1994

The influence of parental alcohol abuse on later adult functioning

Jeanne Randle Hogan

THE INFLUENCE OF PARENTAL ALCOHOL ABUSE ON LATER ADULT FUNCTIONING

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

Psychology

---

by

Jeanne Randle Hogan

June 1994

THE INFLUENCE OF PARENTAL ALCOHOL ABUSE ON LATER ADULT FUNCTIONING

A Thesis

Presented to the

Faculty of

California State University,

San Bernardino

---

by

Jeanne Randle Hogan

June 1994

Approved by:

[redacted]

Faith McClure, Chair, Psychology

5/25/94

Date

[redacted]

Yu-Chin Chien

[redacted]

David Chavez

ABSTRACT

The coping styles and cognitive and psychological adjustment of adult children of alcoholics (ACAs) were examined in this study. A sample of ACAs was compared to adults who came from families in which alcohol was not abused (nonACAs). These groups were distinguished on the basis of their responses to the Children of Alcoholics Screening Test. The subjects' world views (Janoff-Bulman World Assumptions Scale), current coping styles (Lazarus & Folkman Ways of Coping Scale), current levels of anxiety (Speilberger State Anxiety Inventory), and depression (Beck Depression Inventory) were assessed. It was hypothesized that growing up in an environment in which alcohol was abused would influence adult functioning negatively. Specifically, it was hypothesized that ACAs would report more depression and anxiety than nonACAs. Additionally, it was hypothesized that the ACAs would see the world and people as more malevolent and themselves as having little control over outcomes when compared to nonACAs. It was also expected that ACAs would report lower levels of self-worth and use of avoidant coping strategies more often than nonACAs. Moreover, it was anticipated that ACAs would be less likely than nonACAs to use support seeking or problem-solving coping styles. A multivariate Analysis of Variance (MANOVA) was used to evaluate the group differences on each of the

outcomes. The results support the hypothesis that ACAs would report greater depression and anxiety than nonACAs. Furthermore, ACAs were found to utilize avoidant coping style more often than nonACAs. However, the groups did not differ from each other in the use of other coping styles.

Finally, there were no differences between the groups on any of the world assumptions outcomes.

These results are interpreted in terms of the impact of parental alcoholism on later psychological functioning and coping in their offspring.

ACKNOWLEDGMENTS

I have been very fortunate to have had excellent mentorship. I would like to thank Dr. Les Herold for guiding my work and my interest into the clinical field. I would also like to express my gratitude to Dr. Faith McClure for being endlessly supportive, instructive and kind throughout the last two years and for whom I have the deepest respect.

I also wish to extend my appreciation to Dr. David Chavez and Dr. Yu-Chin Chien who have been unfailingly accessible for rewrites, comments and changes in the thesis process.

My indebtedness is immeasurable to the carpool, Robin William and Jeanie Kieley, without whom I would have felt emotionally impoverished during the long and arduous journey through the masters program.

I also want to thank my daughter, Malia, for being independent and understanding when I was too busy to be a mom and whom I love dearly.

I would like to acknowledge my friends Noreen, Pamela and Sherri for their support, love and friendship.

And finally I wish to express my appreciation to my husband, Tim, for the financial support without which I could not have realized my dream.

TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

The effects of parental alcohol abuse are a far reaching and pervasive problem. The consequences of parental alcohol abuse on children require further study, however. It is estimated that there are seven million children in this country under the age of 18 living with an alcoholic parent, according to the report of the Children of Alcoholics Foundation (Stark, 1987). In addition, it is estimated that there are 21 million adult children of alcoholics in the United States.

Depression and Anxiety

It has been established that adult children of alcoholics (ACAs) are at greater risk for alcoholism themselves (Johnson, Sher & Rolf 1991). This may be due in part to the heritability of alcoholism, the coping models provided by the alcoholic parent, and/or by the lack of attention and nurturance experienced by these children. However, other, intra-psychic problems are also presumed to occur more frequently among adult children of alcoholics (Emshoff 1990, Roosa, Sandler, Gehring, Beals & Cappo, 1987, Stark, 1987, Hibbard, 1989, Wilson & Orford 1978, Jarmas & Kazak, 1992). For example, depression and high levels of anxiety are often reported among these ACA individuals when compared to other adults who did not grow up in alcoholic homes (Von Knorring, 1991). In one study, Lipman (1990),

found that the group of ACAs was significantly more depressed (as measured by the Zung Self-Rating Depression Scale) than a comparison group of nonACAs. Further, Lipman found that this degree of depression was clinically significant. Haack (1990) has speculated that ACAs are one of the groups at high risk for the development of anxiety and depressive disorders. She theorized that the nature of the ACA's childhood family environment may lead to a higher need for control and this, in turn, may be a predisposing factor for the development of anxiety disorders in this population. Haack further suggests that appropriate psychotherapeutic intervention, coupled with effective pharmacologic medication can lead to a reduction of the deleterious consequences of growing up in an alcoholic home. In an analogous study done by Post, Webb and Robinson (1991) ACAs were again found to be significantly higher in anxiety levels than nonACAs. In this study the Children of Alcoholic Screening Test (CAST) was used to differentiate children raised by an alcoholic parent from children who were not raised by an alcoholic parent. Anxiety was measured in this study by use of the State-Trait Anxiety Inventory. Results of this study indicated that among female ACAs there was a significantly higher degree of anxiety. A high negative correlation between self-esteem and anxiety was also found for the female ACAs. Male ACAs

did not appear to be as significantly anxious. These findings suggest that there may be gender differences which may result from female ACAs' greater need for familial identification and a higher personal sensitivity to the destructive aspects of parental alcoholism. Thus, while male ACAs may distance themselves, female ACAs may become overly involved or invested in the dysfunctional family members.

Another study that explored the results of growing up in an alcoholic environment was completed by Williams and Corrigan (1992). These researchers found that the only group of people who scored higher on depression and anxiety than ACAs were the group of adult children raised by mentally ill parents. The impact of parental pathology was observed to be diminished, however, if the child had a large or satisfactory social support system. It was suggested that further research should include such variables as the child's psychological developmental stage at the time of the parents' substance abuse.

Similarly, Tweed and Ruff (1989) examined the psychological adjustment of ACAs and noted that ACAs differed from nonACAs in their levels of depression and anxiety. In this study, multiple aspects of functioning were assessed, including psychological well-being, emotional distress, personality characteristics and physical

development. The ACA population was not found to differ significantly from the nonACA population on any of the personality profiles or on other multiple indices of psychological well-being, personality characteristics or personal development. The only differences rested in the elevated levels of depression and anxiety in this (ACA) group compared to the group of same-age peers. In order to deal with the chaos and uncertainty experienced in many of these alcoholic homes, children learn to cope in a variety of ways.

Coping

There are many family environmental factors that differ in alcoholic compared to non-alcoholic homes that may influence offspring of alcoholics to develop some inappropriate coping strategies which could be harmful to the individual in childhood or in later life. This maladaptive behavioral, emotional and cognitive functioning was the focus of a literature review done by Bennet, Wolin and Reiss (1988). These researchers, in evaluating the literature, found that parental alcoholism was strongly linked with behavioral disorders in their offspring such as attention deficit disorder or impulsivity-hyperactivity. Clinicians and researchers have long suggested that chaotic, unstructured environments increase the risk for poor attention and poor impulse control. The exact mechanisms by

which this develops are unclear but may represent an (ineffective) attempt by the child to cope with his/her chaotic environment. Bennett and his collaborators (1988) further noted two interesting trends. First, a connection between children, especially boys, of alcoholics and this increased risk of exhibiting behavioral problems in childhood and adolescence. Secondly, that having a behavioral problem in childhood seems to place the child at increased risk for alcoholism later in adulthood. It is possible that not attending and acting out impulsively provides a form of escape or avoidance for this child and that these coping strategies are, in fact, dysfunctional and over the long term have a negative impact on functioning. Children raised under these conditions may fail to learn appropriate problem-solving strategies and so later in life may resort to alcohol when faced with high socio-environmental demands.

Some ACAs cope differently from the pattern just described and tend to focus intensely on academics and excel in that arena. Hinz (1990) hypothesized that excelling in school was a coping mechanism that allowed these children to feel good about themselves outside of a difficult family situation. It is also possible that academic excellence allowed them to focus on something outside of their family situation. However, although ACAs reported fewer academic

difficulties, they did report more personal problems. Thus, although the strategy of focusing on academics had some positive effects, these children continued to be vulnerable to some psychological problems. ACAs, in fact, reported significantly more concern than nonACAs with interpersonal anxiety, depression, and family problems. In a similar study done by Bingham and Barger (1985) using a group treatment approach for latency age children, they found that some children were more distressed by the disharmony, parental rejection, and fears of abandonment that they experienced than they were by the parents' drinking itself. In order to defend against the feelings of shame and inadequacy these children experienced, they made extraordinary achievements in the external world by succeeding in the academic arena.

