Academia Dysphrenia

ISSN 2394 - 2053 (Print)
ISSN 2394 - 2061 (Online)
www.ojpas.org

REVIEW ARTICLE

Open Journal of Psychiatry & Allied Sciences

Children of persons with alcohol dependence syndrome: risks and resilience, theories and interventions

Abstract

Children of persons with alcohol dependence syndrome (ADS) are susceptible to develop various psychosocial problems and carry them into their later life. They are at-risk group to develop alcohol and other drug use-related complications in their life. Studies have reported that despite adversities in their life, a few children grew into competent adults. These children are observed to have resilience, which in other hand significantly influence the overall development of any given person. Current paper shed light on theories, vulnerability, resilience, and available intervention packages related to children of parents with ADS.

Keywords: Susceptibility. Competency. Development.

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Received: 19 June 2016
Revised: 16 July 2016
Accepted: 10 October 2016
Epub: 2 November 2016

Introduction

Alcohol use has been recognised as a key risk factor for health, social, and economic problems in the communities. It is measured as fifth leading global risks for burden of disease by disability-adjusted life years (DALYs).[1] It is estimated that 20-30% of medical health problems, road traffic accidents, suicide and other deliberate injuries are owing to alcohol use. About four per cent of the global disease burden across the world was due to alcohol.[2]

In India, alcohol is traditionally prohibited and considered to be a 'dry' culture. However, use of alcohol in some form is always present in the country. Prevalence of alcohol consumption in India was reported to be 20-30%, and ten per cent among them were dependents.[3-5] Recently, National Family Health Survey[6] reported that one fourth of male population consumes alcohol in India.

Children of persons with alcohol dependence syndrome (ADS) are at risk to use substances, develop psychiatric disorders, experience neglect from the family, and have cognitive and academic problems.[7-12] Most often, children behaviours are influenced by the family members.[13] Family history of alcohol dependence was present among half (59%) of the college students who were apparently using alcohol.[14] Substance problems run in the families through several pathways such as genetic,[15,16] behavioural and cognitive processes,[17,18] and problematic family environment.[19]

Risk or vulnerability

Risk factors are those characteristics which are present in a group of children, with a higher chance of developing an undesirable outcome.[20] Adolescent children who have tendency to take more risks[21] and sensation seeking are found to be positively correlated with higher levels of alcohol and other drug use.[22] Studies conducted with children of persons with ADS found that children are at-risk to develop alcohol and other drug use-related complications as a result of heredity and environment factors.[23,24] Parental approval of alcohol use escalates the likelihood of high-risk drinking among children.[25]

Those children are found to be more vulnerable to mental health disorders and, general and specific health problems.[26] Children grown up in this environment experience family conflict,[27] negative life events,[28] and, low family cohesion and poor family organisation.[29] Family and personal strengths of persons living in these families found to be inadequate.[30] Parents with ADS reported to have poor parenting skills, poor self-regulation,

and behaviour problems, which negatively influence the development of social competencies in their offspring.[31] Children of persons with ADS showed greater difficulties in neuro-developmental aspects[32] and behaviour problems.[30,33,34] Children of persons with alcohol and drug use displayed higher rates externalising disorders such as attention deficit hyperactivity disorder (ADHD), conduct and oppositional defiant disorders, and internalising behaviours such as depression and anxiety.[12,19,32,35-38]

Resilience

At the end of 20th century, researchers' perspective had begun to change. Longitudinal studies which tracked individuals from childhood to adulthood have revealed that only a minority may develop emotional and behavioural problems even after they are exposed to multiple stressors. Their findings directed researchers to consider the phenomenon of resilience, which is dynamic in nature and brings positive adaptation even in the context of adverse life situations.[39] Benard[40] attributed resilience as social competence in order to elicit positive responses and have positive relationships with others, problem solving skills, having self-control and resourcefulness in seeking help from others, autonomy in terms of having ability to have own identify, and purpose in life.

