Talking about drugs: Examining self-disclosure and trust in adult children from substance abusive families

Susan Renee Mattson

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TALKING ABOUT DRUGS: EXAMINING SELF-DISCLOSURE

AND TRUST IN ADULT CHILDREN FROM SUBSTANCE

ABUSIVE FAMILIES

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Communication Studies

by
Susan Renee Mattson
September 2005
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ABSTRACT

This thesis examines the impact of drugs and alcohol on the family unit. Addiction and alcoholism are rampant in America, and oftentimes the families of the drug addicts or alcoholics are overlooked. Drugs and alcohol have an impact on people who do not abuse them, and this research explores the roles of coping, trust, and the ability to talk about the specific drugs family members abuse.

A web-based survey was used to collect data from voluntary participants, and the responses were then analyzed to see if there were any significant relationships between the nine drug categories and self-disclosure, trust, and self-disclosure avoidance. A bivariate correlation found significant relationships between self-disclosure avoidance and methamphetamines and marijuana.

Talking about the drugs that family members abused is seen to be a healthy behavior in this research. Self-disclosure and self-disclosure avoidance impact how an individual perceives themselves and how they view the world. Growing up with drugs and alcohol in the home is not an uncommon issue, but talking about addiction and the drugs family members abuse is very different. Research
proves that talking about these issues is much healthier than continuing the cycles of denial.
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I would like to thank my family for standing by me through researching a topic that has impacted our lives. I especially want to thank my children for being so understanding and patient, which has allowed me to pursue my dreams.
TABLE OF CONTENTS

ABSTRACT .................................................................................. iii
ACKNOWLEDGMENTS .................................................................. v
LIST OF TABLES ......................................................................... ix

CHAPTER ONE: INTRODUCTION

Background of the Problem ................................................. 1
Statement of the Problem .................................................. 2
Purpose of the Study ............................................................. 2
Conceptual Assumptions ...................................................... 3
Research Hypotheses ............................................................. 4
Importance of the Study ......................................................... 5
Conceptual Definitions .......................................................... 6
Outline of the Research ......................................................... 7

CHAPTER TWO: REVIEW OF THE LITERATURE

Chapter Preview ..................................................................... 10
Defining Addiction ................................................................. 11
Exploring the Various Models .............................................. 11
Statistics Concerning Addicts and Alcoholics 
in the United States ............................................................ 17
Addiction as a Cultural Phenomena: Images, 
Myths, and (Mis)conceptions ................................................ 18
Families and Addiction: Dynamics, Coping, 
Trust, and Self-disclosure ....................................................... 24
Defining Adult Children of Alcoholics/Substance Abusers: Exploring Different Views .... 25
The Family Unit ...................................................................... 29
| Emotional Boundaries: Relating to Trust and Self-disclosure | 31 |
| Coping Mechanisms: Roles they Play in Trust and Disclosure of Adult Children of Substance Abusers | 34 |
| Anti-trust and Silence as a Means of Control | 36 |
| Self-disclosure | 40 |
| Families and the Recovery Process | 42 |

CHAPTER THREE: METHODS

| Chapter Preview | 48 |
| Research Design | 48 |
| Procedures | 49 |
| Instrumentation | 49 |
| Data Collection | 53 |
| Demographic Information | 54 |
| Data Treatment | 56 |

CHAPTER FOUR: ANALYSIS AND EVALUATION OF FINDINGS

| Chapter Overview | 57 |
| Results | 57 |
| Other Findings | 59 |
| Drug Correlations | 61 |
| Drug Frequencies | 62 |
| Discussion | 66 |
| Pharmacological Significance | 67 |
| Social Views of Marijuana and Speed | 68 |
| Drugs and Death | 71 |
Shame, Guilt, and Denial ......................... 73
Summary ........................................... 74

CHAPTER FIVE: CONCLUSIONS
Summary ........................................... 76
Conclusions ...................................... 78
Research Limitations ......................... 82
Recommendations .............................. 83

REFERENCES .................................... 86
LIST OF TABLES

Table 1. Drugs, Trust, Self-disclosure, and Self-disclosure Avoidance ...................... 59
Table 2. Instrumentation Correlations .................. 60
Table 3. Significant Drug Category Correlations .... 62
Table 4. Alcohol and Prescription Drug Abuse in the Home ........................................ 63
Table 5. Speed Alone/ Speed Plus Alcohol Abuse in the Home ..................................... 63
Table 6. Crack Alone/ Crack Plus Alcohol Abuse in the Home ..................................... 64
Table 7. Cocaine Alone/ Cocaine Plus Alcohol Abuse in the Home ................................. 64
Table 8. Marijuana Alone/ Marijuana Plus Alcohol Abuse in the Home .......................... 65
Table 9. Heroine Alone/ Heroine Plus Alcohol Abuse in the Home ............................... 65
Table 10. Steroids Alone/ Steroids Plus Alcohol Abuse in the Home ............................. 66
CHAPTER ONE

INTRODUCTION

The United States of America is often described as the land of opportunity, where a person can make all their dreams come true. What many people neglect to remember is that many of these dreams can easily turn into nightmares comprised of deceit and neglect because of drugs and alcohol.

Background of the Problem

Addiction is rampant in America, with people compulsively abusing everything from chemical substances to gambling, and sex. An individual who assumes the chains of addiction will never affect them are naïve and also in denial because addiction affects the rich and the poor.

Everyday, children witness and are oftentimes made the victims of their parents’ or siblings’ rage, which is usually drug induced. Children in substance abusive households learn to adapt and adjust to varying degrees of adverse situations, because many of them have learned to try and compensate for their family obsessions with chemical dependency.

Early research in families with chemical dependency problems stemmed from observations with dysfunctional
families in the 1950's. Since then, family dynamics and the impacts of addiction and alcoholism have been studied from diverse perspectives. Two common perspectives that are used to examine family life and relationships of addicts/ alcoholics and their family members are from the eyes of the family members who are non-addicts and from the addicts' point of view. A tremendous amount of research has been conducted on how the two perspectives feed off one another and allow for the cycles of addiction and co-dependency to continue and perpetuate.

Statement of the Problem

This research is concentrated on the participants' abilities to discuss the specific drugs of their family member's addiction. Most adult children of alcoholics (ACOAs) or adult children of substance abusers (ACOSAs) do not seem to have a problem disclosing the fact that someone in their family is an addict or alcoholic, but this research is different in that it focuses on whether the same attitude applies when it comes to disclosing their family members' specific drug of choice.

Purpose of the Study

The purpose of the study is to examine the relationships between drugs of choice that family members
abused and the non-addicted family member’s levels of self-disclosure, self-disclosure avoidance, and trust. The study examines which drugs people have a problem talking about and which ones they do not seem to have a difficult time talking about. Self-disclosure is a human behavior that provides insight and awareness into the world of those who are disclosing. This connection is also the basis of forming most human relationships that dwell beneath the surface. Self-disclosure brings people together and provides a forum for individuals to self-reflect and find who they truly are. The main purpose of this study is to examine what levels of self-disclosure, avoidance, and trust exist within the adult children of substance abusers (ACOSAs) population, and how these levels correlate with different groups of drugs.

Conceptual Assumptions

The central underlying assumption that is rooted within the research is that addiction is the product of choice and that many different factors such as the environment, socialization practices, genetic disposition, and the list goes on, that influence how and why people make choices. Addiction cannot and should not be
simplified into an entity that is the negative result of only one variable in a person’s life.

Another conceptual assumption that is rooted in this study is that communicating with people and finding the true self while discovering the ability to express themselves is a vital component to a happy life. Consistent with this research is the assumption that communicating and identifying with other people will help people to be able to reflect and discover who they truly are.

Research Hypotheses

Investigating the drug of choice of family members in relation to trust and self-disclosure allows research to continue exploring the depths and different dimensions of addiction and the family unit.

(H1) The drug of choice the family member abuses will affect the levels of self-disclosure or self-disclosure avoidance about their family member’s addiction and specific drug of choice.

(H2) The drug of choice the family member abuses will affect the levels of trust ACOSAs feel is necessary to talk about their family member’s addiction and specific drug of choice.
Trust and self-disclosure have been shown to have significant relationships with an individual’s decisions to reveal personal information, or information about the family. This research examines these relationships for ACOSAs.

Importance of the Study

Millions of people are suffering and feeling they have no place in this world because of upbringings and problems that are completely out of their control. Addiction and alcoholism have become social problems that seem to have no solution, because each year more and more people are becoming chemically dependant to drugs and alcohol. The cycles are becoming patterns of thought embedded into generations of offspring.

Something needs to change to break these socially engrained cycles of mentally strenuous situations. Talking about issues that have made an impact on the past or issues that currently disturb particular individuals is extremely important to regaining a degree of control in knowing ones true identity. Oftentimes the fear of being negatively evaluated is so strong, that people chose to compromise their own identities by avoiding disclosure of who they really are. Basically they are just living a big
lie. This study attempts to identify how self-disclosure and trust are related to which drug a particular family member abused. Studies such as this one are important because identifying social problems is the first step towards recognition and change. Every day, people are suffering and holding on to burdens and troubles of their past because of fear. Something as simple as promoting awareness can be the first step to fighting the fears and one day impact on the situation; changing how an entire group of people feel.

Conceptual Definitions

Trust is a variable that is extremely multifaceted because of all the layers and dimensions that compose the emotion. The current study examined trust in the sense of individualized trust, meaning trust that is related specifically to talking about the drugs family members abused. The trust discussed in this research is to be understood in the context of talking about addiction and drugs.

The same is true for the other two variables: self-disclosure and self-disclosure avoidance. This thesis was designed to specifically measure disclosure/avoidance about family addiction and specific drugs, not disclosure
on a generalized level. Adult children of substance abusers (ACOSAs) may be very open and willing to talk about themselves, but not about the drugs or addiction in their families, or what they experienced as children. Because of these assumptions, this research has been designed to address self-disclosure and self-disclosure avoidance directly to talking about addiction and drugs of choice (DOC).

Outline of the Research

The next four chapters follow a coherent formula to answering the research hypotheses. Chapter two is the review of the literature, which is an extensive examination of research that has already been conducted that relates to the topic of the current study. The models of addiction are explained, family dynamics of substance abusive households are covered, and literature relating to emotional issues that impact trust and self-disclosure practices of ACOSAs are also investigated. The review of the literature provides a foundation of support for the significance of the study.