Calder and Kostyniuk (1989) asked the alcoholic parent to assess the degree of damage his or her child had sustained as a result of the alcoholic drinking that occurred in the home. The parent was given an instrument in which to report the amount and type of damage that he or she perceived the child had sustained. All of the subjects had children under the age of 17 and the results indicated that there were significant differences between the children of alcoholics and a normative population on several of the scales. Specifically, the results suggested that the

alcohol use contributed to more depression, disrupted family relations, and increased the delinquency and withdrawal of these children. In addition, there was a trend toward higher somatic concerns, anxiety and psychosis in the children of alcoholics. Of particular significance here is the withdrawal observed in these children which may represent use of avoidance as a coping strategy.

A study done by Scavnicky-Mylant (1990) attempted to describe the coping behaviors of 30 young ACAs. Based upon retrospective recall, subjects were asked to enumerate what methods of coping and role behaviors they could identify with at different ages. They were asked to visualize themselves during a specific age period and to describe themselves in relationship to their families. The results indicated that the majority of coping methods fell into three primary categories: confrontive, emotive, and palliative. Confrontive (or problem-focused) coping was defined as an attempt to change the actual stressor. Emotive (or emotion-focused) coping was defined as a method used to regulate one's emotional response to a stressful situation, employed in situations perceived to be unchangeable or chronic. A palliative coping style included such behaviors as ignoring the situation, praying, and hoping the situation would change. In general, the earlier the retrospective memory, the higher the likelihood that

emotive or palliative coping strategies were used. Confrontive coping styles were used when the child got older (middle childhood to young adult periods) and usually with the help of therapeutic intervention in the form of 12-step recovery groups or personal psychotherapy. These findings suggested a that a developmental delay in the area of coping behaviors among young adult children of alcoholics may have occurred, but the current functioning of these ACAs was left unaddressed by this study.

Other issues related to different coping strategies used by ACAs compared to nonACAs were investigated by Protinsky and Ecker (1990). These researchers hypothesized that ACAs would differ from non-ACAs in the way they coped with intimacy, triangulation and individuation. It has formerly been assumed that there is a clear linkage between an individual's present emotional life and his or her previous experience in an alcoholic home environment. Protinsky and Ecker administered measures to test intimacy levels, individuation and triangulation among these subjects, and found that there was a significant difference between ACAs and nonACAs in all three measures. Specifically, the results indicated that ACAs experienced less intimacy and less triangulation with parents than did nonACAs. Further, it was discovered that ACAs experienced greater levels of fusion (lower levels of individuation)

with parents than did nonACAs. These findings are consistent with Bowen's (1978) intergenerational family theory which suggests that there will be less intimacy with parents when a dysfunctional alcoholic home is in process. It could be that children in these families lack models of healthy ways of relating interpersonally. It is also possible that they do not establish close interpersonal relationships as a self-protective coping strategy. This form of coping might be viewed as "avoidant" and although it can have short-term protective qualities, may cause problems later when these individuals are faced with young adulthood where the major developmental task is the establishment of intimacy (Erickson, 1951).

The use of avoidant coping mechanisms can take many forms. Susan Balis (1986), in a clinical overview of ACAs noticed that silence was used by many ACAs in order to avoid problems or stressors. "There are profound silences in an alcoholic home...silence can transmit deafeningly loud messages while verbal communication often conceals more than it reveals, confuses rather than clarifies, creates distance between people rather than bringing them closer" (p. 83).

The issue of using avoidance as a coping strategy is also implied by the research of McCown, Carise, and Johnson (1991). These researchers have suggested that children who grow up in dysfunctional families develop "trait

procrastination" which they defined as habitual difficulty in completing life tasks in a timely fashion, evident in more than one social environment. This coping strategy has been shown to correlate negatively with school performance and life satisfaction, and positively with interpersonal distress and anxiety as well as low self-esteem. It was hypothesized by these researchers that children of problem drinkers may have learned to avoid responding to required behavioral tasks in order to minimize fears of unreasonable parental criticism. Procrastination for such children may be a form of adaptive coping in the short-term but the long-term consequences may be negative. Regarding the procrastination hypothesis, Flannery (1986) has noted similarities between adult children of alcoholics and animals that experience laboratory-induced "learned helplessness." This feeling of being unable to control events in which learned helplessness is the outcome has important implications for self-esteem. This suggests that over the long term this "procrastination" or "avoidance" could contribute to psychological distress, particularly depression.

Finally, the research suggests that children who develop a "problem-solving" coping strategy, rather than using avoidant or procrastination styles, may have better outcomes than those who don't. Bennet and his collaborators

(1988), in their review of the literature, noted that the risk of behavioral problems in childhood and alcoholism in adulthood was lower among those who showed higher levels of "deliberateness" which essentially involves the ability to plan and act on that plan.

ACAs and Self Esteem

Self esteem, according to Reber (1985), refers to the degree to which one values oneself. Many components go into the process of rating oneself either high or low on the esteem scale, and most of these processes are subconscious, many occurring before the age at which the cognitive ability to understand is formed.

Identity development, even in the first months and years of an individual's life, can be adversely affected by parental alcoholism. Important messages are imparted to children regarding their self-worth and their ability to take control of present and future life events. These messages can play an important role in the extent to which a parents' offspring are protected from developing problems in childhood, as well as alcoholism in adolescence and adulthood.

There are some intervening factors, however, that lessen the risk of the offspring of alcoholics experiencing childhood behavioral problems and/or becoming alcoholic themselves in later adulthood. One of the major factors

reported by Bennett, Wolin and Reiss (1988) which seems to reduce these risks is the child's (and later the adult's) ability to act (a behavior) on a plan (a cognitive phenomenon). This might then result in a sense of accomplishment and might represent a way in which a child could develop self-esteem. It was found by Bennett and his collaborators that families who exhibited a highly developed level of deliberateness communicated an important message to their children regarding self efficacy and the child's ability to take control over his/her behavior in successfully meeting difficult challenges in life, and therefore building his/her self esteem. Possessing the knowledge that one has personal control over one's behavior is especially relevant to lifelong alcoholism patterns and may serve to moderate whatever biological predisposition children of alcoholics inherit which places them at increased risk for this malady. This sense of control, in addition to other personal accomplishments, such as academic achievement, are believed to be mediating factors in these ACAs self perception and appear to be esteem building.

However, much of the time the atmosphere in alcoholic homes is characterized by a chaotic imbalance of conditions that result in an impoverished environment with inadequate gratification of esteem needs (Bingham 1985). Compounding the problematic family atmosphere in these families, is the

secretive nature of alcoholic drinking. The child in this alcoholic family system faces grave consequences such as, parental disapproval or punishment, peer rejection, and/or the potential destruction of the integrity of the family if he or she risks telling anyone about his or her home life. This is an example of a family system in which the child cannot concentrate on the developmental tasks that are appropriate for constructing a healthy self concept. The solutions most often utilized by ACAs are diverse, but they follow a trend. Some children look for external solutions to feel good about themselves. They become "super-achievers (Stark, 1987) in order to tackle the world outside, instead of working on the problems inside. Other children take on the "scapegoat" role (Black, 1986) and get into trouble. The result is the same for "super-achievers" as for children who become juvenile delinquents, both groups have low self-esteem.

Emshoff (1990), in his literature on ACAs found a correlation between low self-esteem and a lack of friends, depression and a lowered internal locus of control. Jacobs (1991), in her review of the literature, found that there was a positive correlation between the control of both external and internal events with a high self-concept. Jarmas and Kazak (1992), in their study of ACAs and coping styles, found that the family atmosphere of ACAs is

characterized by high levels of conflict and tension, poor communication, interpersonal isolation, a high achievement orientation, strict control, unclear organization, a lack of trust and inconsistency or unreliability, thus, setting up the ACA for a life of depression and low self-esteem.

Werner (1985) found that one of the mediating factors that differentiated offspring of alcoholics who did and those who did not develop serious coping problems in adulthood was a positive self-concept. In another study done with ACAs, Williams and Corrigan (1992) found that self-esteem scores were considerably lower for subjects who came from an alcoholic environment than for subjects who did not. Similarly, McNeill and Gilbert (1991) found that ACAs who were more external in their locus of control (eg. subjects who looked outside of themselves for solutions) had lower self-esteem scores on the Rosenberg Self-esteem Inventory. Finally, Post, Webb and Robinson (1991) found a significant correlation between anxiety and low self-esteem in female ACAs.

