	F		T	F	F	70
71. T		T		T	*	T	T	*	T	T		*	T	T	71
72. F		F		F	F	F	F	F	F	*	F	F	F	F	72
73. F		F		F	F	F	F	*	F	F		*	F	F	73
74. F		*		F	*	F	F	F	F	F		F		F	74
75. F	F	F	F	F	F	F	F	F	F	F			F	F	75
76. T		*	*	T	T	T	T	T	*					*	76
77. F		F	F	F	F	F	F	F	F			*	F	F	77
78. T		T	T	T	*	*	T	T	T	T		*	T	T	78
79. T		T	T	T	T	T	T	T	T	T	T	T	T	T	79
80. T		T	T	T	T	T		T	T	T	T	T	T	T	80

TOTALS BLANKS	28|3	45|1	13|0	14|0	5|16	47|25	12|1	MEAN
CHANGE	+25	+44	+13	+14	-11	+22	+11	+16.86
✓	38|59	30|76	59|69	53|68	52|48	27|38	59|68	
CHANGE	+21	+46	+10	+15	-4	+11	+9	+15.43
*	11|17	11|3	16|11	10|12	23|14	8|17	9|11	
CHANGE	-6	+7	+5	-2	+9	-9	-2	+ 0.29

Legend: * = incorrect answer
Blank = unanswered question
| = separates pre- and posttest answers

Appendix 10

Client Satisfaction Questionnaire - Raw Data

Client Number One

QSTN	SESSION					
⬇	1	2	3	4	5	6
1	4	4	4	3	3	3
2	4	4	3	4	4	3
3	4	4	3	3	4	3
4	3*	4*	4*	4*	4*	4*
5	4	4	4	4	4	4
6	4	4	3	4	4	4
7	4	4	4	4	4	4
MEAN	4	4	3.57	3.71	3.86	3.59
9	2	2	2	2	2	2
	FILMS		VIDEOS			
GOOD	✓	✓	✓		✓	
OKAY				✓		
NO GOOD						

Legend: * = Not included in calculation of Mean

Client Satisfaction Questionnaire - Raw Data

Client Number Two

QSTN	SESSION					
⬇	1	/	/	4	5	6
1	3			3	3	3
2	3			3	3	3
3	3			3	3	3
4	3*	*	*	3*	3*	3
5	4			4	3	3
6	3			3	3	3
7	3			3	3	3
MEAN	3.14			3.14	3	3
9	2			2	2	2
	FILMS		VIDEOS			
GOOD	✓					
OKAY				✓	✓	
NO GOOD						

Legend: * = Not included in calculation of Mean
/ = Not at this session

Client Satisfaction Questionnaire - Raw Data

Client Number Three

QSTN	SESSION					
⇓	1	2	3	4	5	6
1	3	3	3	3	3	4
2	4	4	4	4	4	4
3	3	4	3	3	4	3
4	4*	4*	4*	4*	4*	4*
5	3	4	4	3	3	3
6	3	4	3	4	4	4
7	4	4	4	4	4	4
MEAN	3.29	3.86	3.57	3.57	3.71	3.71
9	2	2	2	2	2	2
			FILMS	VIDEOS		
GOOD	✓	✓		✓	✓	
OKAY			✓			
NO GOOD						

Legend: * = Not included in calculation of Mean

Client Satisfaction Questionnaire - Raw Data

Client Number Four

QSTN	SESSION					
⇓	1	2	3	4	5	6
1	3	4	3	3	3	3
2	3	4	3	3	3	3
3	2	3	3	3	4	4
4	4*	4*	4*	4*	4*	4*
5	4	4	4	4	4	4
6	3	3	4	3	4	3
7	3	4	4	3	4	4
MEAN	3.00	3.57	3.43	3.14	3.71	3.43
9	2	2	2	2	2	2
		FILMS	VIDEOS			
GOOD	✓					
OKAY		✓	✓	✓	✓	
NO GOOD						