Chapter three is the methods section that explains the basic procedural steps of the study. The sampling size and frame are explained, as well as how the data was
collected. This section also explains the instrumentation of the survey and how the survey was implemented. The scales that were used to measure the dependant variables of the study are the Revised Self-Disclosure Scale (RSDS, Wheeless & Grotz, 1978), Self-Disclosure Avoidance (SDA, Rosenfeld, 1979), and the Individualized Trust Scale (ITS, Wheeless & Grotz, 1977). Chapter three explains these scales and describes studies that have utilized them in the past. This chapter also addresses the treatment of the data.

Chapter four presents the results and significant findings that are related to the research hypotheses. The significant relationships between variables are discussed in this section, exploring the various relationships between drugs in the home and self-disclosure, self-disclosure avoidance, and individualized trust. This section also explores the interrelatedness of the different drugs and the relationships they have amongst each other in the drug spectrum. Other significant findings discussed in Chapter Four are the significant relationships found between the scales used to conduct the study.

Chapter five contains the conclusions of the study. In this chapter, a summary of chapters two, three, and
four is provided. Conclusions about the results and implications are drawn, and the relationships between the drug categories and the variables are discussed. New themes of change and choice are addressed in the implications. Fears and shame that surround family addiction are also discussed in this section. Recommendations for future studies in the discipline were revealed, focusing on the relationships between the same population and motivation to change.
CHAPTER TWO

REVIEW OF THE LITERATURE

Chapter Preview

The chapter reviews important themes and definitions related to studying addictions and the families involved. The four major models of addiction are addressed and defined in attempts to provide a conceptual framework for examining family members of addicts and alcoholics. Statistics about addicts and alcoholics, as well as their families are provided in the second section of the chapter. The third section of the chapter explores common images and myths associated with the socially construed concept of addiction. Next the literature review examines the roles of families in substance abusive families, and defines adult children of alcoholics (ACOA) and adult children of substance abusers (ACOSA). The last section of the chapter examines the effects on communication in substance abusive households through exploring the impacts of families coping with substance abuse, control issues, self-disclosure, and trust.
Defining Addiction

Exploring the Various Models

The concept of addiction has become controversial throughout the decades. The addiction studies field is enormous and encompasses numerous interpretations and perspectives for studying the phenomena of chemical dependency. Substance abusers have been studied with great scrutiny, because of the varying degrees of addiction and the differing or contradictory models for interpreting what being addicted literally means.

Furthermore, the use of (alcohol or drug) AOD interests and elicits extensive involvement from the legal system, business government, the religious community, as well as from the medical and mental health fields. The differing goals and orientations of these disciplines has resulted in sharp differences regarding the explanation of problematic use of AOD. (Harrison & Fisher, 2000, p. 37)

Most researchers and clinicians in the field agree that there are four basic models for interpreting addiction, or what has recently been labeled substance dependency. The best way to explain the different definitions for addiction is to address the major models used for
interpretation. These models are: the moral model, the sociocultural and psychological models, the medical model (disease concept), and the biopsychosocial model. The moral model explains addiction as, "a consequence of personal choice. Individuals are viewed as making decisions to use AOD in a problematic manner and as being capable of making other choices" (Harrison & Fisher, 2000, p. 37). According to this model, people make these choices because of personal or spiritual deficiencies. Religious groups and the legal system have both adapted this model. "A 1988 Supreme Court decision found that crimes committed by an alcoholic were willful misconduct and not the result of a disease" (Harrison & Fisher, 2000, p. 37; Miller & Hester, 1995).

The moral model attributes addiction to personal choices and character flaws, while the socio-cultural and psychological models focus more on external factors. "Other explanations of addiction focus on factors that are external to the individual, such as cultural, religious, family, and peer variables or psychological factors" (Harrison & Fisher, 2000, p. 38). Harrison and Fisher's (2000) explanation of the model further explains, "Perhaps the most accepted view, particularly by those outside the addiction field, is that the problematic use of alcohol
and other drugs is secondary to some other psychological problem or condition" (p. 39). According to this model, it is because of some sort of outside source, or internal ailment that is the primary problem, and AOD addiction is a secondary problem that started because of something else.

The third major model for interpreting addictions is the medical, or disease model, which is very different from the two previously mentioned models. "The disease of addiction is viewed as a primary disease. That is, it exists in and of itself and is not secondary to some other condition" (Harrison & Fisher, 2000, p. 41). The medical model views addiction strictly from a medical standpoint, treating addiction like a disease just like diabetes. E. M. Jellinek (1960) is credited with creating the comprehensive version of the disease model of alcoholism, which has been adapted by many agencies, including Alcoholics Anonymous (AA), the World Health organization (WHO), and the American Medical Association (AMA). "The World Health Organization acknowledged alcoholism as a medical problem in 1951, and the American Medical Association declared alcoholism was a treatable disease in 1956" (Harrison & Fisher, 2000, p. 41). The medical model is usually used to ground genetic research that examines
the possibilities for genetic transference of a predisposed gene making children of alcoholics or addicts more likely to become addicts or alcoholics themselves. The disease model is extremely controversial because of the arguments between biology and environmental factors that could possibly influence the 'addicts' behaviors. Doweiko (2002) explains, "Although the medical model dominates the field of substance abuse rehabilitation in the United States, there are a number of other theoretical systems that also address the problem of drug/alcohol abuse" (p. 30). He further expands, "It is tempting to speak of the medical model, or 'disease model' of alcohol/drug abuse as though there were a single, universally accepted definition of substance use problems. But in reality, there are philosophical differences in how physicians view the disease" (Doweiko, 2002, p. 30). Other problems with the medical model are seen with recovery and relapse issues. "Since the alcoholic or addict is 'powerless' over the disease, inappropriate or even criminal behavior may be attributed to the 'disease.' Relapse may also be blamed on the disease" (Harrison & Fisher, 2000, p. 48). Removing the problem from the individual can be seen as beneficial and as harmful, this
is part of the reason the medical model is so controversial.

The last major model for interpreting addiction is the biopsychosocial model. "In the biopsychosocial model of addiction, the interactions of biological, psychological, cognitive, social development, and environmental variables are considered to 'explain' addiction" (Harrison & Fisher, 2000, p. 51). This model seems to be the composite of the three previously mentioned models of interpreting addictive behaviors.

The different models mentioned obviously denote that there is no single universal definition for addiction in the clinical sense, but the DSM IV does provide criteria for evaluating the difference between use, abuse, and dependence to chemical mind-altering substances.

The term addiction is not part of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). Of all the diagnoses referenced in the DSM IV, substance dependence may come closest to capturing the essence of what has traditionally been labeled addiction. (Walter, 1996, p. 10)

According to Loue (2003), "addiction has been defined as a chronically relapsing (disorder) characterized by
compulsive drug taking, the inability to limit the intake of drugs, and the emergence of a withdrawal syndrome during cessation of drug taking” (p. 19; Koob, Sanna, & Bloom, 1998). Fisher and Harrison (2000) define addiction or chemical dependency as, “Compulsion to use alcohol or other drugs regardless of negative or adverse consequences. Addiction is characterized by psychological dependence and, often physical dependence” (p. 15). For purposes of this research, addiction is defined as an all encompassing disease of the body and spirit that affects the entire existence of the person inclined to compulsively use drugs or alcohol. Because there are so many interpretations for addiction, the psychological dependence will be understood as a disease of the human spirit and physical dependence will be associated with the human body. A disease of the human spirit taints the addict’s ability to make logical decisions about their lives and the lives of the people around them, because they might feel false control under the influence. Contrary to a physical disease that might paralyze body parts making tasks physically impossible, diseases of the spirit inflict emotionally and psychologically impairing feelings and interactions, but oftentimes leaves the addict fully functional. Addiction can be understood as a
disease of the human spirit, because it is the spirit, or sense of self, that is addressed in recovery and must be changed to become healthy.

The disease of addiction is viewed as a problem that occupies many realms of existence, a disease of the spirit, body, and mind. “However in its commitment to the artificial mind-body dichotomy, society struggles to come to terms with the disease of addiction, which is neither totally a physical illness nor exclusively one of the mind” (Doweiko, 2003, p. 46).

Statistics Concerning Addicts and Alcoholics in the United States

The estimated number of drug addicts reported in the U.S. Census Bureau in 2000 is roughly 15,193,000 and this number continues to grow exponentially. The data also shows that 6.9% of Americans are drug addicts (U.S. Census Bureau, 2002, p. 123). The statistics concerning alcohol are even greater, “About two-thirds of adults in the United States consume alcoholic beverages” (Hanson, 1995, p. 300). This does not infer that two-thirds of American adults are alcoholics, but it does reflect the abundance and major role alcohol plays in our society.
Addiction as a Cultural Phenomena: Images, Myths, and (Mis)conceptions

The members of the American drug culture communicate a multitude of messages from various layers of society, beginning with the individual, and moving on to public, national, and global levels. Members of the drug culture are often characterized as social misfits and outcasts, but the researcher argues that drug addicts are much more abundant.

Drug addicts or the modern drug culture is a sect of people that incorporate a multitude of ethnicities and diverse cultural background, yet seem to share a similar scope of reality. Addicts share a commonality that transcends race or gender and the members of the drug culture are all encompassing, being composed of people from all races, genders, and socio-economical statuses. Stereotypes commonly associated with addicts provide a misrepresentation of the people who actually belong to the drug culture. This stereotyping acts to perpetuate cultural myths that associate addiction with minorities and lower economic class statuses.