It appears that the importance of developing a positive self-concept is very difficult to achieve in the chaotic atmosphere of an alcoholic home. Wilson and Orford (1978) report that compared with a control group, ACAs have been found to show a higher incidence of school problems, difficulty in concentrating, conduct problems and truancy

from school, poor school performance, elevated rates of emotional problems such as anxiety and depression and fewer means of coping with emotional upset. ACAs, it seems, have been given more than their share of obstacles to deal with and less than their share of coping abilities to manage them with.

ACAs and World Views

The definition of 'world views' could be described as a group of unchallenged assumptions that cumulatively add up to the way in which an individual analyzes his or her own personal experience of people, themselves and the world. One resulting paradigm can be considered a benevolent or a malevolent experience regarding other people, the self and the world. Findings suggest that people's assumptive worlds are affected by traumatic events (Janoff-Bulman 1989), the impact of which is still apparent years after the negative event occurred. It can be presumed then, that ACAs possess a strongly held set of assumptions about the world and themselves which they consistently maintain and use as a means of planning, recognizing and acting in daily life. These are assumptions that have been learned and confirmed by the experience of many years. Furthermore, once a world assumption is firmly in place, it is very difficult to dislodge. People generally discount or misperceive

incongruent data so as to allow for the continued utility of their basic world assumptions (Janoff-Bulman, 1989).

Personality theorists suggest that a sense of safety and security may be fundamental to the healthy personality and is first developed very early in childhood through responsible, predictable interactions with caregivers (Bowlby, 1969). This basic sense of safety and security can be said to be composed of the dimensions: 1) perceived benevolence of the world and the self; and 2) worthiness of the self (Janoff-Bulman, 1989). Without the foundations of safety and security, children may learn to view the world and people as unsafe or malevolent.

Wilson and Orford (1978), in their review of the literature, found that parental violence was a frequently reported event in homes in which alcohol was misused, and violence toward children was almost as frequently reported. Similarly, Post, Webb and Robinson (1991) reported greater dysfunction, less cohesion, greater conflict, more abuse and more parental arguments in alcoholic families. Correspondingly, Protinsky and Ecker (1990) reported less intimacy with parents, encouraging offspring to prematurely separate from the family and to closely identify with peers when parental alcoholism was present in the home.

Although there is a growing body of research on the impact of parental alcoholism on emotional functioning,

there is relatively less on how this impacts the ways in which these children view the world from a cognitive perspective. Some investigators have examined locus of control in ACAs since the lack of stability and order in these homes can impact the child's sense of personal control over events. McNeill & Gilbert (1991) investigated whether college students from alcoholic homes (a home in which at least one parent is alcoholic) were perceived to be more external in locus of control than their peers. The results indicated that having a parent who drank heavily was significantly correlated with external orientation. External orientation also correlated positively with depression. Finally, a negative relationship between external orientation and level of self-esteem and possible-self (ie., ideal self) emerged. Presumably, it is the conditions that arise as a result of alcoholism that cause the problems for children and not the alcoholism per se. The findings of higher levels of depression and anxiety and lower self-esteem in ACAs may in fact be mediated by a cognitive perspective which is characterized by a minimal sense of control over events.

Clearly, the need for more research on how ACAs make sense of their life experiences and how these experiences impact their views of others and the world is needed.

Summary

The research thus suggests that ACAs may experience more anxiety and depression than nonACAs. It also suggests that the familial environment may also impact coping strategies and how these children come to view themselves and the world although research on these issues is still rather sparse.

Goals of This Study

The purpose of the present study was to assess the influence of parental alcohol use on the psychological and cognitive adjustment of ACAs. Specifically, self esteem and views of self, the world and others, coping strategies, and levels of depression and anxiety were evaluated. The findings for adult children of alcoholics were compared to those of non-adult children of alcoholics. These groups (ACAs and nonACAs) were distinguished on the basis of their responses to the Children of Alcoholics Screening Test (CAST). The subjects' responses to the CAST allowed us to classify them into three groups: ACAs (at least one parent abused alcohol), ACPDs (adult children of problem drinkers) and nonACAs (neither parent abused alcohol).

Hypotheses

It was hypothesized that a) ACAs would show higher levels of depression and anxiety than ACPDs, who would, in turn, show higher levels of depression and anxiety than non-

ACAs; b) ACAs would report lower levels of self-worth than ACPDs, who would, in turn, report lower levels of self-worth than nonACAs; c) ACAs would see the world and people as more malevolent than ACPDs, who would, in turn, see the world and people as more malevolent than nonACAs; d) ACAs would report lower levels of control over events than ACPDs, who would in turn report lower levels of control over events than nonACAs; e) ACAs would utilize more avoidant coping strategies than either ACPDs or nonACAs; and f) nonACAs would utilize more support seeking and problem-solving strategies than either ACPDs or ACAs.

METHOD

Design

A single-factor, between subjects, multivariate, quasi-experimental design was adopted in this study. The independent variable was the subject's category based upon the degree of parental abuse of alcohol. There were three levels of the independent variable: 1) ACAs (at least one parent abused alcohol), 2) ACPDs (adult children of problem drinkers) and 3) nonACAs (neither parent abused alcohol), to which the subjects were assigned based upon their responses to the Children of Alcoholic's Screening Test (CAST). Subjects who scored 0 or 1 on the CAST constituted the non-ACA group, subjects who scored between 2 and 5 on the CAST constituted the ACPD group and those who scored 6 or more constituted the ACA group. The dependent variables included 1) levels of depression, as measured by the Beck Depression Inventory; 2) levels of anxiety, as measured by the Spielberger State Anxiety Inventory; 3) coping style (avoidant, problem focused, and social support seeking) as measured by the Folkman and Lazarus Ways of Coping Scale; and 4) cognitions, including level of self-worth, sense of control over events, and views of others and the world as benevolent or malevolent, as measured by the Janoff-Bulman World Assumptions Scale.

Subjects

The total sample consisted of 236 undergraduate students. Of these, 21 of the sample surveys had missing data and were not included in the analyses. Of the remaining 215 surveys, 82 subjects were classified as ACAs, 16 as ACPDs and 117 as nonACAs according to the CAST. Due to the small number of subjects (16) being classified as ACPDs, these subjects were excluded from further analysis. Of the 199 subjects that remained in the sample, 27% were men (54) and 73% were women (145). These subjects were recruited, on a volunteer basis, from California State University at San Bernardino undergraduate psychology classes and were offered extra credit for participation. They were between the ages of 18 and 55 years with a mean age of 26 years and 6 months (SD = 8.8).

Several ethnic groups were represented with Whites comprising 59% of the sample, Hispanics comprising 16%, Asians/Pacific Islanders comprising 11%, African Americans comprising 7%, Native Americans comprising 1%, and 6% of the respondents categorizing themselves as 'other'.

Most of the subjects came from families whose parents were employed in professional, managerial or highly skilled occupations (80.5%).

The annual family income of the sample was relatively high with only 1% of the respondents reporting a yearly

income of less than $15,000. The largest group, 76% identified their income as between $25,000 and $55,000, while 23% stated that their income is in excess of $55,000 per year. This annual income level is consistent with the high occupational and educational level of this sample in general.

Materials

A questionnaire format was used to gather the data for the study. The questionnaire consisted of five assessment scales and a demographics section (see Appendix A).

The demographics section included questions about socio-economic status (SES), ethnicity, gender, and age of the subject. The rest of the measure consisted of five self-assessment measures: 1) Children of Alcoholics Screening Test; 2) State Anxiety Inventory; 3) Beck Depression Inventory; 4) Ways of Coping Scale; and 5) World Assumptions Scale.

Children of Alcoholics Screening Test (CAST). The CAST was developed by Jones (1982) to aid in the identification of children of alcoholics. This screening instrument can be used to psychometrically identify children who are living with, or have lived with, alcoholic parents. The CAST is a 30-item inventory that measures children's feelings, attitudes, perceptions, and experiences related to their parents' drinking behavior.

The CAST can be used to identify latency-age, adolescent, and adult children of alcoholics. The CAST is a "Yes", "No" inventory where all "Yes" answers are tabulated to yield a total score from 0 (no experience with alcohol abuse) to 30 (multiple experiences with parental alcohol abuse). As mentioned previously, individuals who scored 6 or more were regarded as children of alcoholics (ACAs). Those who scored between 2 and 5 were to be considered children of problem drinkers (ACPDs), but given the small number of these, they were excluded from further analysis. Finally, those who scored either 0 or 1 were considered children of non-problem drinking parents (nonACAs).

The CAST has a reliability coefficient of .98 (Jones, 1983). A chi-square analysis, comparing scores of 82 children of diagnosed alcoholics combined with 15 self-reported children of alcoholics with 118 controls, revealed that the 30 items significantly differentiated children of alcoholics from the control group (Jones 1983).

