A COMPARISON OF ADULT CHILDREN OF ALCOHOLIC FAMILIES WITH
ADULT CHILDREN FROM NON-ALCOHOLIC FAMILIES:
A REPLICATION

DISSERTATION

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY

By

Sandra Y. Dooley, B.S., M.Ed.
Denton, Texas
August 1996
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The purpose of this study was to re-examine the issue of whether adult children of alcoholics experience more depression, anxiety, and lower self-esteem than do children of non-alcoholic families. This study is a replication of the study of David Dodd, entitled *A Comparison of Adult Children of Alcoholic Families with Adult Children from Non-Alcoholic Families*, 1990.

The measures used in this study were as follows: Children of Alcoholics Screening Test, the Beck Depression Inventory, the State-Trait Anxiety Inventory, the Coopersmith Adult Self-Esteem Inventory, and a questionnaire developed by this writer designed to obtain family history regarding not only alcoholism, but other issues of family dysfunctionality as well.

The subjects for this study were 231 students enrolled in the counselor education program at this university, all aged 19 or older. Of the 230 subjects, 31 were male and 199 were female. Eleven males identified themselves as children of alcoholics, as measured by the Children of Alcoholics
Screening Test, and 60 females identified themselves as children of alcoholics. Thus, a total of 71 subjects in this study were identified as children of alcoholics.

T-tests were conducted to see whether any differences existed between the male and female groups. No significant differences were found.

Results of this study showed that family dysfunctionality rather than parental alcoholism was the factor of variability regarding depression, anxiety, and self-esteem. There appears to be a strong relationship between parental alcoholism and family dysfunctionality, but dysfunctionality clearly has more impact upon depression, anxiety, and self-esteem in the adult children of these families than does alcoholism.
ACKNOWLEDGMENTS

In grateful appreciation, I wish to thank Dr. Byron Medler, Dr. Jim Kitchens, and my other committee members whose wisdom and guidance contributed greatly to this work.

Additionally, I wish to thank my husband Marshal, whose love and encouragement have helped me each step of my journey through life.
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CHAPTER I

INTRODUCTION

The purpose of this study is to examine the issue of whether adult children of alcoholics experience more depression, low self-esteem, and anxiety than do adult children of non-alcoholic families. This study is a replication of the dissertation of David Dodd entitled A Comparison of Adult Children of Alcoholic Families with Adult Children from Non-Alcoholic Families (1990) on depression, self-esteem, and anxiety at the University of North Texas (UNT).

This study includes, but is not limited to, many references cited by Dodd, as well as the major writings that have been published on this subject since Dodd’s dissertation in 1990. The same measures used by Dodd will be used in this study. They are as follows: Children of Alcoholics Screening Test (CAST), the Beck Depression Inventory (BDI), the State-Trait Anxiety Inventory (STAI), and the Coopersmith Adult Self-Esteem Inventory (SEI). The hypothesis of both studies is the same: there is a significant difference in levels of depression, anxiety, and self-esteem between adult children of alcoholics and adult children from non-alcoholic families.
The demographic questionnaire used by Dodd has been replaced with a questionnaire developed by this researcher in an effort to obtain more sociographic data and family history regarding alcohol-related issues and other areas of family dysfunctionality. Six years have passed since the Dodd study was completed. In that time, additional research related to children of alcoholics has appeared. The influence of new research and the newly developed questionnaire are the substantive changes from the original study. Whether these factors will result in any significant differences (from Dodd’s) is not known at this time; the purpose of the study as a replication is to examine and to test in an effort to answer that question.

A brief overview on this subject reveals that several researchers in this field have written of the need for continued research on the subject of adult children of alcoholics (ACOAs) and adult children of dysfunctional families (ACDFs). Much of the research is descriptive in nature rather than empirical, and much of it has been gathered through people seeking treatment. El-Guebaly and Offord (1977) suggested a need for more carefully controlled studies using blind data collection and clear operational definitions. Since that time, many studies have been conducted that more clearly define alcoholism and other variables such as age, sex, education, and extent of family disorganization. Jarmas and Kazak (1992) stated that more
research is needed regarding the significance of gender differences. Werner (1991) called for more exploration of the issue of resiliency in ACOAs. Since 1991, more has been written about resilience that appears in an extensive review of the literature in this study. Williams and Corrigan's (1992) study suggested that being raised by severe mentally-ill parents causes greater depression and anxiety than being raised in an alcoholic home. However, the work of Fine (1976) directly contradicted the work of Williams and Corrigan. Werner and Broida's (1991) study concluded that ACOAs do not necessarily have personality problems as a result of parental alcoholism unless other family dysfunctionality is also present. They, too, suggested the need for more study on this subject.

Although the National Association for Children of Alcoholics (1993) estimates that more than 28 million Americans grew up in a home with an alcoholic parent, a survey by the National Institute on Alcohol Abuse and Alcoholism (1985) indicated that only 5% of this group seeks help through therapy.

In 1992, the National Association for Children of Alcoholics (NACA) conducted a nationwide survey using face-to-face interviews with 42,862 Americans who were chosen to ensure that all segments of the United States population--by age, sex, and ethnicity--were represented. Some of the results of that study indicated that nearly 4 million
American women under the age of 30 have alcohol problems, that there is a stronger link between depression and problem drinking in women than in men, and that the male-to-female ratio for alcoholism previously estimated at three to one is closing and is presenting closer to two to one. Despite the discrepancies in estimates, it can be readily seen that large numbers of Americans experience serious problems relating not only to parental drinking but to their own drinking as well. Some of the more serious implications of this widespread problem of problem drinking in our society are commented upon in the Discussion section of this study.

Black (1986) asserted that 34 million individuals in the United States grew up in alcoholic homes. Further, studies also suggest that approximately 15% of the U.S. college population is composed of children from alcoholic homes and that these students are at high risk for alcoholism, depression, and other psychological problems that may impair their ability to function well in the adult world (Cooper & McCormick, 1992). Although no one is really sure why these young adults do not seek treatment, clinicians hypothesize that, as a group, these young adults assumed responsibilities early in life and developed qualities of independence and resilience. The aforementioned personality characteristics--independence and resiliency--often help these individuals to become successful in ways that hide their underlying anger and
hurt. Priding themselves on their strengths, these individuals may be reluctant to admit the need for help, let alone to seek help (Cooper & McCormick, 1992).

In years past, much research has concentrated on the effects of familial alcoholism on personality formation during childhood. Only in the past 10 to 12 years have studies been done with adult children of alcoholics. These studies are somewhat limited because the research has focused on young adults (ages 18 to 23) in the college population (Werner & Broida, 1991). Some of these studies questioned whether the influence of familial alcoholism persists into adulthood.

Woititz, in *Adult Children of Alcoholics* (1983), asserted that alcoholic parents raise children who become adults who exhibit some very specific personality characteristics: difficulty trusting, being very responsible or very irresponsible, having low self-esteem, exhibiting an external locus of control, being approval seeking, having difficulty with intimate relationships, and more. Other writers and therapists who consider themselves experts on the subject of adult children of alcoholics are Black, *It Will Never Happen to Me*; Cermak, *A Primer on Adult Children of Alcoholics*; Ackerman, *Children of Alcoholics* and *Perfect Daughters*. These writers are in general agreement with Woititz regarding the commonality of personality characteristics of ACOAs.
Thus, the generalization accepted by many that ACOAs have specific personality traits (those enumerated by Woititz) that result in predictable psychological problems relating to depression, anxiety, and low self-esteem is questioned in this study. The rationale for questioning this generalization is that many researchers are now unsure whether the specific personality traits enumerated by Woititz always develop in ACOAs or whether those traits always result in depression, anxiety, and low self-esteem. Some research, specifically that conducted by Werner, Williams and Corrigan, Wolins, Higgins, and others, appears to contradict the aforementioned accepted generalization of the findings of Woititz and others in this field. As mentioned previously, writers such as Brown, Burk, and Sher; El-Guebaly, and Offord; and Wolin and Wolin particularly cite the need for more research in depression, anxiety, and low self-esteem in ACOAs and ACDFs.

Some other noted writers and researchers (those who have studied, worked with, or written about this population) are Fossum and Mason, and Subby and Whitfield. Fossum and Mason's book, Facing Shame (1986), addressed the difference between shame and guilt, discussed the origin of shame, and set up a model of shamebound cycle. Fossum and Mason described the rules of a shamebased family, which include issues of low self-esteem and high anxiety. These rules are centered around other rules, such as the unacceptability of
being open about one's problems and feelings, the repression of honest feeling, and the general seriousness of everything. These writers assert that these children miss much in terms of normal life experiences, the absence of which hinders their development, thereby stunting their emotional growth.

Whitfield (1987) wrote about development of the true self as opposed to development of a false or codependent self. Theoretically, the false self developed through the loss or illness of a parent, through a punishing, nonloving parent, or in a home where abuse and chaos prevail. Whitfield identified core issues such as inability to trust, repression of feeling, over-responsibility, and low self-esteem, among others, as being the typical results of growing up in such homes.

Subby (1987), like Fossum and Mason, explored the impact of unhealthy family rules upon developing children. He stressed the coping skills that result from an individual's prolonged exposure to a set of oppressive rules--rules that prohibit open expression of feeling and promote depression, anxiety, and low self-esteem in those bound by such rules.

Contrary to many writers, Brown (1988) rejected the belief that all ACOAs need to be lumped together in one group. Brown expressed the belief that many ACOAs have great individual differences although their experiences as
children in alcoholic homes may have been very similar. Brown asserted that one cannot ignore the genetic factors influencing individuals or other environmental differences in their lives.

Burk and Sher (1990) claimed that many studies show that ACOAs have no demonstrable psychopathology that can be clearly and specifically traced to growing up in alcoholic homes and offers an alternative hypothesis that the general level of stress in the family environment could account for psychopathology. Additionally, they maintain that low self-esteem could occur in an individual merely by being included in a psychiatric group to which he or she may not belong. Conversely, Cermak, who believed that ACOAs represent a unique syndrome, proposed that ACOAs be given a diagnostic label in DSM IV (Cermak, 1985).

Additionally, Werner (1985), in a longitudinal study conducted over a period of 18 years (infancy to age 18), examined the particular trait resilience in relation to ACOAs and concludes that some very influential factors in adult mental health include the individual’s constitutional strength and the quality of early caregiving.