The pervasiveness of the American drug culture often reflects two major themes associated with chemical substance abuse and personal identification: glorification
or alienation. The dichotomy is dually portrayed through Hollywood and pop music by surfacing contradictory messages about substance abuse. The mass media sends messages that glorify drug addiction and portray drug-related activities as symbols of stature and wealth, yet also perpetuate cultural myths that associate addiction with solitude and despair. The dichotomy extremes each hold their individual levels of truth yet neglect to acknowledge the various dimensions involved with addiction and the negotiated cultural identity of the drug culture. "Drugs and drug use have become embedded in the popular mythologies of Western culture. Alcohol and tobacco smoking, two of the socially sanctioned and legitimized drugs, are responsible for more harm and more ills than all the rest put together by a large margin" (Cape, 2003, p. 163). Illegal drugs are often viewed as living entities that fiendishly scam the planet like demons looking for their next prey, while legal drugs are viewed in the exact opposite fashion. Legal drugs or prescriptions are often seen as a miraculous gifts that are here to magically heal all the addicts' problems. The fact of the matter is that whether people are taking legal or illegal drugs, they are most likely taking drugs because they are in some sort of pain, either physical or
emotional, and they are desperately searching for something to make them feel better. In this context addiction is a disease of the human spirit.

The two different types of drugs (legal and illegal) are different in the ways they are taken, as well as in their classification and scheduling. These simple differences are not what make them so incredibly unique from each other though, it is their social acceptance and rejection. The status of acceptance or rejection dictates the ideological perspectives society holds for the user. Orcutt (1976) examines alcoholics and addicts as being categorized deviant types because of moralistic and medical ideologies. "The societal reaction perspective emphasizes that deviance is a process by which social audiences categorically label and treat certain persons as deviant types" (Orcutt, 1976, p. 419). The social acceptance or rejection of the users drug of choice, often acts to categorize the user and attach them to common societal stereotypes. "Stereotypes have however become synonymous with stigmatizing connotations - as a term of abuse. It is not stereotypes as an aspect of human thought and representation, that are wrong; but who controls them, defines them and what interests and uses they serve" (Cape, 2003, p. 166). The ideologies attached to the
moralistic societal views about addiction are what usually keep addicts and their families from talking about their substance abuse issues. The stigma society attaches to addicts' usually affects them and their families in a number of different fashions. "Work and housing opportunities of persons with psychosis, substance abuse disorder, and other mental illnesses are significantly hampered by societal stigma" (Carrigan, River, Lundin, Wasowski, Campion, Mathieson, Goldstein, Bergman, Gagnon, & Kubiak, 2000, p. 91).

Drugs are chemical substances, not living entities therefore they do not have the ability to discriminate. Anyone can become a drug addict, it is not a phenomena restricted only to the poor or uneducated, but a phenomena that has surfaced itself in all social/economical levels in American society. Adrian (2002) conducted a content analysis of abstracts and reports that were produced by the National Institute of Alcohol and Alcoholism (NIAA)'s Internet accessible computerized data-base, and found there to be no support for common myths about addiction and its association with ethnicity or ethnocultural subgroups. Myths associated with drug addiction often involve racial or socio-economical stereotypes stigmatizing addiction to minorities. The relevance of
this study is that addiction is an American problem that most cultural myths do not reflect. Literature and the popular press often highlight drug addiction as an issue that threatens particular ethnicities or socioeconomic classes, but the critic argues that because drugs are not living entities, they do not have the power to discriminate. Addiction is something that people from all points of the demographic spectrum are dealing with, and gender, occupation, or race do not have an impact or influence on the powers chemical substances can have over people. White (1996) provides various examples of white-collar workers, like doctors and lawyers, who are addicts like blue-collar workers. He reports about doctors who passed out during surgery and lawyers leading double lives and ending up dead. Cultural myths try to perpetuate the identification of an addict with ghetto characteristics, neglecting to acknowledge the intensities involved being addicted to drugs and the effects addictions have on the family unit.

Hammersley and Reid (2002) investigate the social mechanisms involved with sustaining of the myths of addiction in Western culture. The study argues that addiction serves as functional role in western culture and one of the major roles it plays is concerned with control.
Hirschman (1995) further elaborates on this idea of social control,

Very often, consumers' addictive behaviors go unrecognized or untreated, just as mild-to-moderate exhibitions of mental disorders go undetected. This is because culturally we reserve the idea of addiction only for certain types of addictive behavior and overlook or mislabel—other. (p. 543)

Addicts seem to be labeled to allow mainstream society to believe they are exerting control over addicts by stigmatizing the culture. An important issue the researcher found in Hammersley and Reid's (2002) work was the surfacing of the stereotypes commonly associated or ascribed to addicts.

Drug addiction crosses race and gender boundaries, the myths associated with addiction have formed a false representation of who is, or who can be a drug addict. The current study acknowledges the misrepresentation of addicts in America, and notes that the drug culture crosses ethnicities and genders and affects everyone.
Families and Addiction: Dynamics, Coping, Trust, and Self-disclosure

The vast drug culture has affected and influenced many individuals and their families. "The family system has recently become the focus of much research regarding factors promoting substance abuse" (Le Poire, 2004, p. 609; Amey & Albrecht, 1998, Christensen, 1998; Friedman & Utada, 1992; Rotunda, Scherer, & Imm, 1995). One of the most common reoccurring themes in researching drug addicts and the families involved with addiction and alcoholism, are the emotional, psychological, biological and generational effects. Le Poire (2004), "emphasizes the fact that all family members are influenced by substance abuse in the family environment regardless of whether the substance-abusive family member is a spouse, a parent, an adolescent child, or a sibling" (p. 621). Researchers have examined various components of addicts and their family's lives and most would agree that the family is affected by the concept of addiction. "According to Vaillant (1983), one out of every three American families is touched by the destructive effects of alcoholism" (Jones & Kinnick, 1995, p. 58). The current statistics about the number of families living with drug addiction are not known, but
most family members would agree that they are indirectly and directly affected by their family members' drug abuse.

Each member of a family influences the other members, whether it is through the transference of a particular hereditary gene, or through daily interactions, family members influence one another. "Familial influence in the etiology of drug abuse can occur in at least two salient ways: through genetics and family 'environment" (Ripple & Luthar, 1996, p. 147). The population that is typically studied in substance abusive family research is adult children of alcoholics (ACOAs).

Although alcoholics in the United States number some 8 to 10 million, in reality the disease of alcoholism affects an estimated 30 million others, including family members and offspring (Woodside, 1988). However, it is only in the past decade or so that this peripheral population has been targeted for study by the mental health profession. (Beesley & Stoltenberg, 2002, p. 281)

Defining Adult Children of Alcoholics/ Substance Abusers: Exploring Different Views

A rather narrow definition of an ACOA has been provided by Russell, Henderson, and Blume (1985) as, "any
person, adult or child who has a parent identified in any way as having a significant problem related to alcohol use" (p. 1). Beesley and Stoltenberg (2002) took this definition and expanded it further to incorporate a more diverse and representative definition, "The literature is consistent in defining ACOAs as adults from a family with alcoholic parent(s), grandparent(s), and/or other family member (p. 281), (Kritzberg, 1990). The current research reviews and draws themes from research conducted in this area, but must make clear that the scope of the research extends much farther to incorporate the representation of people who have been affected by any type of substance abuse by an immediate family member (ACOSA).

Despite the research's perspective, most researchers agree that the immediate family members live a life different from the social norm because of their parents' or spouse's addictions. Most people who grew up with one or more substance abusers living in the home would agree that their lives have been substantially different from those in mainstream society who have not grown up with an addict or alcoholic in the home. Research has indicated that some families of drug abusers are often no different than other dysfunctional families, and feel the generalizations made about addiction do not apply to them.
The researcher acknowledges the individuality each family has, but does argue that these families are dysfunctional, which has directly made an impression upon each member.

Scharff et al. (2004) makes note of Lewis-Harter (2000) who, "suggests that there is not much empirical support for an ACOA personality profile and that the ACOA syndromes reported in clinical literature can be explained by other variables, including family dysfunction" (p. 576). Rutter and Levy (1991) contend, "The children of alcoholics movement tends to be dominated by a nonscientific spiritual posture that is long on rhetoric and short on empirical data" (p. 12). Yet, research also indicates, "An accumulating body of evidence indicates that parental alcoholism has negative effects on members of the family" (Menees, 1997, p. 9). Keller, Catalano, Haggerty, and Fleming (2002) further support this argument by stating, "Children of substance abusing parents have an elevated risk for experiencing disruptions in household composition and for engaging in problem behavior" (p. 399). Levy and Rutter (1991) point out, "Concern for the children of drug addicts has never coalesced into a movement on behalf of these children: moreover; the literature on this subject remains in its infancy" (p. 13). This researcher argues that family members are
influenced on multiple levels by other members of the family unit; which then influences their communication patterns overall, but particularly in interpersonal situations. ACOSAs are often characterized as having had behavior problems as children, often times unable to communicate in great detail about their families. McKeganey et al. (2002) adds to the foundational perspective of addicted families by stating, "It has been shown that parents with a drug problem may experience considerable conflict between meeting the physical and emotional needs of their children and sustaining their drug habit" (p. 234).

This statement does not infer that families with substance abuse issues are all dysfunctional or have problematic relationships but most families in general have problems; this statement does infer that these particular families occupy a space and dimension all their own. Like all controversial topics, families involved with substance abuse differ in their interpretations about how drugs have affected or not affected their lives. The roles and rules of substance abusing families are much different from the traditional nuclear family. The critic acknowledges that because of the rise in divorce rates
across America, the traditional nuclear family is not necessarily the social norm.

The Family Unit

The family unit is constantly changing and has undergone many faces throughout history. At one time the family unit embraced extended family members in the home, but then Westernized societies became industrialized into the typical Euro-American nuclear family. Now American society seems to be embracing the blended family. In addition to the physical characteristics of the family dynamic and its continuously changing face, are the cultural connections a family decides to identify with, making a tremendous impact on the way the family operates.

Research in the field has surfaced a number of different opinions and theories about the relationships between substance abuse and many different behaviors and emotional characteristics. Family units of alcoholics and drug addicts are extremely diverse embracing all types of families physically and culturally. All families have quirks and oddities, but families with substance abusers typically have rules of their own and survival often becomes the theme of their existence. "Children of alcoholics have different expectations. A child who learns
early that no one can be counted on learns equally early to depend on himself or herself, and to be fiercely protective of this autonomy" (Seixas & Youcha, 1985, p. 51). The current research examines the coping mechanisms of substance abusive families and surfaces the relationships between trust and self-disclosure in relation to specific drugs. In reviewing the literature, the researcher has found trust and self-disclosure to be linked to many variables like coping and boundary development. The inability to trust others and the self become issues the ACOSA learns to deal with for most of their lives. "In the alcoholic home, these strategies are developed, even though the family denies the existence of alcoholism" (Ackerman, 1986, p. 6).