State Anxiety Inventory. This scale was developed by Spielberger, Gorush and Lushene (1970) as a self-report measure of trait and state anxiety in normal individuals as well as those with anxiety disorders. It is a 40-item inventory with 20 items related to state anxiety and 20 items related to trait anxiety. For this study, the 20 items related to state anxiety were used. Subjects were

asked to rate statements indicating how they feel on a 4-point scale ranging from almost never (1) to almost always (4). The score range for the state items on the Anxiety Inventory is 20 to 80. Speilberger's scale is one of the most frequently used self-report measure in the assessment of subjective anxiety and is reported to have good internal consistency (alpha = .90) and test-retest reliability (r=.65 to .86) in various studies.

Beck Depression Inventory. The Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock, and Erbaugh, 1961) is a 21-item self-report measure of the intensity or depth of depression. The final BDI score represents a combination of the number of symptoms endorsed by the subject and the severity of each symptom with a range of 0 to 63. The BDI has high internal consistency and discriminant validity (Beck, 1970). It has been shown both in student and psychiatric samples to have a high convergent validity with psychiatric ratings of the severity of depression (Beck, Ward, Mendelson, Mock & Erbaugh, 1961). The BDI is considered to be a sensitive screening device for current symptomology. It has a split-half reliability coefficient of .86. When clinicians ratings of the depth of depression were correlated with BDI scores, validity correlations ranged from .65 to .67 (Beck et al, 1961).

Ways of Coping Scale. This scale was developed by Lazarus and Folkman (1984) and revised by Vitaliano et al. (1985), to assess the methods employed by individuals to cope with everyday stressors. The Ways of Coping Check List (WCCL) contains five scales: Problem-focused ("made a plan of action and followed it"), Wishful Thinking ("wished you could change the situation"), Seeks Social Support ("talked to others and accepted their sympathy"), Blamed Self ("felt responsible for the problem"), and Avoidant ("refused to believe it happened"). The items in each scale are scored on a 4-point Likert-type scale with 1=not used, 2=used somewhat, 3=used quite a bit and 4=used a great deal. The internal consistency has a mean alpha of .82. The scale was normed on a population of 570 subjects who were at the time of the test administration experiencing a stressful event. The scale was shown to be reliable across three different samples.

World Assumptions Scale. This scale, developed by Janoff-Bulman (1989) is useful in gauging how subjects view themselves, the world and others. The scale contains 32 statements measured on a six-point Likert type scale representing eight world assumptions, namely: the benevolence of the world (BW) (taps whether the world is experienced as kind or is experienced as malevolent), the benevolence of people (BP) (assesses whether people, in

general, are considered kind or benevolent), justice (J) (assesses whether the world is experienced as a fair or an unfair place to live), controllability (C) (assesses whether people can control their world by behaving in a proscribed and controlled manner), randomness (R) (assesses whether the individual experiences events as occurring randomly), self-worth (SW) (assesses whether the person's self-concept is positive or negative), self-controllability (SC) (assesses the individual's perception of whether or not it is possible to avert disaster by personal actions), and luck (L) (assesses whether or not the individual views events as really beyond their control). For this study, the concepts that will be used are those that measure benevolence of the world and people, controllability and self-worth. The six-point Likert type scale has endpoints of "strongly agree" (6) and "strongly disagree" (1). Scores on each of the subscales are summed to obtain ratings for each assumption. Factor analyses revealed that the internal consistency for this instrument is very good. Reliabilities obtained for this instrument range from .66 to .76. The scale was normed on three different populations of over 500 subjects, both male and female and is considered to be a very sensitive instrument for measuring a person's world assumptions following the occurrence of an aversive event.

Procedure

An announcement was made during classes in undergraduate psychology courses at California State University at San Bernardino requesting volunteers to participate in a psychology research project. Volunteers were told that all answers were confidential, and only group data would be used in the study. Subjects were asked to sign an "informed consent" (see Appendix B) form, which described the study and the voluntary nature of their participation. After signing the informed consent sheet, the volunteers were given a questionnaire which included the demographic questions and the instruments previously described. The subjects were asked to answer each item as truthfully as possible. The volunteers were treated according to the Ethical Guidelines for Psychologists (APA, 1992) at all times. The questionnaires were taken home and returned at a later time. The subjects were given a debriefing statement (see Appendix C) at that time, informing them as to the purpose of the study, the anticipated date of completion and treatment resources. In addition, information concerning how to obtain a copy of the results was provided. Extra credit slips were given to each volunteer upon completion, as a "thank you" for participating in the study.

RESULTS

Originally, the study was designed to compare Adult Children of Alcoholics (ACAs) with Adult Children of Problem Drinkers (ACPDs) and Adult Children on non-Alcoholics (non-ACAs) on depression, anxiety, self worth, world views and coping strategies. However, due to the small number of subjects fitting the category of ACPD, analyses were conducted comparing ACAs with nonACAs and those fitting the ACPD category were eliminated.

Three Multivariate Analyses of Variance (MANOVA) were run comparing ACAs to nonACAs on the following dimensions: 1) depression and anxiety, 2) self-worth, world views (specifically benevolence of the world and people) and control over events, and 3) coping strategies (specifically, avoidant, problem focused and social support seeking. Three MANOVAs were run rather than one to retain as many of the subjects as possible for each analysis. Note that the number of subjects in each MANOVA differs slightly - this is due to incomplete data on some of the questionnaires. The results of the analyses are summarized as follows:

Anxiety and Depression

The results of the MANOVA comparing ACAs with nonACAs on anxiety and depression are shown in Table 1.

A significant difference between ACAs and nonACAs was detected for anxiety $F(1,195) = 5.35$, $p < .05$ and for

depression $F(1,195) = 4.79$, $p < .05$. As can be seen in Table 1, ACAs reported higher levels of anxiety and depression than nonACAs.

Coping Styles

The results of the MANOVA comparing ACAs to nonACAs on coping styles (problem focused, social support seeking and avoidant) yielded a significant between group difference for use of avoidance as a coping style $F(1,190) = 10.45$, $p < .01$. The groups did not differ in their use of the other coping styles. As can be seen in Table 2, ACAs used avoidance as a coping style more often than nonACAs.

World Assumptions

The results of the MANOVA comparing ACAs to nonACAs on the world assumptions dimensions of self-worth, world benevolence, benevolence of people, and control over events, did not indicate any significant differences between the groups. As can be seen in Table 3, ACAs and nonACAs held similar beliefs about the benevolence of people, benevolence of the world, self-worth and control of events.

Table 1

Mean Differences Between ACAs and nonACAs on Depression and Anxiety

		Group Assignment			
		ACAs (N = 80)		nonACAs (N = 117)	F
Depression	M	9.39	M	6.87	4.79 *
	SD	7.96	SD	7.88	
Anxiety	M	42.75	M	38.55	5.35 *
	SD	12.52	SD	12.26	

* $p < .05$

Table 2

Mean Differences Between ACAs and nonACAs

on Coping Styles

	Group Assignment				
	ACAs		nonACAs		
	(N = 82)		(N = 110)		F
AVOIDANT	M	2.36	M	2.07	10.45 *
	SD	.53	SD	.65	
PROBLEM FOCUSED	M	2.17	M	2.09	
	SD	.52	SD	.61	
SEEKS SOCIAL SUPPORT	M	1.86	M	2.00	
	SD	.74	SD	.76	

* $P < .05$

Table 3

Mean Differences Between ACAs and nonACAs on World Assumptions

		Group Assignment		
		ACAs		nonACAs
		(N = 76)		(N = 118)
BENEVOLENCE OF PEOPLE	M	13.78	M	13.64
	SD	2.41	SD	2.65
WORLD BENEVOLENCE	M	16.25	M	16.00
	SD	4.53	SD	3.01
SELF WORTH	M	11.05	M	11.12
	SD	2.90	SD	3.01
CONTROL OF EVENTS	M	14.54	M	13.65
	SD	3.99	SD	3.76

DISCUSSION

The purpose of the present study was to examine the influence of parental alcohol use on later adjustment in college students. Specifically, ACAs were compared to non-ACAs on their current levels of depression and anxiety, their views of themselves, the world and others, and the type of coping strategies they used in childhood.

The results of this study provided clear support for the hypothesis that ACAs would report higher levels of anxiety and depression than nonACAs. These findings are consistent with those reported in the literature. For example, Johnson, Sher and Rolf (1991) in their literature review, stated that ACAs were more likely to experience problems with anxiety and depression. Similarly, Emshoff (1990), Roosa, Sandler, Gehring, Beals and Capo, (1987), and Von Knorring, (1991) found anxiety and depression to be common problems for ACAs. Other studies with college students (eg. Williams & Corrigan, 1992) and with high school students (eg. Roosa et al., 1988) also suggest that anxiety and depression may be long term sequelae for individuals who grow up in alcoholic families. The robust nature of these findings suggests that there exists a need to intervene early with offspring of alcoholics to prevent long term psychological distress.

