



COAs: Let's Not Assume the Worst

By James G. Emshoff and Laura L. Jacobus



Although research has clearly demonstrated that COAs are at an increased risk for a variety of

social, emotional, and behavioral difficulties, it is important to note that these findings cannot be generalized to individual children.



Nearly two decades of research with COAs has demonstrated that they represent a remarkably heterogeneous group and that there is no standard profile for this population. It has also become apparent that although COAs demonstrate an increased prevalence for a variety of potentially negative outcomes, the vast majority of them will never develop any given difficulty and are remarkably well adjusted (Sher, 1997).

There is a very real tendency for clinicians to ascribe a variety of characteristics to individuals who fit a particular label such as "COA." This practice was documented by Burke and Sher (1990) who demonstrated that mental health professionals were more likely to rate an individual who was described as a "COA" as possessing more psychological difficulties than others, even after the actual behavior of the individual was accounted for. Labeling practices such as these may be especially prevalent in treatment settings such as counseling centers

and mental health agencies, which tend to employ a vocabulary and culture emphasizing pathology and treatment. While this system may have some practical utility, in that children who do require intervention will receive treatment, this practice is potentially damaging. Clinicians must remain cognizant of the fact that simply knowing that a child is a "COA", and thus "at-risk" for a variety of difficulties, does not imply that any type of pathology is present or will inevitably surface.

Taken overall, research has demonstrated that COAs as a group do suffer from a variety of psychological and physical difficulties. However, research has also demonstrated that certain outcomes are more likely to develop than others. One of the most well-documented and strongest effects associated with COA status is the risk of future alcohol and other drug abuse (Sher, 1997). Practitioners

working with COA populations should remain aware that certain outcomes, such as substance abuse, may be more likely to occur than others, and focus their diagnostic attention appropriately.

However, clinicians must base their treatment choices not on the documented likelihood of a particular difficulty occurring, or a standard "COA profile" but instead on the

presenting problems and specific histories of individual clients.

Practitioners should also understand that the clinical significance of much of the research describing COAs as a "high risk" group may be quite small. Simply knowing that a particular result demonstrating differences between COAs and non-COAs is "statistically significant" speaks little to its clinical significance in an applied setting. Statistical significance can be influenced by a variety of research factors, including sample size. Thus, while a particular study may indicate that certain outcomes are more prevalent in COA populations, the actual difference vs. non-COA populations may translate to a very small increase in clinical risk.

Furthermore, real differences in the means of two groups do not tell us anything about possible differences between groups in the population that exceed a clinical threshold. Mean differences could in fact result from a small number of highly affected individuals. Although the disturbance that these individuals face may be great, the impact of these results on the larger population would be quite small. However,

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a simple examination of the relative means of COA vs. non-COA populations would not reveal these subtle, yet important distinctions.

Another practical difficulty of translating research findings to clinical settings is that much of today's research is conducted utilizing research methods that are designed to demonstrate differences, as opposed to developmental patterns. Research that is designed utilizing these methods is more likely to demonstrate differences that may occur between groups instead of highlighting an individual's lifetime likelihood of developing a given disorder. By structuring results so that pathology as opposed to normalcy is emphasized, researchers may unconsciously coerce practitioners into diagnosing and treating a disorder where none exists.

These difficulties can be partially attributed to the fact that a majority of current research operates using a medical model that assumes pathology. An unstated assumption of this medical model is that it is better to diagnose a well person sick than diagnose a sick person well. However, this assumption can only hold true if the negative effects of diagnosis are relatively small. Past research has vividly demonstrated the potentially deleterious effects of labeling and associated stigma on both COAs and other populations (Burke and Sher, 1988).

One manner in which this potential stigma can be reduced is through the use of interventions that are focused on the strengths and competencies that these individuals possess, as opposed to relying solely on treatments that are meant to address expected deficits. By adopting interventions that employ a psycho - educational model as opposed to a strictly

therapeutic model, practitioners can aid children in a manner that stigmatizes as little as possible.

Another way in which this stigma can be reduced is through the increased use of alternative settings such as schools, churches, and recreational youth settings. By housing interventions such as educational support groups in these "normal access" settings, it is possible not only to reduce some of the stigma attached to receiving special attention but also to offer potentially useful information to individuals who would not necessarily be identified as a COA.

Because of the prevalence of alcoholism, it is likely that a majority of individuals have had some exposure to alcoholism, even if they are not COAs. Offering individuals information and education in a variety of settings can allow a broader spectrum of persons access to these vitally important interventions, while reducing the stigma attached to its delivery.

Given the fact that there is no standard profile associated with COA status, practitioners must carefully investigate the specific experiences and risk factors that may contribute to a specific COA's likelihood of experiencing a significant disturbance. For example, COAs often demonstrate lower levels of internal locus of control than do non-COAs. On the other hand, "super functioning" COAs often develop a potentially unhealthy sense of internal locus of control. Practitioners must appreciate the potential for a wide variety of out-comes experienced by COAs.

Knowing that an individual has experienced alcoholism within his or her family should not be used to label an individual as "deviant" or even "potentially deviant." Instead, counselors should utilize this information in a responsible manner, and use this classification as a challenge to gather more specific information regarding a particular individual's experiences and history.

None of this article should be interpreted to imply that we should ignore the very real needs of many COAs, or that we should cease focusing on the practice and policy issues that affect this population. It simply suggests that counselors must understand that each individual is unique and that no standard "COA profile" exists. By understanding these facts, counselors can help avoid potentially stigmatizing treatment where no real need exists.

References

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- James G. Emshoff, Ph.D., and Laura L. Jacobus are with Georgia State University's Department of Psychology. Dr. Emshoff is a member of NACoA's Board of Scientific Advisers.