Issues of importance are rarely addressed or discussed in alcoholic/addictive homes, because if real issues are addressed, eventually, someone might break the chains of denying the substance abuse problems, and make the real family issues visible.

Well-adjusted children who experience daily childhood problems would, most likely, talk about these problems with other family members. Because of the denial of the alcoholism in an alcoholic family, seldom are any of the
children's problems recognized, and the family problem—alcoholism—is never discussed. (Black, 1981, p. 36)

The number of drug addicts in America is more than 15 million, which reflects only reported addicts, not actual addicts who are still functioning throughout societies all over the nation. The pervasive myth of addiction has made it extremely difficult for many children of addicts to openly communicate about the drugs their parents take.

There are at least 22 million adults in this country who have lived with an adult alcoholic parent. Most have survived the whole ordeal and are now out on their own. Nearly all of them, however, live with scars, psychic or physical, as a consequence of parental alcoholism... Because of the nature of alcoholism itself, they have been unable to talk about what went on in their families. (Seixas & Youcha, 1985, p. xi)

Emotional Boundaries: Relating to Trust and Self-disclosure

Crespi (1990) explains, "Children of alcoholics typically spend a major portion of their childhood worrying that people will discover the truth about their families 'secrets'" (p. 84). Addiction and alcoholism are
often kept secret, which notes a type of beginning for family members to learn behaviors that prohibit communicating truthfully and honestly, which they learn from the emotional distance and lack of availability on the parts of the addicts. Crespi (1990) explains,

Most alcoholics connive, rationalize, deny, obfuscate, and generally create chaos in their families. Because they model this behavior and because most alcoholics, even street drunks, really do feel embarrassed and ashamed of their behaviors, children learn to model the very same behaviors. It is difficult to face such issues squarely. (p. 85)

It has been postulated that even if adult children of alcoholics (ACOAs) do not develop problems with alcohol, they often have problems such as developing close interpersonal relationships and maintaining these relationships over time, managing money, and developing positive self-perceptions (Hall, Bolen, & Webster, 1994, p. 786; Goodman, 1987; Sher, 1991).

Growing up in these households can teach children to become emotionally unavailable when they become adults hindering their abilities to disclose and their abilities to trust. “Children of alcoholics never learn the ABC’s of
feeling. The only way they could survive was to constrict themselves emotionally. Because the focus was on alcohol, there was no network in the family that supported affect or communication” (Ackerman, 1986, p. 232). The ability to talk about things is somewhat of a pre-requisite for establishing boundaries. Petronio, Martin, and Littlefield (1984) explain, “Self-disclosure is the mechanism through which we adjust our privacy boundaries” (p. 268). Without self-disclosure these boundaries are enormous.

Boundaries help us establish a child’s personal identity, they promote individuality, and they provide necessary psychological space. When it is not fostered, people have difficulty separating from their parents and families, they experience guilt, identity development is hampered, codependent behaviors are fostered, and individuation cannot really be achieved. (Cespi, 1990, p. 56)

Explaining how families define emotional boundaries and teach to numb emotions is quite simple, because the emotions are there, but the expression of them is often times forbidden or over-ridden by the needs and dramatizations of the addicts in the family. Usually the number one priority of an addict is to use drugs to reach
a state of euphoric numbness and everything else seems to come second, even their children. In essence, an addict’s sole obsession is their drug, and anything that gets in the way of an addict attempting to reach their desired state of mind will be punished. Family members learn to adapt to their physical surroundings and over time learn to become numb themselves in attempts to shield themselves from the polarized extremes of living with a drug addict. "Wegscheider (1981) believes that, in an alcoholic family, members attempt to maintain balance by compulsively repressing their feelings while developing survival behaviors, as well as emotional walls, to ward off the pain associated with the family member’s drinking" (Fisher & Harrison, 2000, p. 174). Emotional availability within the family unit is seen to have a connection to trust and self-disclosure.

Coping Mechanisms: Roles they Play in Trust and Disclosure of Adult Children of Substance Abusers

Throughout childhood and adolescence, people learn coping mechanisms and the emotional connections between people and the contexts of situations. These foundations are what lead individuals into the relationships they experience as adults. Healthy families tend to reinforce
lessons and coping mechanisms for love, hate, anger, fear, and other primal emotions by allowing a type of freedom of expression. The emotional development depends on the ability to express feelings in order to gain an understanding of the emotions streaming through our bodies. Families with substance abuse issues do not typically allow the necessary step of expression to take place to allow emotional advancement to occur. Instead of allowing a forum of expression, these families instill themes like, "don't rock the boat" and "toughen up" that work to nullify and numb emotional development and expression. Substance abusive families seem to have little emotional competence and appear to be trying to reach a state of numbness and exert a type of control over natural emotions. Learning to become numb is usually taught through strict types of discipline, because lack of trust and the inability to talk about family addictions, are a state of mind that is learned as a survival skill in attempts to control the depressing realities of life at home. "According to Woititz (1989), many ACOAs transport their need for control into adult relationships, developing coping skills along the way in order to mediate the chaos and unpredictability in their lives" (Beesley & Stoltenberg, 2002, p. 283). The addicted family teaches
its members to have control over their emotions by not having any emotions at all. Ironically this is one of the major reasons people abuse drugs in the first place, to escape reality and reach a state of numbness where they feel in control of their destinies. This mentality does not stay restricted to the addict though, it bridges over to the people living with them and creates the theme many families incorporate and live by. Beesley and Stoltenberg (2002) explain the connections of control and the dysfunctions of the family, "In particular, the need for control seems to be related to the dynamics in the dysfunctional family of origin" (p. 283).

Anti-trust and Silence as a Means of Control

The alcohol or drug addicted (AOD) family encourages silence and anti-trust tactics as a means of control. Addicted families do not believe that if they deny or ignore another members addiction it will go away, but they do believe that if they do not talk about their families they are exercising control over their emotional capabilities. "As a result of growing up in a dysfunctional environment, the interpersonal functioning of ACOAs is often characterized by the dependence on the approval of others, thereby circumventing the development

People in general are either trying to achieve control, or lose it, all with the hopes of feeling better about life. The concept of control in AOD families is incorporated on just about every level of existence, from completely surface or seemingly insignificant situations, trickling to the depths of existentialism. "Just as the alcoholic in the family strives to control his or her drinking behaviors, the child endeavors to mediate the family chaos by attempting to control himself or herself and others" (Beesley & Stoltenberg, 2002, p. 282).

Attempting to control life is something the addict is doing by conditioning themselves to believe they have control over their addictions because they may be able to function in society.

This attempt to control the uncontrollable is a behavior the addicted family learns from the addict. Children witness their family members trying to control their moods and stressors by taking drugs or drinking alcohol. They mimic this attempt at control by engaging in behaviors to try and control their own emotional responses to their family members' unpredictability due to intoxication. "According to the literature, the control
issues of ACOAs are played out individually in the need to dominate and control the environment" (Beesley & Stoltenberg, 2002, p. 283). Coupling the idea of control in this type of setting is the concept of expectations.

Once people expect something, they instantly feel a loss of control over the situation, since vulnerability becomes a factor. "Because the control of self, environment, and others is an all-consuming task, ACOAs experience persistent frustration and an inability to relax" (Beesley & Stoltenberg, 2002, p. 283). ACOAs are often described as overly controlling, and the current research supports this claim, believing these controlling tendencies are directly related to the cycles of addiction and the recovery process.

The homeostasis or balance a chemically dependent family strives to achieve will instantly be disrupted if the facts about their addictions get out. "Significant to the concept of homeostasis is the notion that, as one family member experiences change in his or her life, the entire family will be affected and will adjust in some fashion" (Fisher & Harrison, 2000, p. 174). Families make changes on both the conscious and unconscious levels, but all efforts are done in attempts to maintain the family balance. One of the most notable sacrifices families
usually adapt to while trying to maintain a balance is learning to be quiet about everything. Because the repercussions are vastly unpredictable, children learn at a young age to simply keep quiet about their parents' habits (Black, 1981, p. 36). "Thus, children who grow up in alcoholic homes learn to monitor the family climate and engage in behaviors designed to minimize the conflict and chaos that are such a part of the alcoholic family environment" (Beesley & Stoltenberg, 2002, p. 282).

Claudia Black (1980) refers to the three rules children of alcoholics learn while growing up: 1) don't think, 2) don't talk, and 3) don't feel. People who were not raised in these types of families may find these rules disturbing or even sick, but as the critic previously mentioned, these are ideas that the child learned as a mode of survival. The house rules are not posted, or rarely even stated, but they are learned through experience almost everyday, until the person no longer lives in an atmosphere where substance abuse is a factor. If these three rules are followed, the result is complete numbness.
Self-disclosure

People do not disclose personal information, or secrets, to others unless there is some sort of comfort or trust. The critic argues that self-disclosure actually depends on trust, and this is why so many ACOSAs experience problems when attempting to openly communicate about the drugs their family members take. ACOSAs have been taught to be numb and not to trust as one of the survival skills previously mentioned in the text. There are in fact two types of trust that are different but related. “One is trusting others; the other is trusting yourself. Children of alcoholics have learned that they can’t count on the alcoholic, and therefore they are fearful” (Seixas & Youcha, 1985, p. 51). Because the seed of anti-trust has been so deeply engrained, many ACOSAs are not even aware of their lack of trust or inability to self-disclose personal information about themselves and their families. “Coming from a family where there is too much drinking means you can’t be sure of others even when they are reliable. How in the world can you trust when there has never been anyone in your life you could count on?” (Seixas & Youcha, 1985, p. 51).