In this study, the hypothesis that ACAs would show lower levels of self-worth was not supported. This is contrary to some of the literature which suggests that ACAs may have lower levels of self esteem than those who did not grow up in alcoholic homes (Williams & Corrigan 1992). However, conflicting results were found by other researchers. Jacobs (1991), for example, found no differences in self-esteem scores between ACAs and nonACAs. The reasons for this are unclear, and the inconsistency in the research is particularly puzzling since the literature consistently shows greater dysfunction, less cohesion, greater conflict, more abuse and more parental arguments in alcoholic families (Black, Bucky, & Wilder-Padilla, 1986). All of these variables have been highly correlated with feelings of low self-worth and anxiety.

The positive findings of this study have some beneficial implications for the large group of individuals who come out of alcoholic homes. The label "ACA" can have negative connotations for some people, but the results found in this study indicate that low self-esteem does not have to be a consequence of being an ACA. One explanation for the fact that many of these subjects appear to have surmounted the more negative aspects of coming out of an alcoholic home could have to do with the fact that this was a sample of college students. These subjects may have raised their

self-esteem through academic achievement (Cermak & Rosenfeld, 1987). Jarmas (1992) has noted that some ACAs might be more likely to pursue a college education in order to cope with feelings of inadequacy, worthlessness, and failure. Hence this sample of college students have, by definition, taken an active role in the control of their external events by seeking an education and in that process may have raised their self-esteem. It would appear that an achievement-oriented coping style might impact self-worth and result in more positive self-evaluations.

An alternative interpretation for the lack of differences in self-esteem scores might be that the scale used in this study had a range of scores of self-worth that was very narrow and so we may be dealing with a population for whom the instrument used to measure self-worth was not sensitive enough. Since the present study used a different method of assessment for self-worth than did Williams and Corrigan (1992), it may be that certain aspects of self-worth are tapped in a variety of ways with the various instruments utilized in the literature, drawing upon different components of this construct. It would be useful in future studies to utilize several self-esteem or self-worth instruments to evaluate whether or not they yield different outcomes.

The hypothesis that ACAs would view people and the world as more malevolent than nonACAs was also not supported. Neither was the hypothesis that ACAs would report lower levels of control over events. The importance of assessing these variables was to understand more clearly whether there were some cognitive components that contribute to the psychological sequelae that we see in ACAs. Beck (1979) and other researchers and clinicians (Black 1981) have suggested that the way in which people view themselves, others and the world contributes to depression, anxiety and other psychological symptoms. We attempted to assess these variables in this study as a way of understanding whether or not it was true for this sample. While we did not find any between group differences in this study, it may be our instrument was not sufficiently sensitive to detect these differences if, in fact, they do exist.

Given that children who grow up in alcoholic families have to learn to cope with the stressors that result from being in a family where there is so much chaos and anxiety, it is important to understand how they manage to negotiate this situation and whether the particular processes that they use to cope early on continue to be employed throughout life. Research suggests that the ways in which people cope with stressful events may impact their long-term psychological well-being. In this study we assessed the

coping strategies used by ACAs to see if they differed from those used by nonACAs. The hypothesis that ACAs would use more avoidant coping styles than nonACAs was supported. Given the level of chaos and anxiety in the alcoholic family it would make sense that the children would look for some coping mechanism that would allow them to detach or disconnect from this chaos. Unfortunately, long term use of an avoidant coping strategy can also have negative outcomes when the individuals have to deal with other life circumstances. Some of the previous research in this area suggests that younger children were more likely to utilize a more emotion-focused coping response while older children were more likely to use more of a confrontive, problem solving approach (Scavnicky-Mylant 1990). Unfortunately, in this study, we did not look at whether or not there were differences in the style of coping used based upon the age that the child was when the alcoholism occurred, nor did we assess whether the avoidant coping style was specific to coping with the alcoholic family environment only. What we did find, however, was that overall, ACAs tended to be more avoidant in their coping approaches than nonACAs. One possible implication of the fact that ACAs use avoidant coping styles more often is that in later life when this coping style is no longer needed, it has the potential to be a hindrance to them. These findings suggest that when a

clinician is working with an ACA, assessing the coping strategies used by the individual and whether or not those strategies continue to be functional, may be important.

Although the research suggests that it is now more important that clinicians look at the range and varieties of coping strategies that are utilized instead of a specific type, in this study we did not take a process-oriented approach that would assess whether our subjects exhibit the ability to use different coping strategies over time and when faced with a variety of stressors. There continues to be a need to evaluate the use of coping strategies in ACAs so we can better understand whether or not they possess a range of strategies that they utilize flexibly depending on what the situation calls for.

Conclusion

The findings of this study suggest that anxiety and depression are indeed higher in ACAs than in nonACAs, that ACAs' cognitive views of themselves, the world and others do not differ from nonACAs as measured by the particular instrument used, but that use of avoidance as a coping strategy is employed significantly more frequently by ACAs than by nonACAs.

Limitations

There are a number of limitations of this particular study. The population for this study consisted of college

students, perhaps a more functional group of subjects than might be found in a more diverse community sample. However, these findings suggest that the mere fact of growing up in an alcoholic home may result in limited negative outcomes and that perhaps ACAs who attend college have had other experiences (such as social support & academic success) which moderate the potential negative outcomes of their early family life. Additionally, in this study, subjects were assessed at one particular point in time, preventing us from knowing how coping is used as a process, or if over time, there would be differences in the subjects' coping styles. Furthermore, we do not know if the particular stressor that a subject was facing would impact which strategy they might use in responding to the coping questions.

Finally, although differences in the Ways of Coping Scale were not observed in this sample, the ways in which being raised in an alcoholic home affects cognitive schemas of self and world and others warrants further assessment.

Future Studies

Additional variables that could be addressed in future studies concern whether or not the parent is still drinking, the gender of the alcoholic parent and the child's age at the time the parent became alcoholic. All of these factors are important with regard to the ACAs level or degree of

anger toward that parent which would directly affect the way in which the subject answers the questionnaire. For example, if the parent is still drinking, the ACAs' level of anger might be higher or more easily accessed than if the parent stopped drinking ten years ago. Also, if the alcoholic parent was the father, the child might be less affected or traumatized than if the alcoholic parent was the mother (Werner, 1985). According to Werner (1985), higher levels of functioning, less self-blame and a greater degree of well-being has been observed among children whose father was alcoholic as opposed to having an alcoholic mother. This is due to two factors: 1) the mother is more attentive in the first two years of life, if she is not drinking, and this period is considered vital to development by many researchers, and 2) fetal alcohol syndrome is much less likely to occur if the father is the alcoholic rather than the mother.

The age of the child when the parent becomes alcoholic is also important in terms of the developmental issues the child is dealing with when the chaos and dysfunction begins. Generally, children need to be "helped through" some developmental stages in order to complete them successfully. If a parent is alcoholic and inattentive in the early years, it is highly likely that a child could become "stuck" in one of these developmental stages at a level of immaturity that

would prevent him or her from individuating from the parent in a normal manner. This would necessarily make criticism of such a parent unthinkable for the child, setting up denial, minimization, self-blame and rationalization.

Research indicates that there are many addictive problems that can cause the same behavioral and emotional difficulties observed in the home of the alcoholic. Most notably they are: gambling, drug taking (prescription or illegal), chronic infidelity, overeating and second generation alcoholism (that is, grandparents who are alcoholic, but the parents do not drink). Persons who are involved in one of these addictions exhibit the same characteristics as alcoholics do, but their children are not called "adult children of alcoholics" and so could not be identified as such on the CAST portion of our questionnaire. These issues, if addressed in future studies, might produce different results.

Finally, it would be helpful to know whether or not a subject has ever been in treatment for co-dependency, as a result of growing up in a home in which psychological problems may result, or if he or she is a member of a support group such as CODA or an ACA 12-step recovery group. An affirmative answer to these questions could well dilute the responses expected on the Ways of Coping Scale and the World Assumptions Scale.