The Kauai Longitudinal Study[41-43] explored the impact of bio-psycho-social risk factors and protective factors on children at-risk in their developmental course. The study identified three clusters protective factors: (a) Protective factors within the individual- resilient children acquired positive characteristics such as activeness, affectionate, cuddly, good-natured, and easy to deal with, agreeable, cheerful, friendly, responsive, sociable, practical problem-solving skills, sense of pride, altruistic, self-confidence, and realistic future plans. (b) Protective factors in the family- presence of at least one competent and trustworthy person in the family such as grandparents, older siblings, aunts, and uncles. The religious beliefs of families were also provided some stability and meaning in their lives. (c) Protective factors in the community- resilient children received emotional support and help during crisis situation from the elders and peer in their community. This study found that one-third of the high-risk children become competent adults due to hard work they invested, loved well by others, played well, and expected well.

Children of persons with ADS having individual factors such as self-esteem, regular exercise, and better school bonding,[44-47] family factors such as family cohesion, adaptability, and child-mother attachment, and community factors such as social trust, social responsibility, and religiosity were found to have lower levels of behavioural problems.[48,49]

Theories

Social learning theory

It is based on the work of Albert Bandura.[50] Children learn to behave through both instruction as well as observation. Consequences of their actions and the responses of people reinforce and modify children behaviours. Children learn to behave through observation and social interaction than verbal instruction. He stressed on self-efficacy, defined as confidence in one's abilities to show appropriate behaviours. It has contributed in the process of developing life skill and social skill programmes.

Problem-behaviour theory

Developed by Jessor,[51] it believes that children behaviours (including risk behaviours) are the product of interactions between individuals and their environment. This theory is concerned with the relationships among three interrelated psychosocial variables (personality system, perceived environmental system, and behavioural system). The personality system includes "attitudes, beliefs, expectations, values and orientations toward self and society". Similar to Bandura, the behavioural system is usually described as a set of socially unacceptable behaviours (the use of alcohol, tobacco, and other drugs, sexual behaviour by persons below a certain age, delinquency and so). Each psychosocial system contains variables that act as instigators or controls on problem behaviour.

Social influence theory

It recognises that children and adolescents are under pressure to engage in risk behaviours (tobacco, alcohol). Social influence includes "peer", "parents' model", "media". Social influence programme anticipates these pressures and equip children with skills to resist them in prior to they are exposed.

Cognitive problem-solving theory

This model of primary prevention theorises that teaching interpersonal cognitive problem-solving skills to children during childhood mitigate and prevent behavioural problems. This model emphasised on competence building among individuals.

Resilience and risk theory

This theory argues that there are internal and external factors that protect against the social stressors, poverty, anxiety, or abuse. If a child has strong protective factors, he/she can resist the unhealthy behaviours that often result from these stressors or risks. Resilience and risk theory provides an important part of a foundation for a life skills approach.

Screening tools

Identification of these children requires active screening using either the Children of Alcoholics Screening Test (CAST)[52,53] or adapting the CAGE[54] questionnaire.

- Do you think your mom/dad needs to cut down on their alcohol use?
- Does your mom/dad get annoyed at comments from other people about their drinking?
- Does your mom/dad ever feel guilty about their drinking?
- Does your mom/dad ever take a drink early in the morning as an eye-opener?

Intervention programmes

Several programmes have been developed to assist children of persons with ADS. In general a programme may focus primarily on either prevention or intervention, but majority of the programmes focus on both elements. Primary prevention

focuses on children at-risk due to their genetic vulnerability or environmental factors or both. Secondary prevention targets children who are already having behavioural problems which predict later alcohol and other drug use. Finally, tertiary prevention is to help children who are already having alcohol and other drug use-related problems and to decrease the associated complications. Few primary prevention models such as curbing the availability, increasing the legal age of drinking, increasing the price of alcohol beverages, and decreasing the selling hours help systematically to reduce alcohol usage among people in the country. A study in an Indian city showed alarming figures in these parametres in relation to school going children.[55]

Al-teen is an example of a community-based self-help programme for children of persons with ADS based on the 12-step approach of Alcoholic Anonymous. Al-teen generally meets in public settings, such as churches or community centres.

Schools and colleges are logical settings for school-based interventions because of children availability. There are some specific programmes exclusively for children of parents with ADS. A school-based support group intervention conducted for children of persons with ADS resulted in improved knowledge, coping strategies, and better social integration for female children.[56]

Stress management and alcohol awareness program (SMAAP)

SMAAP is a competency-building intervention programme developed by Roosa and colleagues.[57] It is a school-based programme conducted for children of persons with ADS for eight weeks duration. The programme emphasised on building self-esteem, providing alcohol-related education, and teaching emotions and problem-focused coping strategies. Short *et al.*[58] found increase in knowledge, social support, and emotion-focused coping behaviour among school children compared to non-participants. In addition, teachers observed increased problem solving and social competence among children.