Often times children who grow up with the disease of addiction and/or alcoholism in the immediate family, talk
about “waiting for the bottom to fall out” because they believed that sooner or later something bad would happen. ACOSAs often have trust issues because throughout the entireties of their lives, they have directly experienced the cycles of addiction and seen their parents’ happy and sober, yet have also witnessed the depths of despair and watched their parents make the choice to continue using regardless of the adverse and extremely negative consequences for everyone involved. ACOSAs have been taught that they will never be the first priority to their families they will always come second to drugs or alcohol. “Clearly, if the primary relationship is with alcohol or other drugs, other relationships will be adversely impacted, and the effect on the family is particularly dramatic” (Fisher & Harrison, 2000, p. 172). The reasons are infinite as to why people may choose not to disclose a family member’s drug abuse, but never disclosing the information can end up being harmful to them health-wise. “Children, as they grow up in this silent system, learn at a very early age that it is not OK to talk about certain things” (Kritsberg, 1985, p. 15). Substance abusive families encourage silence about family dynamics and the way the family operates.
Keeping family secrets often is portrayed by clinicians, researchers, and theorists as having negative consequences for individuals. Even popular U.S. culture discourages family secrets—the failure to openly express information that the family has kept hidden frequently is viewed as detrimental to individual’s psychological well-being. (Vangelisti, Caughlin, & Timmerman, 2001, p. 2; Bradshaw, 1995; Hunt & Paine-Gerne, 1994; Webster, 1991)

Families and the Recovery Process

A relatively new branch of addiction research has focused on the role of family members in the recovery process, and findings support the importance of family involvement. Yet, little attention is paid to the family members of addicts in most recovery centers and non-addicts are left to adjust on their own. Sadly, family members often times do not know how to be supportive of the recovery process, because they still hold the pain of the addict and do not know the person who comes home from the rehabilitation center. “Despite the accumulating evidence for the important role of families, on the whole service delivery remains focused on the individual drinker
or drug user, with the families and other members of the user’s social network playing a very peripheral role” (Copello & Orford, 2002, 1361). To further explain the importance of this issue, Lennox, Scott-Lennox, and Holder (1992) explain:

Because substance abuse treatment programs primarily focus on the abuser, they tend to downplay problems that non-abusing family members experience and can even help perpetuate the cycle of abuse by leaving family dysfunction and individual pathology of non-abusing members unchecked. (p. 3)

Although the addict is the primary person affected by drug abuse, neglecting the importance of the other family members leaves them to continue behaving in the same fashions, whether their family members are using or sober. ACOAs often times try to maintain the family balance and attempt to control their emotions and situations regardless of their family members using status. This attempt to control their emotions is in part due to the fact that substance abusers can go through many different stages of addiction, recovery, and relapse. Friedmann (1996) studied the effects of ALANON on family members of addicts and their personal family perception, “Evidence
suggests the usefulness of ALANON in empowering families and assisting them in reevaluating the family system more positively" (p. 123). Including the family members in the recovery process is incredibly important for healing the entire family. The literature review explains the depths of the effects of addiction and alcoholism on the family as an entire unit, and feels it is important to remind readers that the recovery process is something everyone involved needs to experience as well.

The inability to talk about what has really happened throughout periods in their youth simply perpetuates the communication gap and feeds the social misinterpretations concerning the myths of addiction. Bridging the gap and learning to talk about family member's addictions in general is something sober family members can learn to do. Through years of training, accompanying the cycles of addiction, most sober family members have learned to be able to identify their substance-abusing members as addicts or alcoholics. In the 12-step program, an initial foundation is built upon the identification process, and being able to identify with other addicts and alcoholics. The families of chronic substance abusers have typically gone through at least one type of treatment program, in which the person who is chemically dependant has had to
acknowledge the fact that they have problems or
difficulties in controlling their drug-related habits.
Doweiko (2003) explains, "In becoming aware of the 'self,'
we came to know loneliness. It is only through the giving
of 'self' to another through love that Fromm (1956, 1968)
envisioned people as transcending their isolation, to
become part of the greater whole" (p. 44). Once this
happens, the families are also much more likely to accept
the fact that one of its members is an addict/alcoholic.

This researcher believes that with this acceptance
also comes room for ambiguity on the part of talking to
outsiders about a family member's addiction. "More often
the concept of acceptance is dragged in by the heels with
little or no recognition that acceptance itself plays a
major psychological step" (Tiebout, 1953, p. 60). Simply
acknowledging the addiction is not the same as disclosing
information about the drug of choice that family member is
abusing. Sober family members usually do not have much of
a problem stating that their parent or siblings are
addicts but things seem to change when the conversation
turns to inquiry about the specific drug a family member
is addicted to. Referring to addicted family members in
ambiguous terms acts to recognize, but not necessarily
accept. Tiebout (1953) further explains, "Acceptance is a
step beyond recognition" (p. 62). This could be a reason why people differ in their disclosure habits when it comes to talking about family members' addictions. Using more specific definitions of what type of addict might be more useful for healing purposes. "Appropriate self-disclosure has a large number of benefits: increasing trust, increased liking and, often, loving, increased attraction, and increased mental health" (Rosenfeld, 1979). Disclosing precisely what your family member is addicted to, as well as how the drug is ingested be seen as a risky conversation, depending greatly on where the individual is in their own life. "Unless the unconscious has within it the capacity to accept, the conscious mind can only tell itself that it should accept, but by doing so cannot bring about acceptance in the unconscious" (Tiebout, 1953, p. 62). The specific drug classifications carry with them social judgements, preconceived ideas and basic pharmacological components that people who are not addicted to drugs usually will not want to be associated with; so many times choose not to disclose information about their family members' specific drug of choice.

The researcher predicts that the classes of drugs will influence the levels of trust differently because of many reasons, primary because of the different behaviors
that are a direct result of being under the influence of a particular drug, and social views based on which substances are legal and illegal. "Since much of their lives may be involved in keeping the alcoholism/addiction in their family a secret rather than getting help to deal with it, children of alcoholics/addicts tend not to develop relationships where they can confide in and trust others" (Towers, 1989, p. 12).

Substance abuse and self-disclosure are extremely complex realms of existence that allow a great deal of room for ambiguity and mystery within the family on the parts of the non-addicts. Family members usually do not have a great deal of trouble identifying another member as an addict, but do seem to experience difficulty when questioned about their family members' drug(s) of choice.
CHAPTER THREE
METHODS

Chapter Preview

This chapter explains the ways in which the study was conducted. A description of the research, data collection techniques, testing instruments, participant information, and data treatment are discussed in this chapter.

Research Design

The research was designed to examine the relationships between specific drug categories that were present in substance abusive homes and participant's levels of self-disclosure, trust and self-disclosure avoidance. An internet based survey created through Perseus Survey Solutions was used to collect the data for the study. The independent variables were the specific drug categories, were broken down into two groups: legal and illegal drugs. The survey asked the participants to identify their family members' drug(s) of choice from the list of most commonly abused substances: alcohol, crack, cocaine, heroin, methamphetamines, hallucinogens, steroids, marijuana, and prescription drugs. The survey also included the option to refuse disclosure of the substances abused. Alcohol and prescription drugs were combined to
create the legal drug variable, and the remaining drugs were combined to create the illegal drug variable. The dependent variables were self-disclosure, trust, and self-disclosure avoidance.

Procedures

Participants completed a self-administered survey, consisting of three scales. Respondents completed a total of 70 questions and submitted their answers anonymously through the internet. The Perseus Survey Solutions software was used to create the web-based survey does not collect respondent information; therefore it kept all the data confidential. Survey responses came directly to the researcher’s e-mail, which was then coded into a SPSS database.

Instrumentation

Three scales were used to measure the dependent variables: self-disclosure, trust, and self-disclosure avoidance. The individualized trust scale (ITS) by Wheeless and Grotz (1977) is specifically geared to examine trust between a particular person, or specific interpersonal situation. It does not measure trust in general, but relates trust to a specific instance, specifically talking about a family member’s drug of
choice. Wheeless (1978) reported a reliability of .97 for the 14-item trust scale. Van Lear and Trujillo (1986) conducted a longitudinal study of the social judgement process and chose four items from the ITS. Buller, Stryzewski, and Comstock (1991) used a combination of three scales in their deception research, one of them being the individualized trust scale. Chamberlin (2000) utilized the ITS in research about teacher-supervisor relationships. In Chamberlin’s (2000) research, participants viewed a videotape and then filled out the ITS as a way to evaluate the supervisor they just watched on the tape. Chamberlin (2001) used the ITS in another study about teacher-supervisor perceptions. This research differed from the previous by focusing only on TESL (Teaching English as a Second Language).

Tardy (1988) explains that the ITS, had been created from speaker credibility scales that assess trust and character traits. Wheeless and Grotz (1977) are credited with creating and validating two of the three scales used in the current research about self-disclosure and ACOSAs. Wheeless and Grotz (1977) wrote, “The measurement of trust and its relationship to self-disclosure,” in which they used both the ITS and the original self-disclosure scale.
Self-disclosure was assessed using two different scales that address complex issues such as the multiple dimensions of disclosure and self-disclosure avoidance. The current research utilizes the Revised Self-Disclosure Scale (RSDS) that was developed by Wheeless (1978). "The revised Self-disclosure instrument measures five independent dimensions of self-disclosure: (1) intent to disclose... (2) amount of disclosures... (3) positive-negative nature of disclosure (4) control and depth of disclosure and (5) honesty-accuracy of disclosure" (Rosenfeld, 1979, p. 66). Using this instrument, self-disclosure is considered a multidimensional construct which allows the instrument to overcome problems with reliability and validity.

Leung (2002) uses the RSDS and the Revised UCLA loneliness scale to assess the relationship between loneliness and self-disclosure in university students living in Hong Kong. Chen (1995) conducted a cross-cultural comparative study about the self-disclosure patterns and differences between Americans and Chinese which also utilized the RSDS.

The current study was concerned with self-disclosure reports from ACOSAs and the relationship to their family member's drug of choice. This researcher feels that it is
important to acknowledge that this is a topic some participants might not ever talk about. The Self-Disclosure Avoidance Questionnaire was used to address this concern. Rosenfeld (1979) developed this instrument because,

No instrument for measuring why an individual avoids self-disclosure was found in the literature. Though an individual completing any one of a number of self-disclosure questionnaires might be identified as someone who avoids self-disclosure, the explanations the individual might give remain unknown. It was a preliminary task of this investigation to develop an instrument to measure self-reported explanations for avoiding self-disclosure (p. 66).