APPENDIX A

Questionnaire

1. What is your age? _____

2. What is your sex? (Circle one) M F

3. What is your marital status?

Married _____ Separated _____ Divorced _____
Widowed _____ Never Married _____ Remarried _____

4. What is your ethnic background?

Black_____ Hispanic_____ White _____ Native American _____
Asian/Pacific Islander_____Other (specify) _____

5. Present yearly income for your household:

Under $15,000 _____ $15,000 - $24,000 _____
$25,000 - $34,000 _____ $35,000 - $44,000 _____
$45,000 - $54,000 _____ Over $55,000 _____

6. What is your family's occupation category?

Professional _____ Technical _____ Clerical _____
Managerial _____ Skilled Labor _____ Unskilled Labor _____
Other (Specify) _____

7. Total number of years of education _____

8. How many brothers are older than you? ____ younger than you? _____

9. How many sisters are older than you? ____ younger than you? _____

10. Have you ever thought that one of your parents had a drinking problem?
Yes _____
No _____

11. Have you ever lost sleep because of a parent's drinking?
Yes _____

No _____

12. Did you ever encourage one of your parents to quit drinking?
Yes _____
No _____

13. Did you ever feel alone, scare, nervous, angry, or frustrated because a parent was not able to stop drinking?
Yes _____
No _____

14. Did you ever argue or fight with a parent when he or she was drinking?
Yes_____
No _____

15. Did you ever threaten to run away from home because of a parent's drinking?
Yes _____
No _____

16. Has a parent ever yelled at or hit you or other family member's when drinking?
Yes _____
No _____

17. Have you ever heard your parents fight when one of them was drunk?
Yes _____
No _____

18. Did you ever protect another family member from a parent who was drinking?
Yes _____
No _____

19. Did you ever feel like hiding or emptying a parent's bottle of liquor?
Yes _____
No _____

20. Do or did many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
Yes _____
No _____

21. Did you ever wish that a parent would stop drinking?

Yes _____
No _____

22. Did you ever feel responsible for and guilty about a parent's drinking?
Yes _____
No _____

23. Did you ever fear that your parents would get divorced due to alcohol misuse?
Yes _____
No _____

24. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?
Yes _____
No _____

25. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
Yes _____
No _____

26. Did you ever feel that you made a parent drink alcohol?
Yes _____
No _____

27. Have you ever felt that a problem drinking parent did not really love you?
Yes _____
No _____

28. Did you ever resent a parent's drinking?
Yes _____
No _____

29. Have you ever worried about a parent's health because of his or her alcohol use?
Yes _____
No _____

30. Have you ever been blamed for a parent's drinking?
Yes _____
No _____

31. Did you ever think your father was an alcoholic?
Yes _____
No _____

32. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
Yes _____
No _____

33. Did a parent ever make promises to you that he or she did not keep because of drinking?
Yes _____
No _____

34. Did you ever think your mother was an alcoholic?
Yes _____
No _____

35. Did you ever wish that you could talk to someone who could understand and help the alcoholic - related problems in your family?
Yes _____
No _____

36. Did you ever fight with your brothers and sisters about a parent's drinking problem?
Yes _____
No _____

37. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
Yes _____
No _____

38. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
Yes _____
No _____

39. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?
Yes _____
No _____

40. Did you have a special friend or group of friends of your own age when you were growing up?
Yes _____
No _____

41. Did you have any special relationships with adults when growing up?

Yes _____
No _____

42. If the answer to No. 21 is yes, how many adults were important to you? _____

Answer the following questions about the adult who was most important to you.

43. Who was it? (Circle one)

Mother _____
Father _____
Adult Brother ____
Adult Sister _____
Aunt _____
Uncle _____
Grandmother ____
Grandfather
Teacher _____
Minister/Priest/Rabbi _____
Neighbor _____
Other (please specify)
_____

44. How old were you when this relationship became important to you? _____

45. How often did you see this person?

_____ times/week_____ times/month_____ times/year

46. How long did this relationship last? ___years___months

For those of you who had a parent who abused alcohol please respond to the following questions and describe how you coped when your parent(s) drinking was at its worst. For those of you who did not have a parent who abused alcohol, think of an event during your childhood that you experienced as stressful. Answer the following questions and describe how you coped with that stressful period. Please describe briefly what the stressor was.

_____
_____
_____
_____

The following statements have to do with how you coped with that stressful period. Circle the appropriate number to indicate the extent to which you used the various methods of coping described below:

	Not used	Used Somewhat	Used Quite a Bit	Used a great deal			
	1	2	3	4			
47.	Bargained or compromised to get something			1	2	3	4
48.	Talked to someone to find out about the situation			1	2	3	4
49.	Blamed yourself			1	2	3	4
50.	Hoped a miracle would happen			1	2	3	4
51.	Went on as if nothing happened			1	2	3	4
52.	Concentrated on something good that could come out of the whole thing			1	2	3	4
53.	Accepted sympathy and understanding from someone			1	2	3	4
54.	Criticized or lectured yourself			1	2	3	4
55.	Wished you were a stringer person--more optimistic and forceful			1	2	3	4
56.	Felt bad that you couldn't avoid the problem			1	2	3	4
57.	Tried not to burn your bridges behind you but left things open somewhat			1	2	3	4
58.	Got professional help and did what they recommended			1	2	3	4
59.	Realized you brought the problem on yourself			1	2	3	4
60.	Wished that you could change what had happened			1	2	3	4
61.	Kept your feelings to yourself			1	2	3	4
62.	Changed or grew as a person in a good way			1	2	3	4
63.	Talked to someone who could do something about the problem			1	2	3	4
64.	Wished you could change the way that						

	you felt	1	2	3	4
65.	Slept more than usual	1	2	3	4
66.	Made a plan of action and followed it	1	2	3	4
67.	Asked someone you respected for advice and followed it	1	2	3	4
68.	Daydreamed or imagined a better time or place than the one you were in	1	2	3	4

Not used	Used Somewhat	Used Quite a Bit	Used a great deal
1	2	3	4

69.	Got mad at the people or things that caused the problem	1	2	3	4
70.	Accepted the next best thing to what you wanted	1	2	3	4
71.	Talked to someone about how you were feeling	1	2	3	4
72.	Had fantasies or wishes about how things might turn out	1	2	3	4
73.	Tried to forget the whole thing	1	2	3	4
74.	Came out of the experience better than you went in	1	2	3	4
75.	Thought about fantastic or unreal things (like perfect revenge or finding a million dollars) that made you feel better	1	2	3	4
76.	Tried to make yourself feel better by eating, drinking, smoking, taking medication	1	2	3	4
77.	Tried not to act too hastily or follow your own hunch	1	2	3	4
78.	Wished the situation would go away or somehow be finished	1	2	3	4

79.	Avoided being with people in general	1	2	3	4
80.	Changed something so things would turn out all right	1	2	3	4
81.	Kept others from knowing how bad things were	1	2	3	4
82.	Just took things one step at a time	1	2	3	4
83.	Refused to believe it had happened	1	2	3	4
84.	You knew what had to be done, so you doubled your efforts and tried harder to make things work	1	2	3	4
85.	Came up with a couple of different solutions to the problem	1	2	3	4
86.	Accepted your strong feelings, but didn't let them interfere with other things too much	1	2	3	4
87.	Changed something about yourself so you could deal with the situation better	1	2	3	4
88.	Stood your ground and fought for what you wanted	1	2	3	4

Please answer the following questions for the period when either your parent(s) alcohol use was at its worst or when you experienced the stressor described above. For each item, rate on a scale of 1 (strongly disagree) to 4 (strongly agree) the extent to which each item fit for you. Please circle the appropriate response.

Strongly Disagree ------> Strongly Agree

89.	My friends respected me	1	2	3	4
90.	My family cared for me very much	1	2	3	4
91.	I was not important to others	1	2	3	4
92.	My family held me in high esteem	1	2	3	4
94.	I was well liked	1	2	3	4

95.	I could rely on my friends	1	2	3	4
96.	I was really admired by my family	1	2	3	4
97.	I was respected by other people	1	2	3	4
98.	I was loved dearly by my family	1	2	3	4
99.	My friends didn't care about my welfare	1	2	3	4
100.	Members of my family relied on me	1	2	3	4
101.	I was held in high esteem	1	2	3	4
102.	I couldn't rely on my family for support	1	2	3	4
103.	People admired me	1	2	3	4
104.	I felt a strong bond with my friends	1	2	3	4
105.	My friends looked out for me	1	2	3	4
106.	I felt valued by other people	1	2	3	4
107.	My family really respected me	1	2	3	4
108.	My friends and I were really important to one another	1	2	3	4
109.	I felt like I belonged	1	2	3	4
110.	If I would have died, very few people would have missed me	1	2	3	4
111.	I didn't feel close to members of my family	1	2	3	4
112.	My friends and I did a lot for one another	1	2	3	4

Please pick out the one statement in each group which best describes the way you have been feeling the past week, including today. Circle the number beside the statement you picked.

113. 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it

114. 0 I am not particularly discouraged about the future
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve

115. 0 I do not feel like a failure
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

116. 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

117. 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

118. 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

119. 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

120. 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

121. 0 I don't have any thought of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.