In fact, there is a growing body of research (Hadley, Holloway, & Mallinckrodt, 1993; Williams & Corrigan, 1992; Burk and Sher, 1990; and others) indicating that adults other than those who grew up in alcoholic homes exhibit personality characteristics similar to those usually
ascribed to ACOAs. Often, these individuals grew up in homes where the parents were not capable of meeting the emotional needs of their children. The reasons for the parents' limitations were many: chronic violence, sexual abuse, psychiatric illness, physical illness, and so forth. In the literature, these individuals are referred to adult children of dysfunctional families. These children appear to have many developmental experiences similar to those of ACOAs--poor parenting, non-nurturing home atmosphere, and poor communication with parents. In other words, both groups of families appear to be similar in some important ways that affect the children they raise.

As mentioned, Hadley, Holloway, and Mallinckrodt (1993) claimed that lack of parental emotional availability and failure to respond to children's needs cause children to experience developmental problems and, later, adult personality characteristics commonly and perhaps erroneously ascribed mostly to ACOAs. Some lasting repercussions for both groups appear to be failure to develop a strong sense of self and failure to be capable of attaining intimacy in interpersonal relationships.

In summary, one group of writers, including Black (1986), Woititz (1983), Cermak (1988), and others, firmly believe that the presence of an alcoholic parent in a child's formative years will later result in an adult with the aforementioned personality characteristics, resulting in
predictable psychosocial problems. A second group of writers does not necessarily subscribe to the aforementioned belief, and their writings do not support this hypothesis (Churchill, Broida, & Nicholson, 1990).

On the issue of gender, Ackerman (1987) found that adult daughters of alcoholics are more guilt prone and self-blaming than are those from non-alcoholic families, but are no more external in their orientation. Clair and Genst (1987) studied differences in self-esteem and depression between children of alcoholic fathers and children of non-alcoholic fathers; they found no differences. Churchill, Broida, and Nicholson (1990 suggested that, gender aside, parental alcoholism alone is not sufficient to attribute a set of personality characteristics to a group of adult children; rather, other factors may contribute greatly to the problems experienced by these individuals.

Statement of the Problem

The problem of this study is to determine whether levels of depression, anxiety, and self-esteem in a sample of ACOAs differs from levels of depression, anxiety, and self-esteem in a sample of non-ACOAs. The purpose of this study is to determine whether any results will be found that are significantly different from those of Dodd (1990).
Hypotheses

Four hypotheses have been developed for this study:

1. There is a significant difference in levels of depression between ACOAs and non-ACOAs as measured by the Beck Depression Inventory.

2. There is a significant difference in levels of self-esteem between ACOAs and non-ACOAs as measured by the Coopersmith Self-Esteem Inventory: Adult Form.

3. There is a significant difference in levels of anxiety between ACOA's and non-ACOAs as measured by the State-Trait Anxiety Inventory.

4. There is a significant difference in level of anxiety, depression, and self-esteem between families whose adult children report high dysfunctionality and those who report low dysfunctionality.

Definition of Terms

Adult children of alcoholics: Operationally defined by measures on the Children of Alcoholics Screening Test (CAST). A score of 6 or more on the CAST indicates that a subject is likely an ACOA. All "yes" answers are tabulated to yield a total score ranging from 0 to 30.

Adult children of non-alcoholics: Operationally defined by measures on the Children of Alcoholics Screening Test. A score of 5 or less on the CAST indicates that a subject is not an ACOA.
Depression: Operationally defined by measures on the Beck Depression Inventory (BDI).

Self-esteem: Operationally defined by measures on the Coopersmith Self-Esteem Inventory (Adult Form) (SEI).

Anxiety: Operationally defined by measures on the State-Trait Anxiety Inventory (STAI).

Limitations of the Study

Certain limitations are inevitable in researching any subject. The following is a summary of the limitations of this study:

1. As with almost all of the research done on ACOAs, this study is limited to a sample of the college population which, by definition, implies that the majority of participants are in early adulthood.

2. The absence of random subjects limits this study.

3. Since the nature of the study is voluntary, the results may be affected by the possibility that subjects who are more anxious or depressed may be more likely to respond.

4. All the instruments in the study, including the demographic questionnaire, are self-report in nature. The results of the study may be influenced by the degree (or lack thereof) of candor and frankness each participant chooses to impart to the study.
5. This researcher has chosen to include the same instruments Dodd used as well as a questionnaire developed by this researcher regarding dysfunctionality within the family of origin.
CHAPTER II

METHODS

Subjects

The subjects for this study were students enrolled in Counselor Education courses at a large state-supported university in North Central Texas. Their participation in the study was completely voluntary. Subjects were from both undergraduate and graduate courses. They included a range of ages; however, all were 19 or older. A requirement for a student entering the Counselor Education program at the university is that the student be of junior standing. These subjects were heterogeneous in that each was pursuing studies in counseling at the university, but they were from varied socioeconomic backgrounds; they included both married and single students; some were parents; they were both male and female, although overwhelmingly female; and most were Caucasian. After making application, permission to use human subjects was obtained from the Human Subject Review of the university.

In order to procure subjects for the study, this researcher, after having secured permission from various instructors, entered each classroom, explain the purpose of the study, and asked for students who would be interested in
participating in the study. A goal of the study was to recruit 200 subjects, with at least one-third of those being adult children of alcoholics. The anonymity of each subject was assured. There was a letter of consent for each subject, and the packets of testing materials were distributed to those who chose to participate. Twenty-five minutes was the usual time allowed for completion, but most subjects completed the packet within 20 to 30 minutes.

Of the total number of 230 subjects, 31 were male and 199 were female. Eleven males identified themselves as children of alcoholics, and 60 females identified themselves as children of alcoholics. Thus, a total of 71 subjects out of 230 reported themselves to be children of alcoholics. This sample was predominantly Caucasian and female with few minorities represented.

Instruments

Instrumentation

Five instruments were used in this study: a demographic questionnaire developed by the writer, the Beck Depression Inventory, the State-Trait Anxiety Inventory, the Coopersmith Self-Esteem Inventory, and the Children of Alcoholics Screening Test. As in Dodd's study, the demographic questionnaire and the Children of Alcoholics Screening Test were placed together at the end of each
packet in an effort to avoid contaminating the results of the study.

**Identifying Children of Alcoholics**

The Children of Alcoholics Screening Test (CAST) was used to identify children of alcoholics. The CAST contains 30 items to which "yes" or "no" responses are given. All "yes" answers are tabulated to yield a total score that can range from 0 to 30. The items describe the child’s behaviors, feelings, and experiences in reaction to a parent’s use of alcohol. The CAST measures a child’s emotional distress regarding a parent’s drinking, the child’s view of marital conflict between the parents, the child’s attempts to control parental drinking, their efforts to escape from it, their exposure to family violence that is drinking related, their tendencies to view the parents as alcoholic, and their desire for help (Pilat & Jones, 1984-1985).

The CAST is regarded as a strong test despite the fact that it has not been updated since 1983. It has both reliability and validity and is appropriate for use in research where problem drinking is an issue for individuals and their families. Hart (1989) suggested that CAST is particularly useful in studies of stress-resistant or resilient children.
Schinke (1989) cautioned that the reliability and validity of CAST with regard to age, sex, race, and ethnicity need more research and have not been addressed since the reviews of Maxwell (1985) and Stacey (1985) which appeared in the Ninth Mental Measurements Yearbook (Schinke, 1989).

At that time, 1985, the validity of the CAST was measured by using contrast groups in two studies. The first study used 82 children of alcoholic parents who had been clinically diagnosed, 15 self-reported children of alcoholics, and 118 randomly selected control group children, elementary school age through adolescence. Chi-square analyses were computed, and it was found that all 30 CAST items significantly discriminated children of alcoholics from control group children. The two groups of children of alcoholics did not differ significantly and so were combined to form one group of 97. The group scores were correlated with the total CAST scores and yielded a validity coefficient of .78. Most children of alcoholics never come in contact with a clinical setting. CAST allows researchers to bridge the gap between the clinical and non-clinical setting.

In the second study, the CAST was given to 81 adults ranging in age from 18 to 37 years. Five individuals in this study reported that one or both of their parents had received treatment for alcoholism. These five scored
significantly on the CAST compared to the other 76 subjects, suggesting that the CAST is valid with adult children of alcoholics. Additionally, in both studies, a Spearman-Brown split-half reliability coefficient equal to .98 was obtained (Pilat & Jones, 1985).

Identification of Depression

The Beck Depression Inventory (BDI) was developed by Aaron Beck and his associates in 1961 and is presently the most widely used clinical self-report test of depression. The BDI not only gives a quick assessment of the severity of depression, but additionally highlights some symptoms (such as suicidal intent) that would necessitate prompt therapeutic intervention. The BDI also provides information regarding each subject's negative thinking and expectations (Beck, Rush, Shaw, & Emery, 1979).

In 1971, the BDI was revised as a short questionnaire at Beck's Center for Cognitive Therapy of the University of Pennsylvania. Although Beck is primarily known for his cognitive therapy approach, the BDI is not tied to that theory. It has been used on many groups throughout the years, and various studies report test-retest reliability ranging from .48 to .86 for psychiatric patients and from .60 to .90 for non-psychiatric samples. The internal consistency is .81 to .86 for psychiatric patients.
Regarding validity, research has shown .50 to .80 (Steer, Beck, & Garrison, 1985).

The BDI consists of 21 items, each of which contains four sentences, ranging on a scale from 0 to 3 in terms of severity of complaint. The first 13 items cover the cognitive, affective subscale (pessimism, guilt, self-accusation, crying, and indecision), and the last 8 items relate to sleeping, appetite, and motor activity. The total score is used: scores of 0 to 9 are within the normal range; scores of 10 to 18 indicate mild-moderate depression, scores of 19-29 moderate-severe depression, and a score of 30 and above extremely severe depression. These guidelines were suggested by Beck and Steer (1987).

Sundberg (1992) cautioned that the BDI is relatively state-oriented; answers are based on the past week and today so results may not reflect earlier depressive episodes and may change over time. Although the BDI is regarded as a very good and specific measure of depression, certainly diagnosis of depression should not be made solely on the results of this test (Sundberg, 1992).

Identification of Anxiety

The State-Trait Anxiety Inventory (STAI), developed to provide a reliable measurement of both trait and state anxiety, is generally regarded as one of the best measurements of anxiety by researchers. This instrument was
designed in 1964 with college students and others to be a self-administered scale. Data for the STAI were gathered from more than 5,000 subjects who were college and high school students, military recruits, medical and psychiatric patients, as well as prison inmates. The objective was to provide a simple scale that would measure both state (presently existing feelings of nervousness and worry) and trait (a relatively enduring personality characteristic) anxiety. The STAI is composed of 40 brief items that require the subject to answer on a scale of 1 to 4, with 1 being "not at all," 2 being "somewhat," 3 being "moderately so," and 4 being "very much so." A score of 3 or 4 indicates high state or trait anxiety. It is possible to score high on one scale and low on the other (Speilberger, 1983).