Talking about family member’s addictions and specific drugs they abuse or have abused in the past, may be one of those topics people choose not to talk about. By utilizing Rosenfeld’s (1979) Self-Disclosure Avoidance Questionnaire, the researcher was able to respond to reasons why participants might not want to disclose information about their family members’ addiction and drug of choice.
Data Collection

Participants were recruited using a “snowball” technique through internet chat-rooms and forums dedicated to adult children of addicts and alcoholics. The researcher posted notices, threads, and different types of entries urging people to visit the web-site http://ADDICTION-TRUST-DISCLOSURE.com, to take the on-line survey created for this study. The researcher also asked people to pass the web-site address on to anyone who fit the project description. The following web-sites were used to generate participants for the study:

http://www.12stepforums.net
http://alcoholism.about.com/od/meetacoa/
http://www.addictionrecoveryguide.org/treatment/mb...
http://alcoholism.about.com/mpchat.htm
http://stepchat.com/acoa.htm
http://silkworth.net/info/meetingnchat.html
http://www.essence-of-recovery.com
http://alcoholism.about.com/b/a/068839.htm
coaf@phoenixhouse.org
The sample is one of convenience because of the difficulties in identifying members of a group that have an invisible stigma and no way of identifying who belongs to the group. The snowball technique served as a function to try and get a more representative sample of ACOSAs as the group that they are, and not restricting participation to traditional support group affiliations or people belonging to an organized network. This project is interested in all children of substance abusers, not only those who attend group meetings. By using this approach, the researcher has aimed to gather a more diverse and representative sample of a very large group.

Demographic Information

Participants (N = 70) responded to three questionnaires addressing self-disclosure, trust, and self-disclosure avoidance. The respondents' ages ranged from 18-75 years, but most of the respondents (68.6%) came from the 18-25 year (35.7%) and 26-35 year (32.9%) age categories. More than half (58.6%) of the participants reported that they no longer live with their substance abusive family member, while 28.6% reported that they still live in the substance abusive home. The remaining 12.9% of the participants reported to live in the
substance abusive home sometimes. Women who responded to the survey \((n = 37)\) composed 52.9\%, while men \((n = 27)\) composed 38.6\% of the responses. The remaining number of participants \((n = 6)\) composing 8.6\% of the responses preferred not to disclose their gender. The average number of years participants' family member's have been addicts or alcoholics was between 21-30 years \((M = 5.62, SD = 2.678)\). Respondents were asked to report how many years their family member(s) have been addicts or alcoholics. Of the 70 participants, 11.4\% reported that their family members have been substance abusers for 0-5 years, 14.3\% reported their family members have used drugs or alcohol for 6-10 years, 10\% reported 11-15 years, while 7.1\% family members had abused chemical substances for 16-20 years, the 21-25 and 26-30 year categories both reflected 11.4\% of the responses. The 30-35 years of substance abuse category was the highest in number registering 15.7\% of the response rate. The 36-40 year category had the least number of responses totaling only 4.3\%, while the 40+ years of substance abuse category received 14.7\% of the responses.

Although most of the respondents reported their family members have been abusing drugs or alcohol for more than 20 years, the majority (75.7\%) of the total
respondents reported to living in the substance abusive home for 20 years or less. Twenty-two participants (31.4%) reported to living in the substance abusive home for 0-10 years, and thirty-one participants (44.3%) reported to living in the home for 11-20 years. Of the sixteen remaining participants, thirteen (18.6%) reported to living in the home for 21-30 years. Two of the participants (2.9%) reported to living in a substance abusive home for 31-40 years. One participant (1.4%) reported to living in the home for 41-50 years and one participant (1.4%) reported to living in the home for 51-60 years.

Data Treatment

SPSS 12.0 was used to compute the correlations between legal and illegal substance abusive families and the ACOSAs ability to self-disclose and their individualized level of trust required to talk about family addictions.
CHAPTER FOUR
ANALYSIS AND EVALUATION OF FINDINGS

Chapter Overview

Specific results of the two hypotheses are provided and supported in this chapter. A discussion section is included that address possible implications and connections between the study and social views about drugs, specifically marijuana and methamphetamines, or central nervous system (CNS) stimulants.

Results

A bivariate correlation was used to test the strength of the relationships between the independent and dependent variables. Pearson’s correlation coefficient was the calculation used to determine the significant relationships between the different drugs and self-disclosure, self-disclosure avoidance and trust.

The first hypothesis: (H1) The drug of choice the family member abuses will affect the levels of self-disclosure or self-disclosure avoidance about their family member’s addiction and specific drug of choice, is partially supported. The relationship between self-disclosure avoidance and the different drugs of choice produced significant outcomes with reported
marijuana and methamphetamine using families. Self-disclosure avoidance was significantly related to speed usage ($r = .236$, $p = .049$). Self-disclosure avoidance was also significantly related to marijuana usage ($r = -.256$, $p = .032$).

Significant relationships were not observed between any of the other drug categories, non-disclosing category and self-disclosure avoidance. The hypothesis is only partially supported because significant relationships were not observed between the drug categories and self-disclosure levels. The only significant relationships were seen in the avoidance levels (see Table 1).

The second hypothesis (H2): The drug of choice the family member abuses will affect the levels of trust ACOSAs feel is necessary to talk about their family member's addiction and specific drug of choice, is rejected, therefore accepting the null hypothesis. The research did not find any observable correlations between the specific drugs of choice and the individualized trust variable (ns) (see Table 1).
Table 1. Drugs, Trust, Self-disclosure, and Self-disclosure Avoidance

<table>
<thead>
<tr>
<th>Drug</th>
<th>Self-disclosure</th>
<th>Self-disclosure avoidance</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
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<td>-.218</td>
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<td></td>
<td>sig.  .203</td>
<td>.151</td>
<td>.070</td>
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<tr>
<td>Cocaine</td>
<td>r val. .116</td>
<td>.213</td>
<td>.083</td>
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<tr>
<td></td>
<td>sig.  .340</td>
<td>.077</td>
<td>.496</td>
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<td>Speed</td>
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<tr>
<td></td>
<td>sig.  .630</td>
<td>.049</td>
<td>.166</td>
</tr>
<tr>
<td>Weed</td>
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<td>-.256*</td>
<td>.037</td>
</tr>
<tr>
<td></td>
<td>sig.  .218</td>
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<td>.762</td>
</tr>
<tr>
<td>Steroids</td>
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<td>.024</td>
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<td></td>
<td>sig.  .759</td>
<td>.847</td>
<td>.569</td>
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<tr>
<td>Crack</td>
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<td>.123</td>
<td>-.066</td>
</tr>
<tr>
<td></td>
<td>sig.  .852</td>
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<td>.588</td>
</tr>
<tr>
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<td>.101</td>
<td>.152</td>
</tr>
<tr>
<td></td>
<td>sig.  .361</td>
<td>.404</td>
<td>.209</td>
</tr>
</tbody>
</table>

* denotes significance of p < .05

Other Findings

The three dependant variables: self-disclosure, self-disclosure avoidance, and individualized trust, were
seen to be significantly related. Self-disclosure was significantly related to self-disclosure avoidance ($r = .370, p = .002$). Self-disclosure was also significantly related to individualized trust ($r = .276, p = .021$). Individualized trust was significantly related to self-disclosure avoidance ($r = .256, p = .033$). The significant relationships between the variables help support the argument that talking about drugs, or self-disclosure and trust are interrelated.

Table 2. Instrumentation Correlations

<table>
<thead>
<tr>
<th></th>
<th>Self-disclosure</th>
<th>Self-disclosure avoidance</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-disclosure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r value</td>
<td>-</td>
<td>.370**</td>
<td>.276*</td>
</tr>
<tr>
<td>sig.</td>
<td>-</td>
<td>.002</td>
<td>.021</td>
</tr>
<tr>
<td><strong>Self-disclosure Avoidance</strong></td>
<td>.370**</td>
<td>-</td>
<td>.256*</td>
</tr>
<tr>
<td>r val.</td>
<td>.276</td>
<td>.256*</td>
<td>-</td>
</tr>
<tr>
<td>sig.</td>
<td>.021</td>
<td>.033</td>
<td>-</td>
</tr>
</tbody>
</table>

**significant at 0.01 *significant at 0.05**

The significant correlation between self-disclosure and self-disclosure avoidance was a puzzling finding because of the positive relationship. The best possible explanation for this finding seems to be that disclosure
is a process that develops and changes with time. For example: some of the participants could have been in some sort of counseling or treatment, where others might have never talked about these issues before. Self-disclosure and self-disclosure avoidance are processes that vary with each individual.

Drug Correlations

Six significant relationships between the different drugs, primarily stimulants, have been observed, which lends support to assumptions about people being poly-substance abusing individuals. Cocaine was seen to be significantly related to speed ($r = .586$, $p = .000$), crack ($r = .475$, $p = .000$), and marijuana ($r = .244$, $p = .042$). Speed was also significantly related to prescription drugs ($r = .242$, $p = .043$). Prescription drugs were also found to be significantly related to steroids ($r = .302$, $p = .011$). The only negative relationship that was seen to be significant between the groups of drugs, was alcohol and cocaine. Alcohol was seen to have a significant negative relationship with cocaine ($r = -.393$, $p = .001$).
Table 3. Significant Drug Category Correlations

<table>
<thead>
<tr>
<th></th>
<th>Alcohol</th>
<th>Cocaine</th>
<th>Speed</th>
<th>Weed</th>
<th>Steroid</th>
<th>Prescrip.</th>
<th>Crack</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>-</td>
<td>-.393</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>r value</td>
<td>-</td>
<td>-.393</td>
<td>.586</td>
<td>.244</td>
<td>.302</td>
<td>.475</td>
<td>.000</td>
</tr>
<tr>
<td>sig.</td>
<td>-</td>
<td>.001</td>
<td>.000</td>
<td>.042</td>
<td>.011</td>
<td>.000</td>
<td>-</td>
</tr>
<tr>
<td>Cocaine</td>
<td>-</td>
<td>-</td>
<td>.586</td>
<td>.244</td>
<td>.302</td>
<td>.475</td>
<td>.000</td>
</tr>
<tr>
<td>r val.</td>
<td>-.393</td>
<td>-</td>
<td>.000</td>
<td>.042</td>
<td>.000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>sig.</td>
<td>-</td>
<td>.001</td>
<td>.000</td>
<td>.042</td>
<td>.000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Speed</td>
<td>-</td>
<td>-</td>
<td>.242</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>r value</td>
<td>-</td>
<td>-</td>
<td>.043</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>sig.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Weed</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>r value</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>sig.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Steroids</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>r value</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>sig.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prescrip.</td>
<td>-</td>
<td>-</td>
<td>.302</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>r value</td>
<td>-</td>
<td>-</td>
<td>.011</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>sig.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Drug Frequencies

The legal drugs (alcohol and prescription drugs) accounted for an extremely large portion of the responses. Respondents who identified their family members drug of choice as alcohol (M = .629, SD = .487) was 62.9% and prescription drugs (M = .32, SD = .473) accounted for 32.9% of the responses (see Table 4).
Participants were asked to disclose all of the family members' drugs of choice, because many times addicts are poly-substance abusers, meaning that they abuse more than one substance. The researcher must point out that alcohol was present in every group of drugs that were analyzed.