3 I would kill myself if I had the chance.

122. 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

123. 0 I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

124. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

125. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

126. 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

127. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

128. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back
to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

129. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.

3 I am too tired to do anything.

130. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

131. 0 I haven't lost much wight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.
I am purposely trying to lose weight by eating less. Yes No

132. 0 I am no more worried about my health than usual
1 I am worried about physical problems such as aches and pain; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

133. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely

Read each statement and then circle the statement to indicate how you feel right now.

	Not at all (1)	Somewhat (2)	Moderately So (3)			Very Much So (4)
134.	I feel calm		1	2	3	4
135.	I feel secure		1	2	3	4
136.	I am tense		1	2	3	4
137.	I am regretful		1	2	3	4
138.	I feel at ease		1	2	3	4

139.	I feel upset	1	2	3	4
140.	I am presently worrying over possible misfortunes	1	2	3	4
141.	I feel rested	1	2	3	4
142.	I feel anxious	1	2	3	4
143.	I feel comfortable	1	2	3	4
144.	I feel self-confident	1	2	3	4
145.	I feel nervous	1	2	3	4
146.	I feel jittery	1	2	3	4
147.	I feel "high strung"	1	2	3	4
148.	I feel relaxed	1	2	3	4
149.	I feel content	1	2	3	4
150.	I feel worried	1	2	3	4
151.	I feel over-excited & 'rattled'	1	2	3	4
152.	I feel joyful	1	2	3	4
153.	I feel pleasant	1	2	3	4

Think about the person to whom you are the closest. Please indicate his/her relationship to you. For example, husband/wife, girlfriend/boyfriend, friend, mother/father, counselor, etc.

_____.

Keeping this relationship with this person in mind, read the statement and circle the number which corresponds to the answer which best applies to you. The scale ranges from 1 (very rarely) to 5 (some of the time) to 10 (almost always)

154. When you have leisure time how often do you choose to spend it with him/her

1 2 3 4 5 6 7 8 9 10

155. How often do you keep very personal information to yourself and do not share it with him/her?
1 2 3 4 5 6 7 8 9 10

156. How often do you show him/her affection?
1 2 3 4 5 6 7 8 9 10

157. How often do you confide very personal information to him/her?
1 2 3 4 5 6 7 8 9 10

158. How often are you able to understand his/her feelings?
1 2 3 4 5 6 7 8 9 10

159. How often do you feel close to him/her?
1 2 3 4 5 6 7 8 9 10

160. How much do you like to spend time alone with him/her?
1 2 3 4 5 6 7 8 9 10

161. How much do you feel like being encouraging and supportive to him/her when he/she is unhappy?
1 2 3 4 5 6 7 8 9 10

162. How close do you fee to him/her most of the time?
1 2 3 4 5 6 7 8 9 10

163. How important is it to you to listen to his/her very personal disclosure?
1 2 3 4 5 6 7 8 9 10

164. How satisfying is your relationship with him/her?
1 2 3 4 5 6 7 8 9 10

165. How affectionate do you feel towards him/her?
1 2 3 4 5 6 7 8 9 10

166. How important is it to you that he/she understands your feelings?
1 2 3 4 5 6 7 8 9 10

167. How much damage is caused by a typical disagreement in your relationship with him/her?
1 2 3 4 5 6 7 8 9 10

168. How important is it to you that he/she be encouraging and supportive to you when you are unhappy?
1 2 3 4 5 6 7 8 9 10

169. How important is it to you that he/she show you affection?

1 2 3 4 5 6 7 8 9 10

170. How important is your relationship with him/her in your life?

1 2 3 4 5 6 7 8 9 10

Please read the following sentences and circle the number which best indicates how you view yourself.

	Really untrue (1)	Sort of Untrue (2)	Sort of true (3)		Really true (4)
171. I feel confident that I am mastering my course work			1	2	3 4
172. I do well at my studies			1	2	3 4
173. I rarely have trouble with my homework assignments			1	2	3 4
174. I usually feel intellectually competent at my studies			1	2	3 4

Please indicate your views of the following statements on a scale of 1 (strongly agree) to 6 (strongly disagree):

	STRONGLY AGREE (1)					STRONGLY DISAGREE (6)
175. Misfortune is likely to strike worthy, decent people	1	2	3	4	5	6
176. People are naturally unfriendly and unkind	1	2	3	4	5	6
177. Bad events are distributed to people at random	1	2	3	4	5	6

178.	Human nature is basically good	1	2	3	4	5	6
179.	The good things that happen in this world far outnumber the bad	1	2	3	4	5	6
180.	The course of our lives is largely determined by chance	1	2	3	4	5	6
181.	Generally, people deserve what they get in this world	1	2	3	4	5	6
182.	I often think I am no good at all	1	2	3	4	5	6
183.	There is more good than evil in the world	1	2	3	4	5	6
184.	I am basically a lucky person	1	2	3	4	5	6
185.	People's misfortunes result from mistakes they have made	1	2	3	4	5	6
186.	People don't really care what happens to the next person	1	2	3	4	5	6
187.	I usually behave in ways that are likely to maximize good results for me	1	2	3	4	5	6
188.	People will experience good fortune if they themselves are good	1	2	3	4	5	6
189.	Life is too full of uncertainties that are determined by chance	1	2	3	4	5	6
190.	When I think about it, I consider myself very lucky	1	2	3	4	5	6
191.	I almost always make an effort to prevent bad things from happening to me	1	2	3	4	5	6
192.	I have a low opinion of myself	1	2	3	4	5	6
193.	By and large, good people get what they deserve in this world	1	2	3	4	5	6
194.	Through our actions we can prevent bad things from happening to us	1	2	3	4	5	6
195.	Looking at my life, I realize that chance events have worked out well						

	for me	1	2	3	4	5	6
196.	If people took preventive actions, most misfortunes could be avoided	1	2	3	4	5	6
197.	I take the actions necessary to protect myself against misfortune	1	2	3	4	5	6
198.	In general, life is mostly a gamble	1	2	3	4	5	6
199.	The world is a good place	1	2	3	4	5	6
200.	People are basically kind and helpful	1	2	3	4	5	6
201.	I usually behave so as to bring about the greatest good for me	1	2	3	4	5	6
202.	I am very satisfied with the kind of person I am	1	2	3	4	5	6
203.	When bad things happen, it is typically because people have not taken the necessary actions to protect themselves	1	2	3	4	5	6
204.	If you look closely enough, you will see that the world is full of goodness	1	2	3	4	5	6
205.	I have reason to be ashamed of my personal behavior	1	2	3	4	5	6
206.	I am luckier than most people	1	2	3	4	5	6

APPENDIX B

INFORMED CONSENT

I am volunteering to participate as a subject in this study. I understand that the purpose of this study is to investigate the effects of parental alcohol use and other childhood stressors on later adult functioning. I understand that I will be asked to complete a paper and pencil questionnaire which will include questions about my family of origin and any parental alcohol use that occurred while I was growing up. I will also be asked questions about how I feel about myself now, how I feel about myself in relationship to others, and how I feel about my academic and/or career experiences. The questionnaire will take approximately 45 minutes to complete. I am aware that some of the questions asked will be personal and that I may feel uncomfortable when asked to recall my childhood experiences in relationship to my family.

I understand my name will NOT be included on the survey itself and that my ANONYMITY WILL BE MAINTAINED AT ALL TIMES. I also understand that my participation in this study is voluntary, that all my questions will be answered, that I may refuse to answer any questions at any time, and that I may withdraw from the study at any time without penalty or prejudice.

I understand that all information collected in this study will be treated as confidential, with no details released to anyone outside the research staff without my separate, specific, written consent. I also understand that if the study design or use of the information is to be changed, I will be so informed and my consent reobtained. I understand that I may derive no specific benefit from participation in this study, except perhaps from feeling that I have contributed to the development of knowledge about parental alcohol use and how it effects later adult adjustment. I hereby allow this research project to publish the results of the study in which I am participating with the provision that my name and/or other identifying information be withheld.

This study has been approved by the Psychology Department's Human Subjects Review Board and is being conducted by Jeanne Hogan and Jeanie Kieley under the supervision of Dr. Faith McClure, Psychology Department, California State University, San Bernardino, (909) 880-5598. I may contact Dr. McClure at any time with my questions, comments, or concerns. I understand that if I have any questions, comments, or concerns about the study or the informed consent process, I may also contact the CSUSB Human Subjects Institutional Review Board through the Office of the Dean of Graduate Studies located in AD 127, (909)

880-5058.

APPENDIX C

DEBRIEFING

Thank you for participating in this study. As indicated in the informed consent form, the purpose of the study is to examine the effects of parental alcohol use and other childhood stressors on later adult functioning. It is hoped that the results of this study will help us gain an increased understanding of the effects of parental alcohol use and childhood stressors. We are also interested in learning about any childhood relationships that may have had an impact, in a positive sense, on how children coped, and how they are currently functioning.