An individual who is defined as being high in trait anxiety does not always evidence that characteristic openly, but is one who is anxiety prone and who experiences state anxiety more often when presented with a wide array of stimulus conditions than do individuals with low trait anxiety (Katkin, 1978).

Test-retest reliabilities for the trait scale for male and female college undergraduates were established as .73 and .77 over a six-month period, indicating good stability. Internal consistency of the state scale, as measured by the Kuder-Richardson 20, ranges from .83 to .91. The Manifest
Anxiety Scale and the IPAT Anxiety Scale were used with the trait anxiety to correlate scores and thus provide concurrent validity. Correlations ranged from .73 to .85, giving the scale high concurrent validity. Validity was obtained by contrasting results with norming groups with the criterion of different degrees of stress within the groups. The scores on the state anxiety rise markedly under stress, indicating that the state scale does measure changes in an individual's subjective experience of anxiety (Spielberger, 1983).

Thus, the research on the STAI indicates that this scale is both reliable and valid in terms of assessing individual differences in anxiety-proneness and transitory experience of anxiety.

Because the state scale of anxiety is not relevant in this study, only the trait scale of anxiety will be used to assess how each subject generally feels in terms of anxiety-proneness.

Identification of Self-Esteem

The Coopersmith Adult Self-Esteem Inventory (SEI) is a self-report instrument designed to measure an individual's perception of his or her personal traits and characteristics (self-esteem). Each questionnaire contains 25 statements about the self. Subjects are to indicate which statements are "like me" or "unlike me." The separate measures are the
School Form for 8- to 15-year-old children, accompanied by an eight-item Lie Scale to assess defensiveness, and the Adult Form for individuals past the age of 15. The Adult Form was used in this study. The SEI is well known and widely used as a measure of self-esteem. Both the School Form and the Adult Form are brief and easily scored, and both possess reliability and validity. Each scale provides a total score as a measure of self-esteem. The higher the score, the higher the subject's self-esteem. The highest score possible is 100 (Peterson & Austin, 1985).

A common criticism of the SEI is that researchers are unable to agree on a precise definition of self-esteem. However, the Coopersmith manual (1993) defines self-esteem as a "set of attitudes and beliefs that a person brings with him or herself when facing the world . . ." (p. 1). Self-esteem provides a mental set that prepares the person to respond according to the expectations of success, acceptance, and personal strength.

Despite the drawback of not having a universally accepted definition of self-esteem, it is widely accepted by researchers that the SEI has much to recommend it as a widely used and accepted measure of self-esteem because it possesses reliability and validity for use in research (Peterson & Austin, 1985). The Adult Form is highly recommended for use in research although the School Form is not recommended for individual assessment presently due to
several factors not enumerated here inasmuch as the School Form was not used in this study.

Identification of Family Dysfunctionality

The demographic questionnaire was designed by this writer for the purpose of obtaining more family history regarding not only alcohol-related issues but also other issues relevant to family dysfunctionality. This questionnaire, the Family Dysfunctionality Screen, will hereafter be referred to as FDS in this study. The FDS poses eight questions on issues of family history that this writer concluded were germane to dysfunctionality after reading Kitchens (1991), Fossum and Mason (1986), and Subby (1987). In originating the eight questions, number 1 related to family alcoholism, number 2 to rigidity and power, number 3 to blame, number 4 to family secrets, number 5 to repression of feeling, number 6 to chaos, number 7 to resolution conflict, and number 8 to depression/anxiety.

In providing a rationale for the inclusion of the specific issues asked about in the FDS, three writers just cited wrote specifically about the issues and conflicts present in dysfunctional homes. Kitchens (1991) wrote about unrealistic parental expectations and parents who are rigid and must always be right. Kitchens asserted that children who experience rigid parents often feel guilty, experience a sense of failure, and are usually seen as very serious and
hard-working with little self-esteem. This rigidity, the lack of flexibility, is seen in parents who tolerate no deviation on the part of the child. Normal mistakes are not allowed. The result is frequently domination of children who lack self-reliance, who experience low self-esteem, and who are fearful of trying new things.

Kitchens (1991) also wrote of chaos and crisis often being a characteristic of dysfunctional families. These parents keep the home in emotional turmoil. There is great tension, and conflicts are rarely resolved. The conflicts may recede in the background, or they may escalate, but resolution is rarely experienced. This chaotic environment frequently produces children who don’t learn how to resolve conflict. As adults, they have some difficulty in establishing and maintaining intimate relationships.

Following this line of thinking, Fossum and Mason (1986) set out a list of family rules for a shamebound family system. Some of the rules are as follows:

1. Control. Be in control of all behavior and interactions.
2. Blame. If things don’t go well, blame someone.
3. Perfection. Always be right.
4. Denial. Deny feelings, especially ones such as anxiety, fear, and anger.
5. Incompleteness. Don’t ever bring any conflict to resolution.
6. No talk. Don't talk openly about shameful, abusive, or compulsive behavior. Fossum and Mason (1986) made the point that these rules force children to focus on survival rather than growth. It is a different task for children of such homes to develop a sense of personhood or achieve much self-acceptance.

The third researcher whose work was used in formulating the questions on the FDS was Subby (1990). Subby wrote that the rules of a dysfunctional family system interfere with normal psychoemotional development, close off healthy communication, foster mistrust, and make intimacy impossible. Subby's rules were as follows:

1. Do not talk about your problems.
2. Do not talk about your feelings.
3. Do not think or feel anything.
4. Do not trust.

These three researchers have many commonalities in their writings regarding what constitutes family dysfunctionality. The commonalities upon which this researcher focused in attempting to measure dysfunctionality are as follows: parental alcoholism, rigidity, blame, secrets, repression, chaos, conflict resolution, and depression/anxiety. By design, no questions indicated more or less importance that the others.

Eight separate questions with a "yes-no" response were developed. Each question deals with an issue considered
relevant to family dysfunctionality. Each question is worth one point, the scale being 0 to 8. A composite score was created by counting the number of "yes" responses. A higher score (6 to 8) indicates more dysfunctionality within the home whereas a lower score (0 to 5) indicates dysfunctionality within the home.

In an effort to determine significance, Dodd (1991) conducted in his study a $2 \times 2$ Multivariate Analysis of Variance (MANOVA) using dependent variables simultaneously. The independent variables were analyzed by group (parental alcoholism status), by gender, and by their interaction effects on levels of self-esteem, depression, and anxiety.

The first analysis compared ACOA and non-ACOA groups without regard to gender differences. Dodd (1991) found that no significant difference existed. The second design compared males vs. females and found no significant differences. The third design, examining interaction between group and gender, also found no significant difference. Although Dodd found no significance at the .05 level, he did find that ACOAs scored lower in self-esteem and higher in anxiety and depression that did the non-ACOA groups. His finding was consistent with the literature concerning the ACOA population at that time (1990); however, recent research, cited in this study, indicates different findings.
It is the belief of this researcher that by inclusion of types of family dysfunctionality within the demographic questionnaire and asking subjects to identify specific areas of trauma that they may have suffered in their families, significance between the groups or between the sexes may be found.

Many researchers presently claim that contrary to earlier findings (those studies that clearly trace the development of specific personality traits to growing up in an alcoholic home) many adults other than ACOAs exhibit similar personality characteristics to those usually ascribed to ACOAs. These individuals appear to share similar developmental experience in that they experienced poor parenting, poor communication with parents, and a non-nurturing home atmosphere. Whether these similar experiences uniformly result in low self-esteem, depression, and anxiety is questioned in this study. There may be many non-alcoholic factors present: chronic violence, abuse, mental or physical illness, lack of honest emotional expression, repression of feeling, family secrets, and more. The present questionnaire is structured to facilitate subjects' responses to the just-cited experience in family life. It is hoped that the findings of this research will contribute in some way to what is presently known about the population of ACOAs and ACDFs.
The Measures and the Cut-offs

The measures used in this study included the following:

Beck Depression Inventory (BDI)
- 0-9 score equals minimal depression
- 10-16 equals mild depression
- 17-29 equals moderate depression
- 30-63 equals severe depression

Coopersmith Self-Esteem Inventory (SEI)
- There exists no exact criterion for high, medium, low
- High equals high self-esteem

- The standardized mean according to Coopersmith (1987) is 70-80; the standard deviation is 11-13.

State-Trait Anxiety Inventory (STAI)
- No exact criterion exists.
- Range is 20-80.
- High equals high anxiety.

Family Dysfunctionality Screen (FDS)
- 0-5 equals low level of dysfunctionality
- 6-8 equals a higher or more severe degree of dysfunctionality

Children of Alcoholics Screening Test (CAST)
- 0-1 equals not having an alcoholic parent
- 2-5 equals a problem drinker
- 6 or more equals child of alcoholic
CHAPTER III

REVIEW OF THE LITERATURE

Much has been written on the subject of alcoholism, its psychological and emotional effects upon the alcoholic and upon the spouse and children of the alcoholic. However, relatively little had been written before 1983 on the subject of whether or how living in an alcoholic home affects the child once that child has aged chronologically and moved into the adult years of life. How do these adults fare developmentally in comparison to adults from non-alcoholic homes? Do these adults suffer more depression, anxiety, and lower self-esteem than other adults do?

Predictable Personality Characteristics, Developmental Problems, Rules, and Roles

Cermak (1988), in *A Time to Heal*, addresses particularly the issues of anxiety and self-esteem. Cermak asserted that living in a chemically dependent family is never normal, that the familial interactions within that home cause children to lose their ability to trust in others, themselves, and the world, resulting in a loss of spontaneity and other deficits in personality that may last
a lifetime. Cermak identified some typical problems of adult children of alcoholics (ACOAs) as denial and repression of feeling, defensiveness, depression, a chronic sense of emptiness, great anxiety over what is unknown, and low self-esteem that manifests itself through lifelong deference to other people and their wishes. Despite the high achievements of many ACOAs, according to Cermak, as a group these adults over-rely on others, read many self-improvement books, and typically believe that others always know more and are more competent than they are.