Legend: * = Not included in calculation of Mean

Client Satisfaction Questionnaire - Raw Data

Client Number Five

QSTN	SESSION					
⬇	1	2	3	/	5	6
1	4	4	3	/	3	3
2	3	3	3	/	3	4
3	3	3	4	/	3	4
4	4*	4*	4*	/*	4*	3*
5	4	4	3	/	3	4
6	4	4	4	/	4	4
7	3	4	3	/	4	3
MEAN	3.43	3.57	3.29		3.43	3.43
9	2	2	2	/	2	2
		FILMS	VIDEOS			
GOOD	✓	✓				
OKAY			✓		✓	
NO GOOD						

Legend: * = Not included in calculation of Mean
/ = Not at this session

Client Satisfaction Questionnaire - Raw Data

Client Number Six

QSTN	SESSION					
⬇	/	/	/	4	5	6
1				4	3	4
2				4	4	4
3				3	3	4
4	*	*	*	4*	4*	4*
5				4	4	4
6				4	4	4
7				4	4	4
MEAN				3.86	3.71	4
9				2	2	1
			FILMS VIDEOS			
GOOD					✓	
OKAY				✓		
NO GOOD						

Legend: * = Not included in calculation of Mean
/ = Not at this session

Client Satisfaction Questionnaire - Raw Data

Client Number Seven

QSTN	SESSION					
⇓	/	/	/	4	5	6
1				4	3	4
2				4	3	3
3				3	3	3
4	*	*	*	3*	4*	4*
5				4	4	4
6				3	4	3
7				3	3	3
MEAN				3.43	3.29	3.29
9				2	2	2
		FILMS	VIDEOS			
GOOD				✓	✓	
OKAY						
NO GOOD						

Legend: * = Not included in calculation of Mean
/ = Not at this session

Appendix 11

POST-SESSION REPORT

(Describing Feelings About Session)

RAW DATA

PARTI-CIPANT	SESSION 1	2	3	4	5	6	MEAN
One	8	7	8	7	7	7	7.33
Two	7	/	/	7	7	7	7.00
Three	8	8	9	8	8	8	8.17
Four	7	8	6	6	5	7	6.50
Five	7	8	8	/	7	7	7.40
Six	/	/	/	8	8	9	8.33
Seven	/	/	/	5	6	7	6.00
Mean	7.4	7.75	7.75	7.0	6.88	7.43	

Legend: / = Was not at this session

Appendix 12

RIVER HEIGHTS FAMILY LIFE EDUCATION CENTRE

PROGRAM QUICK FEEDBACK SHEET

QUESTIONS 1-3 RAW DATA

QSTN	PART ICIP ANTS							
	1	2	3	4	5	6	7	MEAN
1	5	5	4	5	4	5	4	4.57
2	3	4	5	4	4	5	3	4.00
3	4	5	4	5	4	4	4	4.29
MEAN	4.0	4.67	4.33	4.67	4.0	4.67	3.67	

Question 1: USEFULNESS: Will you be able to make use of the ideas provided in these Sessions? 1 2 3 4 5

Question 2: NEW KNOWLEDGE: Did you gain new knowledge or insight into this topic? 1 2 3 4 5

Question 3: EFFECTIVENESS: How well do you think the sessions were organized, presented, and facilitated? 1 2 3 4 5

Question 4: What was the most valuable aspects of the workshop for you?

Participant's Comments:

* Clarifying some of the questions I had about ACOA.

* The open minded discussion of topics.

* The amount of information in the handout material was useful in increasing my understanding.

* Insight acquired through the information provided, which dispelled some old myths which I had and gave me new information to ponder.

* Interaction.

* Good discussion - sharing of experiences.

* ACOA issues.

Question 5: What could have made the program more effective?

Participant's Comments:

* I believe it was comprehensive.

* Shorter films, assigned topics for discussion which would keep subject matter narrower and cover that material more intensely.

* Not being a professional in the area, I don't know.

* More group discussion.