If you have had a stressful childhood experience and would like to talk to a counselor or join a support group, there are several available local resources. The CSUSB Counseling Center provides very low cost counseling services to students and members of the community and they may be reached at 880-5040. Information about support groups in the community may also be obtained from the California Self-Help Center, toll free (800)222-link. In addition, local mental health departments also provide counseling services: in San Bernardino, the number for the Department of Mental Health is 387-7171 and for Riverside it is 358-4500. In addition to these services, there are several 12-step groups available: Alcoholics Anonymous (825-4700) Adult Children of

Alcoholics (783-2255), Coda and Al-anon (824-1516), to name a few.

If you have any questions about this research project or would like to find out what the results are when completed or obtain a copy of the results (available in June, 1994), please contact Jeanne Hogan or Jeanie Kieley through:

Faith McClure, Ph.D.
CSUSB, Psychology Department
Office: TO 13
Phone: 880-5598

REFERENCES

American Psychological Association. (1989). York, Pennsylvania: Lancaster Press, Inc.

Beck A., Rush A.J., Shaw, B. & Emery, G. (1979). Cognitive Therapy of Depression. NY: Guilford Press.

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J. & Erbaugh, J. (1961). An inventory for measuring depression. Archives of General Psychiatry, 4, 561-571.

Bennett, L.A., Wolin, S.J., & Reiss, D. (1988). Deliberate family process: a strategy for protecting children of alcoholics. British Journal of Addiction, 83, 821-829.

Bingham, A. & Barger, J. (1985). Children of alcoholic families. Journal of Psychosocial Nursing 23(12) 13-15.

Black, C., Bucky, S.F., & Wilder-Padilla, S. (1986). The interpersonal and emotional consequences of being an adult child of an alcoholic. International Journal of Addictions, 21, 213-232.

Blane, H.T. (1988). Prevention issues with children of alcoholics. British Journal of Addiction 83, 793-798.

Bowen, M. (1978). Family therapy in clinical practice. Northvale, N.J.: Aronson.

Bowlby, J. (1969). Attachment and Loss (Vol 1): Attachment. London: Hogarth.

Brennan, K.A., Shaver, P.R., Tobey, A.E. (1991). Attachment styles, gender and parental problem drinking. Journal of Social and Personal Relationships 8, 451-466.

Calder, P. & Kostyniuk, A. (1989). Personality profiles of children of alcoholics. Professional Psychology: Research an Practice 20(6) 417-418.

Cermack, T.L. & Rosenfeld, A.A. (1987). Therapeutic considerations with adult children of alcoholics. Advances in Alcohol and Substance Abuse, 6(4) 17-32.

Cooper, A. & McCormack, W.A. (1992). Short-term group treatment for adult children of alcoholics. Journal of Counseling Psychology 339(3) 350-355.

Cutter, C.G., Cutter, H.S.G. (1987). Experience and change in al-anon family groups: adult children of alcoholics. Journal of Studies on Alcohol, 48,(1) 29-32.

Drake, R.E. & Vaillant, G.E. (1988). Predicting alcoholism and personality disorder in a 33-year longitudinal study of children of alcoholics. British Journal of Addiction 83, 799-807.

Emshoff, J.G. (1989). A preventive intervention with children of alcoholics. Prevention in Human Services 7(1) 225-253.

Erickson, E (1968). Identity: Youth an Crisis. New York: Norton.

Fischer, B. (1987). The process of healing shame. Alcoholism Treatment Quarterly. 4(2) 25-38.

Flannery, R. (1986). The adult children of alcoholics: Are they trauma victims with learned helplessness? Journal of Social Behavior and Personality, 1, 497-504.

Haack, M. (1990). Collaborative investigation of adult children of alcoholics with anxiety. Archives of Psychiatric Nursing. 4(1), 62-66.

Hibbard, S. (1989). Personality and object relational pathology in young adult children of alcoholics. Psychotherapy 26(4) 504-509.

Hinz, L.D. (1990). College student adult children of alcoholics: psychological resilience or emotional distance? Journal Of Substance Abuse 2, 449-457.

Jacob, T, Seilhamer, R.A. & Rushe, R.H. (1989). Alcoholism and family interaction: an experimental paradigm. American Journal of Drug and Alcohol Abuse 15(1) 73-91.

Jacobs, P.S. (1991). Characteristics of the self in children of alcoholics: a review. Alcoholism Treatment Quarterly 8(2) 67-74.

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. Social Cognition 2(7) 113-136.

Jarmas, A.L., Kazak, A.E. (1992). Young adult children of alcoholic fathers: depressive experiences, coping styles, and family systems. Journal of Consulting and Clinical Psychology 60(2) 244-251.

Johnson, J.L., Sher, K.J. & Rolf, J.E. (1991). Models of vulnerability to psychopathology in children of alcoholics. Alcohol Health and Research World 15(1) 33-42.

Kenny M.E. & Donaldson, G.A (1991). Contributions of parental attachment and family structure to the social and psychological functioning of first-year college students. Journal of Counseling Psychology 38(4), 479-486.

Lazarus, R.S. & Folkman, S. (1984). Stress, appraisal, and coping. New York:Springer.

McCown, W., Carise, D., Johnson, J. (1991). Trail procrastination in self-described adult children of excessive drinkers: an exploratory study. Journal of Social Behavior and Personality 6(1) 147-151.

McNeill, V.N., Gilbert, B.O. (1991). External locus of control in children of alcoholics. Psychological Reports 68(2) 528-530.

Minuchin, S. (1974). Families and family therapy. Cambridge, M.A. Harvard University Press.

Nardi, P.M. (1981). Children of Alcoholics: a role-theoretical perspective. Journal of Social Psychology 115, 237-245.

O'Sullivan, C.M. (1991). The relationship between childhood mentors and resiliency in adult children of alcoholics. Familiy Dynamics Addict 1(4), 46-59.

Parker, D. & Harford, T. (1988). Alcohol related problems, marital disruption, and depressive symptoms among adult children of alcohol abusers in the United States. Journal of Studies on Alcohol, 49, 306-313.

Pilat, J.M. & Jones, J.W. (1984). Identification of children of alcoholics: Two empirical studies. Alcohol Health and Research World, Winter.

Plescia-Pikus, M., Long-Suter, E., & Wilson, J. (1988). Achievement, well-being, intelligence, and stress reaction in adult children of alcoholics. Psychological Reports 62, 603-609.

Protinsky, H.P. & Ecker, H. (1990). Intergenerational family relationships as perceived by adult children of alcoholics. Family Therapy 17(3) 217-222.

Reich, W., Earls, F., Powell, J. (1988). A comparison of the home and social environments of children of alcoholic and non-alcoholic parents. British Journal of Addiction 83, 831-839.

Roosa, M.W., Sandler, I.N. & Gehring, M, et.al. (1988). The children of alcoholics life-events schedule: a stress scale for children of alcohol-abusing parents. Journal of Studies on Alcohol 49(5) 422-429.

Roush, K.L., DeBlassie, R.R. (1989). Structured group counseling for college students of alcoholic parents. Journal of College Student Development 30 276-277.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms. American Journal of Orthopsychiatry 57(3) 316-329.

Scavnicky-Mylant, M. (1990). The process of coping among young adult children of alcoholics. Issues in Mental Health Nursing 11(2) 125-139.

Stark, E. (1987). Forgotten victims: children of alcoholics. Psychology Today 21(1) 58-62.

Tweed, S.H. (1991). Adult children of alcoholics: profiles of wellness amidst distress. Journal of Studies on Alcohol 52(2) 133-141.

Vitaliano, P., Russo, J., Carr, J., Maiuro, R., & Becker, J. (1985). The ways of coping checklist: Revision and psychometric properties. Multivariate Behavioral Research 20(1) 3-26.

Von Knorring, A.L. (1991). Children of alcoholics. Journal of Child Psychology and Psychiatry and Allied Disciplines 32(3) 411-421.

Werner, E.E. (1985). Resilient offspring of alcoholics: a longitudinal study from birth to age 18. Journal of Studies on Alcohol 47, 34-40.

Williams, O.B. & Corrigan, P.W. (1992). The differential effects of parental alcoholism and mental illness on their adult children. Journal of Clinical Psychology 48(3) 406-414.

Wilson, C. & Orford, J. (1977). Children of alcoholics. Journal of Studies on Alcohol 39(1) 121-142.

Wright, D.M., Heppner, P.P. (1991). Coping among nonclinical college-age children of alcoholics. Journal of Counseling Psychology. 38(4), 465-472.