In the early eighties, Cermak and Brown (1982), both of Stanford University Medical Center, began treating alcoholics and their families in family group therapy. One of the observations of the therapists was that the issue of control characterized and dominated these sessions. Control seemed to be an underlying factor of other issues such as trust, responsibility, and the ability to be vulnerable and to acknowledge personal needs. The children of these families manifested conflict regarding the subject of feelings; feelings were viewed by these children as bad, in that any expression of feeling really meant a loss of control. In conjunction with that attitude, all experienced the expression of anger as being especially out of control. The repression of feeling resulted in intense feelings of depression and loss. Being indecisive or seeking help from others was viewed by these children as a cause for great
anxiety and panic. ACOAs are commonly regarded as overly controlled, hypervigilant, untrusting individuals who repress most of their feelings but manage to experience chronic guilt. Whitfield (1987) also noted that control is an issue that allows ACOAs to numb their feelings and allows them to develop and maintain through adulthood a false self.

Sexias and Youcha (1985) also found in their study of 200 patients in group therapy that ACOAs suffer from a pervasive sense of lack of control that manifests itself in depression and anxiety. These researchers believe the overwhelming sense of lack of control is a result of living in a family environment characterized by the erratic and unpredictable behavior of an alcoholic parent, that behavior renders the child helpless in terms of exerting any control over his or her own life or environment. In adulthood, this helplessness often becomes a feeling of powerlessness that cripples a person's ability to function as an independent adult able to express feelings and needs.

Additionally, Ackerman (1983) has asserted that ACOAs feel unable to control any major aspect of their lives, a feeling (helplessness) that manifests itself in depression and unhealthy ways of coping with life's difficulties. Similarly to Sexias and Youcha (1985), Ackerman attributes this helplessness and lack of control to growing up in a chaotic home environment where the child was, in fact, at the mercy of an unpredictable, capricious, drinking parent.
Black (1981), in *It Will Never Happen to Me*, also addressed the issues of depression, anxiety, and self-esteem. Black believed that children who are rigidly controlled in chemically dependent families and who feel no sense of power or control over their lives, become adults who often experience much depression and who appear incapable of feeling close to others. Black characterized these children as having assumed childhood roles of the Responsible One, the Placater, and the Adjuster. As adults, these individuals tend to rely solely on themselves.

Wegscheider (1981) identified family roles somewhat differently. She included the hero, scapegoat, lost child, and the mascot. Her thesis is that the role each person in the family plays has a tremendous impact in terms of self-worth upon that future adult's self-esteem and that children such as these are doomed to personal disintegration. Additionally, the rules Black maintains that govern alcoholic families (Don't Talk, Don't Trust, Don't Feel) really manifest themselves when the children reach their mid-twenties and experience pervasive depression, fear, and anxiety that may appear not to be related to their present living circumstances. Like Cermak and Brown (1982), it was Black's contention that alcoholic families typically deny and repress most of their feelings for many years and that ACOAs often do not learn how to recover from their grief; thus, that grief becomes a long-lasting depression. Black
is adamant that ACOAs are a particular population with specific needs common to them as a group.

More specifically, Woititz (1983) listed 15 characteristics of personality she believed ACOAs possessed. Among these characteristics, Woititz maintains that ACOAs guess at what is normal, judge themselves mercilessly, have problems being close to others, constantly seek approval from others, are loyal to others even when it is not deserved, and simply feel different from others.

Ackerman (1987), contrary to Woititz (1983), asserted that not all adults raised in an alcoholic home are affected in the same ways. Ackerman identified age and gender of parent and child, cultural values, degree of alcoholism, and individual differences in the child’s personality and ability to handle stress as well as variables that cause ACOAs to differ. Like Ackerman, Sexias and Youcha (1985) added to that list: heredity, family rituals, birth order, availability of supportive relationships, economic stability, and family, ethnic, and community attitudes. These factors are referred to in the literature as protective factors while the risk factors have been studied and written about much more extensively.

Ackerman (1989) in Perfect Daughters addressed the subject of women who grew up in alcoholic homes in terms of Erikson’s (1985) eight stages of development. Ackerman commented that these girls never experienced the emotions of
childhood, are rigidly controlled, and typically become adult women who are overly conforming and people-pleasing. In the developmental stage that Erikson terms identity vs. diffusion, Ackerman believed developing the skills necessary for emotional intimacy to be the most critical developmental task and the most difficult one for ACOAs to accomplish. According to his theory, the origin of intimacy problems is fear of abandonment by others. Children in alcoholic homes usually become emotionally isolated from their own feelings because of the inconsistency, inconstancy, and rejection that characterizes alcoholic parents.

Jackson (1954), one of the early writers on the subject of the impact of alcoholism on family members, commented that the whole family goes through predictable stages, beginning with denial and attempts to eliminate or hide the problem, and that each member behaves as if they believe their actions can return the family to stability.

In 1969, more than two decades ago, Margaret Cork, in The Forgotten Children, contributed to the subject of ACOAs by studying over 1,000 current or formerly alcoholic parents and 115 children (59 male, 56 female) regarding their impressions of their particular family situation. The study was conducted with a self-report questionnaire. Cork’s findings concluded that 90% of the ACOAs lacked self-confidence, felt rejected by their parents, and felt great anxiety regarding the always inconsistent and unpredictable
behavior of a drinking parent. Most of Cork's subjects lived in economically middle-to-upper class circumstances, and most lived in a two-parent home. More than 70% of the ACOAs reported that the non-drinking parent was often depressed and anxious, and at least 50% of these children reported feeling depressed and anxious themselves. In this early study, Cork concluded that ACOAs exhibited severe problems in psychological growth and family functioning. Despite the losses these children feel, Cork maintained that, as a group, ACOAs hide their grief and often compensate for their losses through overachievement. Further, Cork suggested that alcoholic families may be a breeding ground for the development of adult borderline personality disorder.

In research conducted by Dodd and Roberts (1994), 60 adult ACOAs and 143 adult non-ACOAs were administered the BDI, SEI, STAI, and CAST. No significant differences were found between the groups on self-esteem, depression, or anxiety. All but one of the ACOA group noted family dysfunctionality. When ACOAs who noted family dysfunctionality were grouped with non-ACOAs, significant differences were found on the three variables between functional and dysfunctional groups. Family dysfunctionality, not parental alcoholism, appeared to be the major factor of variability between ACOAs and non-ACOAs.
Rules

Tharinger and Koranek (1988) found that the alcoholic sets the rules for the family. It is his or her wishes that are obeyed, his or her feelings that are expressed, his or her anger that is allowed. Everyone else in the family learns to adapt to the alcoholic's wishes, whims, and feelings.

Accordingly, the roles each family adapts to stunt their ability to grow, to share honest feelings and thoughts. Roles typically give way to depression, teaching individuals to avoid confrontation, and increasing anxiety. These researchers concluded that ACOAs suffer from physical and emotional problems, including depression, anxiety, and low self-esteem more than children from non-ACOA families.

Depression

Depression, anxiety, and low self-esteem, as well as manipulative and rebellious behavior, hyperactivity, school problems that include delinquency, and high rates of absenteeism have been noted by Moos and Billings (1982) as issues typically faced by teenage children of alcoholics. Although their article addressed the effects of a parent's recovery from alcoholism on the children, it also questioned the extent to which other family factors may affect the functioning of these children. Unfortunately, simply
because a parent ceases active drinking, the family interactions are not guaranteed to become any healthier.

Kammier (1971) noted that what does appear to improve the emotional health of the child, however, is the regular participation of the child in Alateen. El-Guebaly and Offord’s (1977) study supported Kammier regarding the destructive impact of parental alcoholism on the ability of children to function well. Kammier’s work raised questions about whether a family history of alcoholism specifically contributes to antisocial behavior; more study is needed.

As with Moos and Billings (1982), El-Guebaly asserted that children in his study from families of relapsed alcoholics suffered more from depression and anxiety than did the children of the control group. Not only did these children suffer more depression and anxiety, but as they approached adulthood, personality disorders and alcoholism frequently manifested themselves. El-Guebaly noted the need for more carefully controlled blind data studies in order to ascertain other significant predictors of emotional disturbance in childhood that may or may not be closely related to parental alcoholism. However, El-Guebaly concluded that children of alcoholic homes appear to be at greater risk for the serious emotional disturbances of adulthood than children from non-alcoholic homes. This author suggested that these children need to be studied in
relation to children with parents of other types of serious illness, such as schizophrenia and depression.

Bowen (1978) believed that the family members who are most dependent on the drinker experience more anxiety and depression than other members of the family. These individuals become preoccupied with love-hate relationships and experience great psychological and characterological impairment.

Jarmas and Kazak (1992), in a study of college students with both alcoholic and non-alcoholic parents, studied 84 ACOAs and 123 non-ACOAs for perceptions of their families, levels of depression, and coping styles. As predicted, ACOAs showed greater introjective depression and relied more heavily on aggressive defenses than did non-ACOAs. The ACOAs had no more feelings of abandonment or helplessness than the non-ACOAs, but they experienced significantly more feelings of guilt, inferiority, and a sense of having failed to live up to expectations. Additionally, Jarmas and Kazak found that young ACOAs of alcoholic fathers (rather than mothers) perceived their families as more conflictual and isolated, less communicative, less organized, and less predictable. These data suggested that in families in which the alcoholic is the father, more chronic upheaval and fighting is experienced. Consistent with the findings of Goodwin (1977), these researchers found increased substance abuse among male ACOAs.
Jarmas and Kazak (1992) concluded that paternal alcoholism has a long-lasting impact upon children, that ACOAs experience more depression, rely more on aggressive defenses, and view their families as more inconsistent than do non-ACOAs. The researchers also suggested that further study is needed to clarify the impact of the alcoholic parent’s gender as to determine whether these findings might also apply to families with different psychopathology.

Anxiety

A study conducted by Webb, Post, Robinson, and Moreland (1992) at a large southern, state-supported college was originally intended to clarify clinical reports that suggested ACOAs develop dysfunctional personality traits and dysfunctional methods of coping. The study found that significant levels of anxiety existed in ACOAs and that these findings may be gender related. Of 234 subjects, 59 subjects identified themselves as ACOAs and 175 as non-ACOAs. Children of Alcoholics Screening Test (CAST), Children of Alcoholics Information Test (COAT), and State Trait Anxiety Inventory (STAI) were used, and the findings indicated no significant differences on self-concept, a result that was congruent with other literature. There were significant differences, however, on anxiety levels between ACOAs and non-ACOAs. As with the Clair and Genst study (1986), the study by Webb et al. was overrepresented in
females and commented on the need for future research to examine male and female groups separately.

