



## 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,

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

---

**“NEARLY TWO DECADES OF RESEARCH WITH COAs HAS DEMONSTRATED... THAT THERE IS NO STANDARD PROFILE FOR THIS POPULATION.”**

---