After alcohol and prescription drugs, methamphetamines ($M = .243$, $SD = .432$) or speed accounted for the third largest group of addicts in the study. Seventeen (24.3%) participants reported their family members' drug of choice to be methamphetamines/speed. Eight (11.4%) of the reported speed addicts also identified alcohol as a drug of choice.

### Table 4. Alcohol and Prescription Drug Abuse in the Home

<table>
<thead>
<tr>
<th>Legal drugs ($n = 67$)</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>44</td>
<td>62.9</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>23</td>
<td>32.9</td>
</tr>
</tbody>
</table>

### Table 5. Speed Alone/ Speed Plus Alcohol Abuse in the Home

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speed</td>
<td>17</td>
<td>24.3</td>
</tr>
<tr>
<td>Speed + alcohol</td>
<td>8</td>
<td>11.4</td>
</tr>
</tbody>
</table>
Nine respondents (12.9%) identified their family members as being addicted to crack (M = .129, SD = .337), of those nine, three (4.3%) reported alcohol as a substance their family member abused as well.

Table 6. Crack Alone/ Crack Plus Alcohol Abuse in the Home

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crack</td>
<td>9</td>
<td>12.9</td>
</tr>
<tr>
<td>Crack + alcohol</td>
<td>3</td>
<td>4.3</td>
</tr>
</tbody>
</table>

Respondents who identified their family members as being addicted to cocaine (N = 13, M = .186, SD = .392) accounted for 18.6% of the total responses. Three of the thirteen responses (4.3%) identified their family member as being addicted to cocaine and alcohol.

Table 7. Cocaine Alone/ Cocaine Plus Alcohol Abuse in the Home

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine</td>
<td>13</td>
<td>18.6</td>
</tr>
<tr>
<td>Cocaine + alcohol</td>
<td>3</td>
<td>4.3</td>
</tr>
</tbody>
</table>

Marijuana (M = .186, SD = .391) addicts represented 18.6% of the respondent rate, with thirteen family members identified. Of the thirteen identified, six (8.6%) were
also identified as having a chemical dependency to alcohol.

Table 8. Marijuana Alone/ Marijuana Plus Alcohol Abuse in the Home

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>13</td>
<td>18.6</td>
</tr>
<tr>
<td>Marijuana + alcohol</td>
<td>6</td>
<td>8.6</td>
</tr>
</tbody>
</table>

Heroin (M = .057, SD = .234) accounted for the least number of responses, with only four (5.7%) ACOSAs identifying a family member as addicted to this drug. Three (4.3%) of the reported four heroin addicts, are also identified as having a problem with alcohol.

Table 9. Heroin Alone/ Heroin Plus Alcohol Abuse in the Home

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>4</td>
<td>5.7</td>
</tr>
<tr>
<td>Heroin + alcohol</td>
<td>3</td>
<td>4.3</td>
</tr>
</tbody>
</table>

Reported steroid abusers (M = .043, SD = .204) accounted for 4.3% of the total response rate, registering three reported addicts. Of the three, one (1.4%) was also identified as having a chemical dependency to alcohol.
Table 10. Steroids Alone/ Steroids Plus Alcohol Abuse in the Home

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steroids</td>
<td>3</td>
<td>4.3</td>
</tr>
<tr>
<td>Steroids + alcohol</td>
<td>1</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Hallucinogens were included in the list of the survey, although there was a 0% response rate that identified a family member as being addicted to any type of hallucinogen.

The final category to be discussed in this section is the response rate of the participants who chose not to disclose their family members' drug(s) of choice. Four (5.7%) of the participants chose not to disclose (M = .057, SD = .234).

Discussion

The research has provided evidence that a relationship exists between marijuana and speed and the participants' willingness or unwillingness to discuss the specific drugs of their family members' choice. Participants who reported marijuana as their family members' substance of choice also reported extremely low levels of avoidance. They did not see themselves as having any difficulties talking about the fact that their family...
member was addicted to marijuana. However, just the opposite was true with participants who reported their family members to be addicted to speed or methamphetamines. The participants reported high levels of avoidance, meaning that they did not like to talk about the fact that their family member was addicted to speed.

Pharmacological Significance

Readers can interpret these results on numerous different levels because the two drugs that showed significance are pharmacologically different. Marijuana, or cannabinoids, has an active ingredient of "delta-9-tetrahydrocannabinol (THC)" (Fisher & Harrison, 2000, p. 19), which acts to slow down. Speed, or crystal meth/ methamphetamines, are central nervous system stimulants. One (marijuana) is transmitting chemicals to slow down, while the other (speed) is composed of chemicals that transmit reactions designed to accelerate the central nervous system. "CNS stimulants affect the body in the opposite manner as do the CNS depressants. These drugs increase respiration, heart rate, motor activity and alertness" (Fisher & Harrison, 2000, p. 19).
Social Views of Marijuana and Speed

Because of their basic pharmacological components, these drugs also have very different social connotations which most likely factor into influencing the avoidance or lack of avoidance. Fisher and Harrison (2000) also point out the social acceptability of marijuana, "Marijuana is the most widely used illegal drug. Over 22% of adults in the 18-25 year range reported to using marijuana in the last year, with 12.8% reporting use in the previous month" (p. 27). Keeping this statistic in mind, the research must remind the reader that 35.7% of the sample population used in this study, were in the age bracket of 18-25 years. This definitely could have influenced the results in the perspective of social acceptability. Therefore the researcher was not surprised at the significant positive correlation between the variables. This type of mentality or socialization process is known as naturalization. Marijuana has become naturalized or normalized, meaning that it is common. Television shows depict the act of smoking marijuana, songs on the radio talk about it, the act of smoking weed has become extremely normalized since the 1970’s and the hippie movement.

This same mentality does not extend across the drug spectrum though. Regardless of the massive admitted
addicts to speed, the drug has not been normalized as marijuana has. The reasons for this are simple; the two drugs are of completely different classes. Copello and Orford (2003) explain,

Over the years, the social environment has played a very minor role in addiction theories that have in the main focused on individual factors (e.g. neuroadaptation, motivation, and self-efficacy). Once the social environment becomes central to the understanding of addiction problems, it is possible to incorporate a wider view of addiction into trainings as well as service planning and provision (p. 1362).

It is obvious that something needs to change in order for adult children of meth users to feel comfortable enough to at least talk about their lives and their pasts. A greater social view or understanding of addiction would definitely help, but that is much easier said than done. It is human nature to question things, life in general, this is why transforming a society to understand a concept that they reject seems inconceivable. But it is here where critical thought begins addiction is rejected because the masses of society can not figure out why a person would
choose to do something to continuously devastate their bodies. The reality is that most people do drugs to escape because they feel beyond repair and done with life anyway. Deeper problems exist below the problems they have with drugs, most addicts will describe extreme stories that they feel drove them to do drugs. In essence addicts explain that they did not know how to handle their life situations, so they made the choice to escape it or avoid reality. In context of the society we live in, the individualist drive rejects this type of hopeless mentality, leaving the gap of misunderstanding. Making issues that are centered around addiction public is extremely important because the various models and views need to be known and understood in their contexts. "How can admitting powerlessness empower someone? How can yielding or surrendering produce strength? Although these ideas may seem contradictory to those of schooled in Western tradition, they have a long history in Eastern philosophy" (Herndon, 2001, p. 8). The traditional Western roots our society has chosen to define as the foundation of our society has made it difficult for alternative views about life to be understood. It is a misunderstanding because ACOSAs do not want to perpetuate the helpless mentality, they simply want to be able to talk about the
fact that they usually don’t understand their addicted family member either. Irvine (1997) explains, “The tendency to moderate intense emotions, to stigmatize unpleasant emotions, and to find non-emotional replacements for negative emotions constitutes the core of contemporary American middle-class ‘emotional culture’” (p. 350).

Drugs and Death

One of the biggest issues that most people cannot comprehend in relation to drug addiction is the relationship it has to death. There have been zero noted deaths attributed to marijuana overdose, but the same is not true of stimulant abusers. CNS stimulants accounted for 46% of total drug-abuse related deaths (Fisher & Harrison, 2000, p. 19).

The researcher feels this is an important issue to raise because the fear of death is a concept that almost all humans will admit to contemplating at least some point in their lives. Everyone has thought about the fact that all life ends at some point, whatever is born must one day die. Death is inevitable but the significance of death plays an important role in the chemically addicted family because the odds of dying are significantly increased.
Whether it is through an overdose, or because of the erratic behaviors that drug induced states often present, families of drug addicts must face the fears of their members' dying. The fear of their members dying is often much deeper than what a so-called normal family might experience, because the possibility of death is always on the forefront. Every time a speed addict goes to snort a line, smoke their pipe, or inject the drug into their veins, they take the risk of dying, on top of the fact that they are slowly killing themselves and damaging their brains.

These are all facts that most people know and acknowledge. Families of addicts know that their addicted members can die at any time, but most of them also believe that there is nothing that they can do about these sad truths. This is often times where the roles of shame and guilt feed into the denial factor that the entire family can help to perpetuate. The denial of the addict is often extended to their family members because they feel shame and guilt about their family member who is addicted to drugs, specifically speed. The shame and guilt contributes to the denial because sober family members often describe a certain loss of control over the addict. This fear of the loss of control is one of the most noted reasons
explaining the cycles of addiction, and how it is constantly being "passed" down from one generation to the next. It seems to be the mentality that is being transferred whether or not any biological factors may also contribute. This loss of control can manifest in many different ways but when sober family members feel they can no longer reason or have a logical argument with their addicted family member, a certain guilt or shame that is connected to the specific drug transpires.