Another recent study (El-Guebaly, Staley, Leckie, & Koensgen, 1992) focused on the relationship between anxiety disorders and alcohol abuse and compared the characteristics of adult sons and daughters of alcoholics who suffer from anxiety disorders with those suffering substance abuse disorders. The sample was part of a larger study of patients being treated at an 850-bed teaching hospital during a period of 8 months. The subjects included 60 anxiety disorder patients and 60 substance abuse patients. The instruments used in the study included CAST, Codependence Assessment Inventory (CDAI), Michigan Alcoholism Screening Test (MAST), and Drug Abuse Screening Test (DAST). Those subjects identified as ACOAs also were interviewed about their family's history of alcoholism and the subjects' problems within the family, at school, with peers, and with the police. Another family member, with each patient's consent, was also interviewed. Of the 60 patients identified as having anxiety disorder, 23 had an alcoholic parent. Of the 60 in the substance abuse program, 28 had an alcoholic parent. Of the ACOAs in the anxiety disorders program, 52.2% had an alcoholic father, 8.7% had an alcoholic mother, and 39.1% had two alcoholic parents. Thus, the gender distribution of the alcoholic parents of
the anxiety disorder patients was similar to gender
distribution of the ACOAs in the substance abuse program.

The findings of this study indicate that an overlap
between the two disorders exists. The researchers found
more similarities than differences between the two groups.
There was a significantly higher percentage of females in
the anxiety disorders program, but the researchers reported
that gender did not have much impact on the results.

The study suggested the need for more research
regarding the cause-and-effect relationship between anxiety
and alcoholism; further, the impact of anxiety disorders on
patterns of family dysfunctionality needs to be studied.
Perhaps future comparisons between the adult children of
alcoholics in these two groups may give us more knowledge
regarding vulnerability to these disorders.

Also addressing the subject of anxiety is a study done
by the Department of Human Services of a large southern
college (Post, Webb, & Robinson, 1991). The subjects were
230 students solicited from sociology and human services
classes. A total of 58 of these identified themselves as
ACOAs; 22% were male, and 78% were female. The subjects
were administered the CAST, COAT, Personal Attribute
Inventory (PAI), and STAI. Sex and age differences were
evaluated using ANOVA, and the relationship between self-
esteeem, anxiety, and knowledge of ACOA issues was evaluated
using the Pearson Correlation.
The results of this study showed no main effects or interactions for sex or age regarding knowledge of alcoholism, self-esteem, or anxiety. Among females, a significant correlation between self-esteem and anxiety was found, but among males, there was no significant relationship among knowledge of ACOA issues, self-esteem, or anxiety. It is hypothesized that the results may in part be attributable to the widely held belief among researchers who study these issues that women identify more strongly with family and tend to become overly involved, while men tend to distance themselves from such families (alcoholic) and look to others who may be more capable of addressing their emotional needs. Thus, while the study showed no main effects for sex regarding knowledge of alcoholism, self-esteem, or anxiety, the study did suggest that among females, there was a significant correlation between self-esteem and anxiety. Female ACOAs with greater anxiety tended to have lower self-esteem. Gender differences were suggested in this study although no main effects for sex are shown. This study suggested gender differences in self-esteem of ACOAs.

Resilience

One of the few longitudinal studies on ACOAs was conducted by Werner (1986) on resilient offspring of alcoholics. Werner followed a group of children from birth
to age 18. The 49 subjects (22 male) were tracked at ages 1, 5, 10, and 18. Most of these children (76%) were reared in chronic poverty and received little nurturing or emotional support from their families. By age 10, one-third of the children of alcoholics needed remedial education, and by age 18, 30% had established records of serious delinquencies. Over 40% of this group had serious coping problems by age 18, but significantly different from the results of many other studies, 59% of these children by age 18 appeared resilient and strong and did not appear to suffer serious difficulties. Resilience, as defined in this study, refers to a group of personality characteristics possessed by children of alcoholic homes who did not develop serious coping problems in childhood or adolescence. As a group, the resilient children reported more responsible, caring, and socialized behavior. They projected more self-control and were more achievement-oriented than the troubled group. The resilient group possessed more internal locus of control and believed that their own behavior determined their life events whereas the troubled group believed luck and fate determined their lives.

Werner (1986) concluded that constitutional characteristics of a child and the availability of early caregiving are decisive factors in determining mental health. Some of the important factors were the child's temperament, intelligence, achievement orientation, positive
self-concept, a more internal locus of control, and belief in self-help.

Gelman, in *Newsweek*, May 1991, reported in an article focusing on how children cope with stress, that there are sharp differences in children’s responses to trauma in their lives. In response to the stress brought on by divorce or abuse, for example, some children become nervous and withdrawn while others thrive regardless of their circumstances. According to this article, resilience research conducted in an effort to discover why some children succeed under extraordinarily painful circumstances has found that children born with an easy temperament or disposition usually handle stress much better than children born with a nervous temperament. Even children who appear to have been nervous from infancy are capable of developing resilience under certain circumstances. Having an attentive parent or mentor, for example, appears to be an important factor in developing the strength to cope well under trying circumstances.

Another study dealing with the subject of resilience in children of alcoholics (Bennett, Wolin, Reiss, & Teitelbaum, 1987) indicated these children are more capable of developing strength and coping skills if the families are able, in spite of alcoholism, to plan and execute family rituals and to value relationships, thus imparting to their children some important messages regarding their own ability
to control present and future life events. These messages allow the children to feel a stronger sense of family identity than they otherwise might feel and allow them to avoid the sense of helplessness so commonly found in children of alcoholics.

A dissertation addressing resilience (Harter, 1991) studied a group of young university students, some of whom were identified as ACOAs, with control subjects whose parents evidenced no problems with alcohol. The purpose of the study was to identify predictors for positive adjustment in college-age people. Results for both groups indicated that good adjustment was a combination of individual characteristics and family characteristics. An internal locus of control combined with high cohesiveness within the family were predictive of positive functioning.

Kitchens (1990) in Pathways to Recovery and Mastrich and Birnes (1988) in The ACOA's Guide to Raising Healthy Children wrote extensively on the subject of ACOAs overcoming their pervasive sense of fear, feelings of inferiority, and excessive need for control. Kitchens addressed the diminished person who may or may not have been reared in an alcoholic or drug-dependent home, but who did grow up in a dysfunctional home (meaning a home where the needs of the child were not met). Mastrich and Birnes addressed the adult child of an alcoholic, who is now trying to rear healthy children despite his or her own emotional
problems. Kitchens asserted that in order to develop a healthy personality, a child needs security, love, acceptance, boundaries, guidance, discipline, and positive role modeling. His book includes self-administered exercises focusing on recovery from growing up in a home in which many of those needs were not met. Mastrich and Birnes presented case studies in which ACOAs speak of their difficulties in reacting normally to their children’s behavior due to their own fears, feelings of inferiority, and sense of helplessness regarding their ability to change their or their children’s lives. This book provides a parenting guide to help ACOAs overcome their own problems and allow them to raise healthy children.

*The Resilient Self* (Wolin & Wolin, 1993) is a strong rebuttal to the writers who have asserted that growing up in a troubled painful home where the needs of the children are not met is an automatic assurance that specific personality traits will develop that cause these children as adults to have problems with depression, anxiety, and self-esteem. Wolin and Wolin did not deny the pain or damage that children in troubled families typically suffer; however, they did identify seven various strengths that help those children heal themselves and go on to lead healthy, happy lives. The contention of *The Resilient Self* is that the recovery movement and inner-child philosophy have for too long focused on the pain and damage of children in troubled
families and that such focus has caused many children to become stuck and unable to move toward self-healing. Some of the strengths identified by Wolin and Wolin that are helpful in the healing process include insight (asking oneself tough questions about the family and giving oneself realistic answers rather than the denial and rationalization typically utilized); independence (physical and emotional distance from the family); relationships (choosing safe and healthy people in one’s life); initiative (not allowing learned helplessness to reign); creativity (imposing order on what was formerly chaotic); humor (finding the comic in the tragic); and morality (extending oneself to help better mankind). The message of this book is that it is entirely possible to free oneself from the role of victim and to become a healthy, happy individual.

Resilient Adults (Higgins, 1994) deals with the subject of adults who appear as individuals who function at a higher psychological level than might be expected, given the mentally/emotionally impoverished families in which they grew up. Higgins, a licensed psychologist, chose 40 subjects who were first judged to have grown up in severely or catastrophically stressful families.

Each of the 40 met the following conditions:

1. As adults, they had a highly developed sense of concern for others as well as self.
2. They developed relationships that were active and thriving.

3. They make consistent and successful attempts to recognize and understand the needs of others and to differentiate those needs from their own.

Each subject was interviewed for four hours, and the level of background stress was evaluated using the FES.

Higgins (1994) wrote about resilience as a process, not as a genetically determined character trait. She dealt first with prevalence and effects of abuse and summarizes what is generally known about resilience, then proceeded to explore a developmental approach to the capacity to love, focusing on the locus of hope that sustained each subject in childhood. She continued exploring the role of faith and division in sustaining resilience and then commented upon the social and political activism that characterizes these adults.

Higgins (1994) defined resilience as the process of self-righting and growth. Because alcohol is an enabler of abuse, it is crucial to note that 10% of adults in the United States grew up in alcoholic homes. She reported the estimated lifetime prevalence of alcoholism is 13.5%, and more than one-third of alcoholics evidence other serious mental disorders that surely influence the developmental process of their children.
Themes that emerged persistently with each subject included clinging to hope (as a child), a pivotal incident through which each began the process of psychological distancing from their families, and a surrogate who provided some nurturing. As adults, each struggled with setting limits with their families, rejecting the role of victim and holding not only the self but others accountable for the consequences of their behavior, refusing to minimize the damage their families caused because "their intentions were good" or "they did the best they could." As resilient adults, these subjects placed great importance on loving well, working well, and continually working to maintain and enhance their own good mental and emotional health.

Three researchers, Havey, Boswell, and Romans (1995), using 442 undergraduate students, studied students' perceptions of the applicability of Woititz's (1983). Woititz identified 13 generalizations which she believed characterize ACOAs. Her work was based on clinical populations and, as such, may not apply to a non-clinical population.

A common theme in ACOA literature is that ACOAs are destined to be more dysfunctional than are other adults unless intervention occurs. It is also suggested strongly in the literature that all ACOAs are at risk, even those who appear not to evidence symptomology described by Woititz (1983) and others. Despite the body of literature focusing
on negative outcomes for ACOAs, much is currently being
written that supports the theory that ACOAs are not destined
to develop emotional and behavioral problems. These
researchers believe that an overreliance on clinical
populations has led to an overly pessimistic view of ACOAs.