Students together and resourceful (STAR)

STAR programme is designed for the students. Main objectives of the programme are to increase social competence and to provide accurate information on alcohol use and its complications on individuals and family among children. Group exercises are directed to help students recognise and express their feelings and to practice specific skills, such as problem-solving, decision making, stress management, and alcohol refusal skills.

A randomised study was conducted to compare the programme with non-participant children of parents with ADS. Results indicated that children were successful in developing stronger social relationships, autonomy, and an improved self-concept. Furthermore, children stated increase in number of friends and perceived social support.[59]

Strengthening families program (SFP):[60]

It is developed by Kumpfer and Marsh (1983). This programme provides training for parents, children, and families. Sessions for parents focus on education about alcohol and other drugs, communication skills, and utilisation of reinforcement and other techniques to guide children's behaviour. The children's social skills programme includes sessions on emotions, anger management, problem-solving, communication, peer resistance, and alcohol and other drugs information. Typically the programme is a fourteen-session package conducted in churches or community centees, two to three hours in a week. In a randomised controlled trial the programme was found to reduce risk factors, increase resilience (competence when under stress), and decrease alcohol and other drugs use among children of alcohol and other drugs abusers.[61]

Children having opportunities in courage, esteem and success (CHOICES):[62]

It is a school-based programme developed for third and fourth grade students. This programme is focused on coping strategies, emotions identification, and family. Overall the programme has 11 sessions, weekly one hour session with individuals and 30 minutes session with mentors. Horn and Kolba[63] evaluated the efficacy of the CHOICES programme and found improvement in self-esteem, isolation, loneliness, coping strategies, and knowledge on programme content among children who participated in the study.

Teen club program[64]

It is a two-year programme of 90 minutes' meeting every week. It is a group programme for female teenagers with drug involved families and, lack of family and social support. The programme focused on problem-solving, health education, social behaviour, home visits for crisis intervention.

Focus on families program

It is a 16 weeks intervention (biweekly 90 minutes' sessions) for families of person with methadone maintenance. They used home-based case management strategy in this programme. Content of the programme consists relapse prevention, stabilization, and improvement of family management practices. A study evaluating the efficacy of this programme found improvement in parenting skills, decrease in parental drug use, and involvement with deviant peers, better family management, and positive changes in children's behaviour or attitudes.[65]

Friends in need program[66]

Emphasised teaching, strategies, and skills for coping with aversive environment where they live. They found improvement in behaviours, self-worth, and decreased physical aggression for the intervention group.

Life skills intervention

Life skills intervention is considered to be the single most effective strategy for reducing risky behaviours among children. The World Health Organization (WHO) advocated universal life skills education programme for every school across the world and recommended to consider it in both formal and non-formal education system.[67] Individuals may react to the similar drug in different ways on different occasions. Life skills-based education for drug use prevention focus on two factors which are enhancing personal and interpersonal skills in socially accepted way. Life skills-based

education for drug use prevention contributes to the primary goals of drug education for children such as, to delay the onset of use; to stop harmful use; to increase their awareness of the consequences of drug use; and to enhance decision-making ability for healthier lifestyle choices. Giving importance to cultural diversity, in some communities' no-use may be a primary goal.

Conclusion

Research studies across the world suggest several appropriate levels of intervention and prevention programme components. Including basic information on harmful consequences of substance use in school curriculum is very much required. Research studies in recent past revealed that peer led education found to be effective in preventing and delaying initiation of alcohol and other drug use. Family intervention focused on parenting skills training help in empowering parents with suitable parenting skills in order to reduce the risk among their children. Comprehensive community programmes which focus social norms with regard to substance use are another important underutilised area. Preventive programmes need to include information and education, skill building in terms of coping and social competence, social support, create environment for safe expression of feelings, and healthy activities.

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Arelingaiah M, Pandian RD, Sinu E. Children of persons with alcohol dependence syndrome: risks and resilience, theories and interventions. Open J Psychiary Allied Sci. 2016 Nov 2. [Epub ahead of print].

Source of support: Nil. **Declaration of interest:** None.