Shame, Guilt, and Denial

Shame and guilt are two primary reasons people choose not to disclose information about the drugs their family members take. "Guilt, once considered unpleasant, but instructive, has become so dangerous as to be avoided if at all possible" (Irvine, 1997, p. 350). By choosing not to disclose this information, sober family members seem to be really harming themselves, because they are allowing the guilt and shame to continue to develop into rationalizations, justifications, and overall denial. Denial is a theme that seems to be tightly woven into the addicted family. By failing to break away from the shame and guilt associated with another person's addiction, ACOSAs can actually work to keep the cycles of addiction
perpetuating. ACOSAs of speed addicts have reported being dishonest and unwilling to be open with others about their family members drug of choice. Individuals who deny the chemical addiction of their family members are not being honest with others and most importantly they are not being honest with themselves. This lack of honesty, or hiding from the truths of reality does not make a healthy foundation to grow and develop as a human.

Summary

The significance of the study lies here: feeling the inability to talk about the life you have led being involved with a speed addict as a family member, does not allow for healthy development mentally, physically, and spiritually. Talking about things individuals have been through helps people know and truly understand who they are. Family members' of marijuana addicts do not seem to experience the same levels of shame, guilt, and denial about their family members habits, and much of this can be attributed to the social contexts and views of the drugs themselves. The chapter explored various implications of the research as well as providing possible reasons for why ACOSAs might choose not to tell people that their family member is addicted to methamphetamines. Reasons for
self-disclosure avoidance or lack of avoidance were discussed between reported speed and marijuana families. Differing social views that exist between the two drugs were discussed, as well as the differences in their basic pharmacological components.
CHAPTER FIVE

CONCLUSIONS

Summary

The research has provided a solid foundation connecting the behavior of talking about family addiction with the theoretical underpinnings involved with substance abuse research. Chapter one addressed the problem and significance of the study.

Chapter two, the review of the literature, covered an extensive amount of information. Conceptual definitions of pertinent terms were provided. The models of addiction: moral, medical, and biopsychosocial lenses for interpretation were presented and explained. In this section, the research also noted that the current study was founded upon biopsychosocial assumptions with regard to addiction studies and beliefs. The family dynamics and connections involved with growing up in a substance abusive home were discussed and defined. The literature review also explained the state of the field concerning research that has focused on adult children of substance abusers (ACOSA) versus adult children of alcoholics (ACOA) and the similarities, differences, and cross-over behaviors. The behaviors that were focused on had an
overall connection that related to self-disclosure and trust. Coping, emotional development, homeostasis, and other familial connection behaviors associated with addiction were also discussed.

Chapter three, methods, took the conceptual definitions that were laid out in chapter two, and operationalized them into variables that measured the intended behavior. The revised self-disclosure scale (RSDS) was the instrument used to measure self-disclosure about family member’s drug(s) of choice. The RSDS was created by Wheeless and Grotz (1977). The individualized trust scale (ITS) was used to measure levels of trust participants felt they needed to talk about their family member’s drug(s) of choice. The ITS was also created by Wheeless and Grotz (1978). The final scale used in the study was the self-disclosure avoidance (SDA) scale, which was created by Rosenfeld (1979). This scale proved to be extremely vital to the study, because it was the only variable that produced a significant relationship to partially support hypothesis number one. The results section discusses significant correlations between the three scales and the relationships or connections across all three. In the methods chapter, data collection
techniques, procedures, instrumentation, participant demographics, and data treatment are discussed.

Chapter four, data analysis, explained the results of the survey and concluded that hypothesis one was partially supported, because levels of self-disclosure avoidance were found to be significantly related to methamphetamine and marijuana abusing families. Significant relationships were not observable between the drug categories and the RSDS or ITS. A discussion section was also included in this chapter which surfaced possible influences.

Conclusions

Family members drugs of choice impact self-disclosure avoidance. The study found that adult children of speed users were much more likely to avoid disclosing which drugs their family members used. Adult children of marijuana addicts proved to be just the opposite as the methamphetamine group; they did not avoid talking about which drugs their family members abuse. The two significant groups were at the opposite ends of the avoidance spectrum when talking about family addiction and the specific drugs.

The choice to avoid talking about past or current life situations is a very important issue because many
people send a great deal of their lives punishing
themselves about issues that are out of their control. As
reported in the literature review, many substance abusive
families feed and perpetuate unhealthy control issues that
do not allow room for growth and development. Because the
biopsychosocial model of addiction is the theoretical
foundation of the research, the assumption came be made
that children raised in substance abusive environments
learn part of their controlling, or lack of controlling
dispositions from their family and surroundings. Unhealthy
models of human behavior that influence development make
it extremely difficult for individuals to know that any
different way of life exists and it is hard to realize
that not all life is as depressing as they have seen.

Choosing to avoid disclosure is just that, a choice,
an active decision to continue the cycles of denial and
the addict mentality. Tactics that were embedded in
childhood usually carry over into adulthood, and there are
masses of people who do not know that they have a choice
to change the ways they live their lives. Communicating on
different levels and self-disclosure can be a cathartic
experience. Storing negative emotions does nothing but
damage, because part of facing the life you have lived and
all that lies ahead depends on being able to talk about
the things you have experienced. Baring the burdens and carrying the shame and guilt of a family members addiction perpetuates the unhealthy mentality of addiction. Choosing not to disclose is on the path of denial, which affects stress levels, mental and physical health. Holding on to shame and denial produces a stress that is unnecessary. Ironically, people aim to control the uncontrollable, and since this cannot be done, they oftentimes inflict unnecessary mental and physical anguish to themselves and others. ACOSAs have the choice to separate themselves from their family members addiction. Everyone that lives in America and in most parts of the World, has the choice to separate themselves, or simply walk away from the addict mentality that revolves around control, shame, guilt, and basic overall pain.

Examining the self-disclosure patterns in this particular population (ACOSAs) is extremely important, because if people cannot talk about their lives in an addictive home, than they are most likely still engaging in mentally unhealthy behaviors that actually affect our entire society. Mental, emotional, spiritual, and physical anguish affect everyone because of the way the American social system is set up. As independent as Americans claim to be, we still end up supporting one another either
through the tax system or other social programs, so why then do we try to make everything so difficult for each other? Talking about drugs should not be such a stigmatizing experience, but obviously it is. Privlege has a great deal to do with this, but ultimately part of the problem talking about drugs seems to be the fear of negative evaluations that accompany the uncontrollable. The fear of the unknown is a heavy issue in addictive households that seems to be part of the reason the cycles and generational affects of drug abuse and addiction continue. Households that seem to do everything they can to control the uncontrollable by taking drugs to numb pain or escape from a reality they do not want to face are actually doing the opposite of what they think they are doing. Avoiding life is wasting life, and choosing to perpetuate the unhealthy mentality surrounding addiction is just as bad. The problem is that until you are aware that something is not right, you simply do not know. If ACOSAs are not aware that they do not have to deny their lives and be ashamed of something that was beyond their control, they do not know the benefits of being able to set those burdens free. Part of facing life and embracing life is being able to effectively communicate about yourself, and who you believe yourself to be. People can
not erase their pasts, even though most people would agree that they would like to forget at least one episode, and since this is true, only two options remain: to face it or keep running away. The options are not a mystery to ACOSAs, but the fear of the unknown is an emotional issue that most often has not been developed. They know the choice is there, but most ACOSAs have never seen a role model take the choice to face the fear of the unknown and face life, instead of the daily methods used to continually avoid it. ACOSAs know that they can either face their pasts and be able to talk about it, or they can keep avoiding parts of their lives, and continue denying or avoiding everything altogether.

Research Limitations

The sample size is the biggest limitation of this research. Although every drug of choice category, except hallucinogens, had responses they were limited in number. For instance, participants who had responded that heroine was their family members drug of choice registered only four in numeric representation. Adult children of heroine abusers should not be generalized and could not be generalized according to these four people. These four
people are a part of the same group, but do not represent the masses of adults whose parents were heroine users.

Another limitation of the current study is the fact that it was conducted over the internet. Although the internet can be seen as an advantage to researchers because it allows people from all over the world to communicate, network, and contact can be made with people you would have otherwise never met, the internet also has its flaws. The internet can be seen as a limitation of this research, because the sample of ACOSAs, are only representative of those who have access to the internet. Although the internet is almost universal in the academic realm, it is not everywhere. This research views the internet as both a benefit and a limitation, future researchers should take this into consideration.

Recommendations

Future research should try to address the power of choice and examine if ACOSAs are even aware that they have a choice not to be ashamed and miserable about things that were completely out of their control in the first place. Therapy and other types of therapeutic outlet usually inform people that they have the power to change their own lives. A very interesting study would be to inquire about
whether ACOSAs feel they have a healthy role model for understanding and coping with emotional issues that life presents. It would be interesting to see if ACOSAs feel they have ever seen one of their family members make the choice to live differently and choose to make a conscious decision to be happy for an extended period of time.

Other research in this area should examine the differences between adult children of alcoholics (ACOA) and adult children of substance abusers (ACOSA), because they have a great deal of similarities, but ultimately are two extremely different groups of people. The research on both groups is relatively slim considering the number of people who actually fit the description, but most of it clumps all children of addicts into one pretty dysfunctional mold. Just as the drugs affect the users differently, the ultimate result or product if you will, of their children is that they are complexly different.

A great deal of economic revenue in this country is from the alcohol industry and it has become naturalized or normalized, and illicit drugs are no where near this level of social acceptance. The stigma does become attached to the drug abuser which either becomes transferred consciously or unconsciously to the child, regardless,
children of drug users feel they are of a different population than children of alcoholics.

Research conducted in the addictions field focusing on the immediate family members is extremely important because most people in society especially in the academic realm, are completely unaware of the problems that exist and continue to grow. Forcing awareness is one of the first steps that needs to be taken to reinforce healthy change.
REFERENCES

Ackerman, R. J. (1987). Same house, different home: Why adult children of alcoholics are not all the same. Pompano Beach, FL: Health Communications.