The subjects of this study (Havey, Boswell, & Romans,
1995) were 442 undergraduate students enrolled at a mid-
sized university in the midwest. The sample age ranged from
18 to 28 with 63% being female. Of the 442 participants, 79
(18%) identified themselves as ACOAs by answering "yes" to
the question, "Have you ever felt that one or both of your
parents have or had an alcohol problem?" CAST was also used
in this survey. When the two groups (ACOAs and non-ACOAs)
were compared, the ACOA group indicated a parental drinking
problem on over half the items whereas the other subjects
indicated few drinking parent problems. The difference was
found to be statistically significant at the .001 level.

Students were classified as ACOA or non-ACOA by the
method explained. They were also classified into three
groups based on perceived level of stress in childhood
homes. Students were rated in the following way: low
stress (n = 150), average (n = 193), and high stress
(n = 99).

Results of the MANOVA indicted no significant main
effects for parental alcoholism or perceived family stress
Additionally, a test was conducted on levels of stress for
ACOAs and non-ACOAs. ACOAs reported significantly higher levels of stress than did non-ACOAs. This research suggests the resilience of some ACOAs. The analysis indicated that in a nonclinical sample, degree of perceived stress rather than parental alcoholism appeared to be the key variable. These results suggested that the literature, which emphasizes the difference between ACOAs and non-ACOAs, may be ignoring similarities between the two groups.

Genetics

The study of Goodwin (1977), *Is Alcoholism Hereditary?*, suggested a relationship between hyperactivity in children and psychiatric disturbances in adult life. Goodwin believed a genetic influence is present in many alcoholic families that predisposes offspring not only to hyperactivity but also to acute anxiety. The results of Goodwin's study indicated that contrary to previous studies cited, environmental factors did not play a large role in the development of alcoholism in ACOAs.

Gender

Berkowitz and Perkins (1988) concurred with Werner (1986) that ACOA's are more resilient than many studies have indicated. They studied the differences between personality characteristics of a nonclinical sample of ACOAs and children from non-alcoholic families in addition to addressing the issue of gender both of the alcoholic parent
and of the child. Using an alcohol survey with an undergraduate group of college students, these researchers studied 860 students who were measured on four different personality scales. The results showed that ACOAs were more similar than different from their peers, that parental alcoholism affected some aspects of personality, but that it was not as pervasive as previous studies had suggested.

Regarding the issue of gender, the findings of this study (Berkowitz & Perkins, 1988) suggested that the effects of parental alcoholism may be highly gender specific. Females with alcoholic fathers reported lower self-esteem and greater self-deprecation than did males, and males with alcoholic fathers reported greater independence and autonomy than did females. Females appeared more depressed than did males, and both genders reported more responsibility and decision making than did students from non-alcoholic families. Women showed more interest in interpersonal relationships, and men appeared to be more task oriented. Further, it was concluded that drinking patterns of fathers may produce more trauma in children because of the accompanying aggression and subsequent family fighting.

Sexias and Youchas (1985) reported that lack of trust and depression certainly manifests in both sons and daughters of alcoholics, but females particularly are likely to experience difficulty in long-term relationships, in part because they often develop a hard shell; they become very
protective of their inner feelings and learn early in life not to expect emotional support or security from their fathers.

Other researchers who have studied gender differences in addition to Ackerman (1989), Sexias and Youchas (1985), and Berkowitz and Perkins (1988) have suggested that alcoholic fathers more than mothers may be unpredictable and violent in their behavior at home. Alcoholic fathers tend to leave the home to drink, then often return to engage the family in fighting and conflict whereas alcoholic mothers tend to drink secretly, staying at home and attempting to maintain the facade of family constancy and stability. Kristberg (1988) noted that the unpredictability and tendency toward aggression manifested by many alcoholic fathers teaches female children not to trust men to fulfill their needs for love and affection and instills within them a fear of abandonment that leads to deep insecurity and fear in their adult lives. The Jekyll-Hyde personality that is characteristic of many alcoholic fathers (warm and loving when sober, angry and abusive when drinking) results in intense anxiety and anger capable of poisoning the daughter's adult relationships with men all her life (Ackerman, 1989).

A study by Jones and Zalewski (1994) tested the hypothesis that ACOAs are more prone to shame and dependence that are non-ACOAs. The sample included 60 women, 30 ACOAs
and 30 non-ACOAs, ranging from 22 to 55 years of age, who had begun treatment within the previous six months. Dependent measures were Depression Proneness Rating Scale and Adapted Shame-Guilt Scale. Female ACOAs were found to be more depressed than were non-ACOAs. However, they were not found to be more shame prone.

Measures used were MAST, CAST, and ASGS. Results of the tests were that female ACOAs entering therapy were found to be significantly more prone to depression than were non-ACOAs. These results supported prior research of an increased lifetime proneness to depression of female ACOAs and of greater levels of dependence among female ACOAs in nonclinical populations (Jones & Zalewski, 1994).

Contrary to the findings just cited, Chafetz, Blene, and Hill (1971) found for the most part no differences between the sexes in terms of the effects of parental alcoholism. Their study did show that males from alcoholic families tended to have problems in school, be risk-takers, and have more serious accidents. The study also found that both sexes have a difficult time becoming emotionally open and responsive adults. The researchers suggested that more study is needed on self-concept, deviant behavior, interpersonal relationships, and gender differences of ACOAs.

Another longitudinal study of 20 years conducted by Rydelius (1981) found that alcoholic fathers who were in
their early twenties produced offspring who had more physical illness, social problems, and antisocial behavior (among the males). Fewer girls developed serious mental health problems in adulthood than did the males. Miller and Jang (1977) did a 20-year study of 259 children; 147 children had an alcoholic parent, and 112 did not. The results showed that although these troubled children were likely to have drinking problems in adulthood, a child’s future mental health could not be predicted on the basis of parental alcoholism. Other variables included the gender of the child, the severity of crises in early childhood, the child’s evaluation of his or her self-esteem, and psychological well-being in early adulthood.

In addition to Rydelius (1981), another longitudinal study of 40 years conducted by Beardslee, Son, and Vaillant (1986) examined the degree of exposure to parental alcoholism during childhood and the effects of that exposure in adulthood. This study of males only predicted that varying degrees of exposure to parental alcoholism, including both the amount of drinking and the chaotic family functioning due to that drinking, would correlate with higher rates of emotional disturbance in adulthood. The outcome of the study supported the prediction. Significant levels of alcoholism, sociopathic behavior, and other disturbances were found in proportion to the levels of drinking and chaos in the homes where these men grew up.
Another study that appeared to support the findings of Rydelius (1981) and those of Beardsley, Son, and Vaillant (1986) is one by Jacob and Leonard (1986), who studied data from 134 families, not in treatment, but who had been intact families for at least 5 years. The results showed that alcoholics with the most severe drinking and chaotic behavior significantly increased the psychological problems of their wives and children. Daughters of alcoholics showed more social competency deficits than did the controls, and sons of alcoholics rated higher on behavioral problems and delinquency than did sons in the control group.

Through the last decade, several noted researchers reported that low self-esteem, high anxiety, and depression are obvious characteristics of teenage drinkers. Kaplan (1979) reported that the motivation to drink was positively correlated with levels of psychological frustration, feelings of helplessness and powerlessness, inability to delay gratification, and parental approval of a person's first drinking experience. Coopersmith (1967) concluded that high self-esteem among children is linked to perceived parental care and concern. Children with low self-esteem were described as having feelings of rejection and disrespect; many children of alcoholics exhibit similar characteristics.

Subjects of the Coopersmith study (1967) were 300 undergraduate college students at a southern university:
n = 116 (39% males) and n = 194 (61%) female volunteers. The mean age was 22 years. Most students reported a grade point average of 1.2 to 3.0, and the mean GPA was 2.5. All students were taking core courses in psychology, counseling, student development, and nursing. Participation was voluntary. Students completed seven questionnaires, including MAST, SEI, CAST, BDI, and STAI. They also took the Assertiveness Self-Report Inventory (ASRI) used to measure assertiveness. The ASRI is a 25-item true or false inventory.

The results for anxiety and depression indicated a low degree of anxiety and no depression. The scores for self-esteem revealed high levels of self-esteem and assertiveness. Mean scores for alcohol abuse indicate that these students were abusing alcohol and that one or both parents had a drinking problem. The 19 to 22 year-olds were more likely to abuse alcohol, but 54% of the 26 and older group reported alcohol abuse. A higher percentage of males (60%) as compared to females (51%), abused alcohol. Those with lower GPAs were more likely to abuse alcohol than were those with higher GPAs (Coopersmith, 1967).

The findings from this study (Coopersmith, 1967) support other studies that suggest that college students who abuse alcohol are more likely to come from an alcoholic family than are those who do not abuse alcohol. This study concluded that the demographic social variables of gender,
age, and GPA are associated with alcohol abuse in college
students and that self-esteem, assertiveness, family abuse
of alcohol, anxiety, and depression are related to alcohol
abuse in college students. The best single predictors of
alcohol abuse, in order, are family abuse of alcohol,
depression, anxiety, self-esteem, and low GPA.

The studies just cited appear to support the
(1986), and others that alcoholism has lifelong
psychological consequences for children growing up in
alcoholic homes. Harrigan (1984) maintained that when
comparing children from alcoholic homes with children from
non-alcoholic homes, children from the latter were three
times more liable to be removed to foster care, twice as
liable to marry before age 16, and attempted suicide more
often as adults. Notwithstanding this body of knowledge,
what becomes increasingly clear in the literature is that
although alcoholism within the family appears to be
predictive for emotional disturbance in adulthood, other
severe illnesses in addition to alcoholism often result in
those same emotional disturbances.

Severe Mental Illness

Williams and Corrigan (1992) posed the question as to
whether growing up in a family with mentally ill parents
produced more destructive effects upon the children than
being raised by alcoholic parents. Fine, Yudin, Holmes, and Heinemann (1976) earlier addressed this question and concluded that children of both alcoholic parents and psychiatrically ill parents suffered more anxiety than did the children in the normal control group. According to Fine et al., children of alcoholic homes evidenced more social aggression and delinquency than did children of mentally ill parents. Children of alcoholic parents also showed more emotional detachment than did any of the other children. Williams and Corrigan's study (1992) produced some results contrary to those of Fine et al. These researchers studied 178 undergraduate and graduate psychology students. They used CAST, SEI, BEI, and STAI, as did Dodd (1990) and this current study. The results of the 139 students who completed all the measures were that 45% were ACOAs, adult children of mentally ill parents, or both. Of the remaining 76 subjects, 22 were randomly selected to form a comparison group. The children from the latter group had significantly higher self-esteem, less depression, and less anxiety than did the children in the first two groups. Adult children of mentally ill parents showed greater depression and anxiety than did ACOAs and the control group. Both ACOAs and children of mentally ill parents had lower self-esteem and more anxiety than did the individuals in the control group. However, the impact of parental pathology for both groups lessened when the adult child had a satisfactory social
support network. Overall, as the study predicted, the results showed that adult children of mentally ill parents experienced lower self-esteem, greater depression, and more anxiety than did ACOAs and others.