* More interesting films and more dynamic presentation.

Question 6: What follow-up sessions would you like to have offered in the future?

Participant's Comments:

* Co-dependency.

* Action groups to promote changes in society and government which enhances the treatment of alcohol abusers.

* An opportunity (confidential) to discuss one personal experience.

* More specific focus on abuse issues, cause and effect.

Question 7: Comments: Re size of group:

Participant's Comments:

* Good size - confusing to get to know one another.

* Close small groups, easier to relate and get to know the other participants.

* 6 - 10 is a good size.

* Just fine. Bigger may not have lent itself as well to open discussion.

* Try to keep under 10 people.

* About right if all participate.

Other

Participant's Comments:

Question 8: How did you hear about this program?

Friend	7
TV/Radio	
Church Bulletin	
Free Press	
Winnipeg Sun	
Leisure Guide	
Brochure	

River Heights Cardinal _____
Called the Centre _____
Other _____

Appendix 13

COMMUNITY RESOURCES

Adult Children of Alcoholics

Telephone: (204) 943-5954

Self-Help group offers support to people who were raised in alcoholic or dysfunctional families.

Al-Anon Central Services

Telephone (204) 943-6051 304-310 Donald St. R3B 2H4

Self-Help group for friends and family members of alcohol abusers. Not affiliated with Alcoholics Anonymous.

Alcoholics Anonymous

Telephone (204) 942-0126 505-265 Hargrave St. R3B 2K3

A Fellowship of Self-Help groups of those who have a desire to quit drinking.

Alcoholism Foundation of Manitoba

Telephone (204) 944-6200 1031 Portage Ave. R3G 3R8

Assists individuals, agencies, and groups with problems involving the abuse or misuse of alcohol, drugs and other substances.

Disseminates information respecting the recognition, prevention and treatment of the abuse or misuse of chemicals.

Conducts a program of research and prevention.

Operates the following rehabilitation centres:

Christie Centre: (944-6235) 586 River Ave. R3L 0E8

Adult and youth non-resident continuing care programs.
Affected persons program.

Men's Unit: (944-6200) 1041 Portage Ave. R3G 0R8

A residential, continuing care program.

Impaired Drivers Program: (944-6290) 1031 Portage Ave
R3G 0R8

Women's Unit. (944-6229) 588 River Ave. R3L 0E8

A women's residential, continuing care program.

Kia Zan, Inc.: (204) 772-9836) 60 Balmoral St. R3C 1X4

Operates a residential treatment centre for men and women (18 - 35 years) who are dependent on alcohol or other chemicals. Program includes group and individual counselling.

Salvation Army - Anchorage Telephone (204) 946-9401
180 Henry St.

A drug and alcohol rehabilitation residential program for adult males and outpatient treatment for females.

Families Anonymous (204) 668-5111 1750 Grosvenor Ave R3N 0H9

A self-help group for relatives or friends of people abusing alcohol or drugs.

Health Sciences Centre (204) 787-3889 75 Emily St. R3E 1Y9

Provides a hospital based detoxification centre for individuals in acute withdrawal. Works closely with other community agencies, organizations that deal with alcohol and drug abuse.

Native Alcoholism Council of Manitoba (204) 586-8395
160 Salter St. Prichard House R2W 4K1

Provides counselling and referral for Native people affected by alcohol and drug abuse. Promotes alcoholism prevention.

Main Street Project (204) 942-0434 75 Martha St R3B 1A4

Provides 24 hours crisis intervention and emergency referral including a detoxification centre and emergency shelter. Operates an intoxicated persons detention area.

St. Boniface General Hospital. (204) 237-2715.
409 Tache Ave R2H 2A6

Chemical dependency program provides treatment to get patient off narcotics. Focus especially on mental illnesses. Provides counselling for persons involving abuse and alcohol.

Women's Post Treatment Program (204) 783-5460 246 Toronto St

Individual and group counselling for women who have had any chemical addiction and are struggling with emotions related to childhood sexual abuse.