In 1994, Neff, Department of Psychiatry, University of Texas Health Science Center, did a study comparing the effects of parental alcoholism, parental mental illness, or no parental pathology, using a random community sample of 1,784 subjects. Neff conducted household interviews as part of a study of socioeconomic and sociocultural determinants of racial/ethnic differences in drinking patterns. Respondents were classified into groups regarding parental alcoholism, mental illness, both, or no pathology. Overall, parental alcoholism was more commonly reported (9% of males and 11% of females) than was parental mental illness (6% of males and females). The combination was rare (2% for males and 1% for females).

As many writers have noted, much of the literature regarding the damaging effects of parental alcoholism upon adult adjustment has been based upon clinical populations. Neff’s (1994) research suggests that as research moves out of clinical populations and into the community, the effects of parental alcoholism are less pronounced or perhaps less noted. Neff’s female subjects who had parents with severe mental illness did report significantly higher levels of depression and anxiety. Neff further suggests that intense
ACOA effects may be specific to clinical settings. The data from Neff's study do not suggest that parental alcoholism is associated with poor adult adjustment, but parental illness may be a more salient factor.

Another point of view is taken by Burk and Sher (1990), who maintained that healthy ACOAs do exist and are overlooked because they have no demonstrable psychopathology and do not appear to fit into the group as characterized by the many researchers cited in this current study. Of course, the professional success of these individuals may hide their anger and feelings of loss. A commonly held belief in the literature is that only 5% of ACOAs ever seek help and that frequently these individuals were forced as children to develop strength, resilience, and adaptability—qualities that enhance them externally but may do little to address inner conflict.

Sher, Department of Psychology at the University of Missouri, has written extensively about ACOAs. Sher (1990a) published an overview of research methods and findings in which he reported on many aspects of ACOAs that have been written about in recent years. Sher addressed the subject of family interactions in both alcoholic and non-alcoholic families as well as the subjects of depression, anxiety, and psychological characteristics of ACOAs. Among other findings, Sher reported that Steinglass (1981) studied alcoholic families both clinically and in their home
environments. Some of Steinglass's findings are that alcoholic families showed impaired problem-solving, lack of resolution of conflict, and more negative and hostile communication than the non-alcoholic families in the control group. However, Steinglass also asserted that disturbed family interactions characterized not only alcoholic families but other families as well. Steinglass concluded that the research on family environment and family interaction did not adequately address the relationship between family variables and the eventual adjustment (into adulthood) of ACOAs.

Regarding anxiety and depression particularly, Sher (1990b) asserted that even though several studies indicated that ACOAs reported higher levels of anxiety and depression, the designs of such studies made it difficult to specifically attribute the child's maladjustment to parental alcoholism. The relationship between alcoholism and depression appears to be complex, and there is still much controversy about whether it is genetic in nature.

Sher (1990b) maintained that although it is quite clear that ACOAs are at risk for many negative outcomes, certain disorders such as anxiety and depression may be more attributable to disturbed family relations such as marital conflict or parental separation than to parental alcoholism. There are many studies of alcoholic families using the Family Environment Scale (FES) that show that alcoholic
families experience less family cohesion than others, greater restriction of feeling than others, and have higher levels of conflict in general than non-alcoholic families. Many of these differences appear to be related to the current drinking status of the alcoholic parent. The inner conflict of ACOAs was examined in a study conducted by Robinson and Goodpaster (1991), focusing on locus of control and the imposter phenomenon. Locus of control is defined by perception of one’s control over one’s actions and their consequences (internal locus of control) versus the belief that outcomes in life are determined by luck, fate, or chance (external locus of control). The view held by many researchers is that external locus of control is associated with anxiety, depression, mental illness, and drug and alcohol abuse. The second issue examined is imposter phenomenon: intense inner, hidden feelings of being phony, an inability to take pride in one’s accomplishments, self-doubt, and a tendency to attribute success to external causes. People who develop this condition live in constant fear that others will discover they are not capable or intelligent after all. Researchers report that imposters experience great anxiety and depression. They suffer fear of failure and lose the joys that ordinarily accompany success. Of course, the alcoholic home is a perfect setup for the development of these related psychological
disturbances, with inconsistency, unpredictability, arbitrariness, and chaos present in these homes.

Robinson and Goodpaster (1991) examined the influence of one or more alcoholic parents on the two conditions previously cited. Subjects were 48 college students and 21 members of a local Adult Children of Alcoholics group. The subjects were administered the Imposter Test, the Nowicki-Strickland Internal-External Control Scale for Adults, and a family history survey. Individuals with an alcoholic parent who attend a support group were compared with those with alcoholic parents not attending, and individuals with non-alcoholic parents.

The findings of the Robinson and Goodpaster (1991) study revealed a highly significant difference in external locus of control, ACOAs being most external and students with non-alcoholic parents being least external. ACOAs also had the highest scores for imposter phenomenon, and students with non-alcoholic parents scored lowest. The findings support the widely held belief of those who work and study in this field that parental alcoholism does indeed significantly interfere with a parent’s ability to be warm, protective, nurturing, and consistent in their child-rearing practices.

Robinson and Goodpaster (1991) indicated that ACOAs have a significantly lower belief that their success/failures were under their control (indicating lack
of internal locus of control). Interestingly, both groups of ACOAs showed the lack of internal locus of control, but those who attended a support group showed the lowest scores of all. These subjects also showed the highest scores for external locus of control. The reasons for this are unclear. One possible explanation is that some ACOAs feel a need to join a support group because they are so externally controlled that they have a high need for others to help them cope and validate their self-worth. They look to others for guidance. If this is true, the implication is that ACOAs who do not join a support group are attempting to rely on their own strengths and abilities in coping with life. The aforementioned is only a hypothesis based on the findings of the study, not a conclusion.

As Burk and Sher (1990) asserted, not all ACOAs are in need of therapy or support groups. Some may, in fact, be stronger and more resilient than others, and some may be so entrenched in denial (of the problems) that they are unable or unwilling to receive help. Much more research is needed on the subject of the correlation between alcoholic parents and self-image and locus of control.

Impact of Therapy

The study of Cooper and McCormick (1992) attempted to assess the impact of an 8-week therapy group for ACOAs. The subjects were college students at Stanford who indicated an
interest in ACOA issues. Students were told that the group would consist of 8 weeks of intensive group experience dealing with issues believed to be common to ACOAs. The total number was 24, and all four groups were led by a male and female therapist. Instruments used were the UCLA Loneliness Scale, Version 2 (UCLA), the Multiple Affect Adjective Check List—Revised (MAACL-R), and the Interpersonal Dependency Inventory (IDI). The purpose of the UCLA was to detect loneliness in everyday life since loneliness has been associated with depression and alcoholism in many studies. The MAACL-R was included to assess changes in affect level and to assess the effectiveness of the therapy. The IDI was included to assess interpersonal dependency in terms of emotional reliance on another person, lack of social self-confidence, and assertion of autonomy. Subjects' scores on the UCLA were very close to the mean, and scores on the MAACL-R were much higher than the norms, indicating significantly high anxiety, depression, and hostility. Scores on the IDI were close to the mean.

The results of the study supported the existence of an ACOA typology and also supported the use of brief group therapy for ACOAs. Following 8 weeks of group experience, the subjects' hostility feelings greatly diminished. This finding was further supported by follow-up testing 8 weeks later.
Another study in which ACOAs showed improvement after treatment was conducted by Moos and Moos (1984) who studied a group of patients and their wives two years after treatment. Essentially no difference was found in family functioning between the recovered group and the control group. This study provided some evidence that families of recovered alcoholics are capable of functioning reasonably well; however, the relapsed families in the group showed much less cohesiveness and emotional range of expression than did the other two groups.

Regarding the issue of family functioning, the researchers hold widely divergent opinions. Most concur that serious conflict and role dysfunctions exist within these families, and many studies speculate that alcohol is not the major marital problem, that these families will operate marginally even if the alcoholic recovers.

The Moos and Moos (1984) study supported the hypothesis that non-alcoholic spouses in relapsed families did more than their share of role functioning and that relapsed families showed less cohesion and more conflict than did families of recovered alcoholics. The overall results indicated that families of drinking alcoholics reported more depression, anxiety, and family arguments and less agreement regarding task performance. These findings concur with those of Jackson (1954) that families of recovered alcoholics avoid conflict and tension because they fear
renewed drinking. In relapsed families, the alcoholic member participated very slightly in household tasks, and the spouse generally functioned for both. Families with more severely impaired alcoholics showed higher anxiety and depression among the non-alcoholic spouses.

Relapsed Families

Referring to the study by Moos and Billings (1982) previously cited, the children of relapsed families also experienced more depression and anxiety than did the children in the control group, and the parents of the relapsed families showed less cohesion, less emotional expression, and less independence than did control families. The findings of Moos and Billings corroborated those of El-Guebaly and Offord (1977) relating to the destructive effect of parental alcoholism upon the functioning of children. These studies further indicate that children in relapsed families suffer more depression and anxiety than children in recovered families. These findings support the belief that when parents are successful in controlling their drinking, the emotional disturbances experienced by their children may diminish. Whether these children’s improvement is permanent and carries into adulthood is an unanswered question for which more research is needed. Many disturbances such as personality disorders and alcoholism often do not appear until early adulthood so it is possible that some children’s
symptoms are minimal until early adulthood when they begin to encounter the stresses of adult life.

Self-Esteem and Anxiety

Although it cannot be denied that clinical studies usually support the widespread belief that parental drinking is destructive to the personality development of children prior to age 18, Churchill, Broida and Nicholson's study (1990) examined the impact of parental drinking on ACOAs past the age of 18, and their findings do not support the previous research. Using data from 127 men and 318 women between the ages of 18 and 70, this study showed no significant relationship between parental alcoholism and either locus of control or self-esteem. This study used the Rotter, Internal External Locus of Control ("LOC"), the Jackson Personality Inventory, and the CAST. Based on the findings, Churchill et al. concluded that parental alcoholism is simply not enough in and of itself to produce the specific personality characteristics cited by much previous research, nor is parental alcoholism alone enough to produce depression, anxiety, and low self-esteem without other dysfunctionality being present in the home.

In keeping with the Churchill et al. (1990) study, Werner and Broida (1991) conducted a study of 195 adults, aged 18 or more, in a large corporation. The study used the Moos Family Environment Scale (FES), the Jackson, and the
Rotter. The results showed that low self-esteem correlated with a more external locus of control and that ACOAs were different from adult children of non-alcoholic families only when other dysfunctionality was present. The conclusions reached were that growing up in an alcoholic home did not especially predict lower self-esteem or a more external locus of control. Family dysfunction, whether alcoholism is present or not, is a predictor for lower self-esteem and more external locus of control. These findings are consistent with those of Churchill et al. (1990), previously cited. Therefore, caution needs to be exercised when correlating personality variables with parental alcoholism. The indications are that dysfunctionality associated with parental alcoholism tends to affect self-esteem and locus of control.

Adult Children of Dysfunctional Families (ACDFs)

Although the literature yields mixed results, what is becoming clear is that other adults exhibit similar symptoms and personality traits who have grown up in families with chronic violence, incest, and/or other severe psychiatric illnesses. These families are similar to chemically dependent families in their lack of ability to respond to the needs of developing children and in their general emotional unavailability for those children.
Hadley, Holloway, and Mallinckrodt (1993), in a study comparing ACOAs with ACDFs, asserted that the two groups are not significantly different. ACOA has become a popularly accepted term by both the public and by mental health professionals. Most often, ACOA connotes a group of people who presumably share both developmental experiences and common personality deficiencies. What many researchers are finding, however, is that the aforementioned experiences and deficiencies are also experienced by other adults, many of whom grew up in homes where there was violence, incest, physical illness that may have resulted in the loss of a parent, and psychiatric illnesses suffered by one or both parents, unaccompanied by alcoholism. The strong suggestion in this study is that adults whose parents provided them a home in which violence, incest, or psychiatric illness was present, but where there were not problems with alcohol, do indeed have similar pathology to adults who were raised in alcoholic homes. The measures used were a family events inventory, the Self-Report Family Inventory (SFI), the Bell Object Relations-Reality Testing Inventory (BORRTI), the Self-Expression Inventory (SEI), Internalized Shame Scale (ISS), and the Problem History Scale (PHS).

An underlying theme of this particular study (Hadley et al., 1993) is that lack of parental emotional availability, for any reason, leads to developmental problems. Regarding personality deficiencies, Hadley et al. (1993) maintained
that nothing specific to the problem of alcohol abuse automatically produces these deficits although an overwhelming body of literature asserts otherwise.

The participants in the Hadley et al. (1993) study were 97 adults who came from clinical and community settings who identified themselves as growing up in dysfunctional families. The measures used were a family events inventory, the SFI, the BORRTI, the ISS, and the PHS. A total of 53 of the 97 adults reported one or both parents had been alcoholic, and 35 reported some other type of severe family dysfunction.

The results of the Hadley et al. (1993) study suggested that ACOAs and ACDFs are not significantly different in family dysfunction, self-expression, and problems with compulsive behaviors. Even though the level of family dysfunctionality was high, no significant differences were found between ACOAs and ACDFs. The degree of dysfunctionality was associated with internalized shame and the presence of emotional and addiction problems.

The findings of Hadley et al. (1993) suggest that addictions, insecure attachment in object relations, internalized shame, partner violence, and intense family conflict result in serious detrimental effects in adulthood. Many participants in this study had suffered the loss of a parent due to death or divorce. Object relations psychology supports the belief that depression, alcoholism, and
juvenile delinquency are common results when a child experiences the loss of a parent. Intense anxiety is commonly experienced by children who are witness to great fighting and unresolved conflict. Unresponsive, abusive, or simply inconsistent parenting can produce many symptoms similar to those normally reported by ACOAs. Additionally, as in chemically dependent families, ACDFs have generally adopted a responsible role in their homes to compensate for the parental lack of functioning. The competence of these children often creates an external image of stability and goal-directedness, but it may hide the same anxiety, depression, and inner conflict that many successful ACOAs hide.
CHAPTER IV

RESULTS AND DISCUSSION

In order to illustrate the results of the study, some simple descriptive tables and statistics are used. This study is a descriptive one and cannot be used to generalize beyond the groups included in the study to the population at large.

The amount of missing data in the study was very limited. A total of 18 (out of 230) subjects did not complete the FDS; 4 did not complete the SEI; and one subject did not complete the STAI. T-tests were conducted to compare the 18 subjects not completing the FDS with the 212 subjects who did complete it. Dependent variables included the STAI, SEI, BDI, CAST, and gender. No significant differences were found between completers and non-completers although there was a tendency for a higher percentage of males to be non-completers (27% of non-completers versus 12% of completers).

Of the total number of 230 subjects, 31 were male and 199 were female. Eleven of the 31 males (35%) reported themselves to be children of alcoholics. Sixty of the 199 females (30%) reported themselves to be children of alcoholics. A total of 71 (30.87%) subjects reported
themselves to be children of alcoholics. Sex was shown not to be a predictor in this study for anxiety, self-esteem, or depression. T-tests were conducted to determine whether gender was significant. No significant difference was found.

The findings in this study are threefold: a comparison of subjects from alcoholic and non-alcoholic families; a comparison of subjects from more and less dysfunctional families; and a comparison on each item of the FDS regarding the three dependent variables of depression, anxiety, and self-esteem.

In comparing the less dysfunctional families to the more dysfunctional families in this study, the FDS was used. The Dodd study assessed dysfunctionality with a single item:

Would you consider the family in which you were raised, while you lived with your family to be

(please circle the appropriate number)

1. Very functional  2. Functional
3. Dysfunctional  4. Very dysfunctional

Conversely, this study attempted to ascertain low versus high levels of dysfunctionality rather than merely accepting the subject’s assessment of his or her home situation. As previously noted, the FDS is composed of eight "yes-no" questions, each relating to a specific issue of family dynamics. A score of 0 to 5 indicates that a
subject experienced less rather than more dysfunctionality within the family, and a score of 6 to 8 indicates that a subject experienced more dysfunctionality within the family.

Table I is a comparison of the FDS on levels of depression, anxiety, and self-esteem. The mean and standard deviation for each of the nine levels on the three dependent variables are presented in Table I.

Table I

A Comparison of the FDS on Three Dependent Variables

<table>
<thead>
<tr>
<th>No. of Yes's = Scores</th>
<th>FDS</th>
<th>BDI Mean</th>
<th>S.D.</th>
<th>SEI Mean</th>
<th>S.D.</th>
<th>STAI Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>4.06</td>
<td>3.82</td>
<td></td>
<td>91.13</td>
<td>9.65</td>
<td>30.06</td>
<td>8.02</td>
</tr>
<tr>
<td>1</td>
<td>4.93</td>
<td>6.56</td>
<td></td>
<td>81.33</td>
<td>18.68</td>
<td>34.60</td>
<td>9.61</td>
</tr>
<tr>
<td>2</td>
<td>4.57</td>
<td>4.16</td>
<td></td>
<td>85.14</td>
<td>13.92</td>
<td>32.14</td>
<td>6.87</td>
</tr>
<tr>
<td>3</td>
<td>5.53</td>
<td>3.93</td>
<td></td>
<td>82.00</td>
<td>15.06</td>
<td>35.03</td>
<td>10.08</td>
</tr>
<tr>
<td>4</td>
<td>5.83</td>
<td>6.83</td>
<td></td>
<td>81.06</td>
<td>15.07</td>
<td>35.31</td>
<td>9.31</td>
</tr>
<tr>
<td>5</td>
<td>6.00</td>
<td>6.20</td>
<td></td>
<td>79.63</td>
<td>18.67</td>
<td>34.72</td>
<td>10.99</td>
</tr>
<tr>
<td>6</td>
<td>7.25</td>
<td>6.66</td>
<td></td>
<td>70.30</td>
<td>18.67</td>
<td>39.07</td>
<td>11.21</td>
</tr>
<tr>
<td>7</td>
<td>9.09</td>
<td>8.12</td>
<td></td>
<td>66.57</td>
<td>20.81</td>
<td>40.90</td>
<td>12.21</td>
</tr>
<tr>
<td>8</td>
<td>7.72</td>
<td>6.21</td>
<td></td>
<td>76.47</td>
<td>19.43</td>
<td>42.33</td>
<td>13.15</td>
</tr>
</tbody>
</table>

In looking at the subjects who scored 0 to 5 on the FDS versus the ones who scored 6 to 8, a distinction can be made between less and more dysfunctionality by examining the
scores and seeing that the trend for depression and anxiety is clearly upward for those scoring in the 6 to 8 range and clearly downward for self-esteem (indicating higher self-esteem) for subjects scoring in the 0 to 5 range.

The rationale for providing a cut-off between 0 to 5 and 6 to 8 on the FDS is that there is a decisive and clear upward trend in depression and anxiety and a clear and decisive downward trend for self-esteem for subjects scoring in the 6 to 8 range. After gathering and examining the data, the cut-off was determined, based on observation of the above numbers.

Regarding depression, subjects who scored in the 6 to 8 range report higher levels of depression than do those scoring in the 0 to 5 range. In the lower range, the means for depression were 4.06 to 6.00 whereas subjects scoring 6 to 8 on the FDS have means from 7.25 to 9.09. The more dysfunctionality subjects reported in their home lives, the more depression they appeared to experience.

On the variable of anxiety, subjects who scored 0 to 5 on the FDS reported average levels of anxiety, as measured by the STAI. The range for the STAI, according to the Manual for the State-Trait Anxiety Inventory, is 20 to 80, with a mean of 30. Subjects who scored 0 to 5 on the FDS had means from 30.06 to 35.31. Subjects scoring 6 to 8 on the FDS had significantly higher means, 39.07 to 42.33. Thus, subjects who reported more family dysfunctionality
commensurately reported very high levels of anxiety. These scores indicate statistical significance between the two groups on the variable of anxiety.

Regarding self-esteem as measured by the SEI, the Coopersmith Self-Esteem Inventory reports a standardized mean of 70 to 80 with a standard deviation of 11 to 13. Subjects in this study who scored 0 to 5 on the FDS had means from 80 to 92, well above the average mean as reported by the SEI Inventory. In other words, subjects who had experienced less dysfunctionality within their homes reported high levels of self-esteem. Subjects scoring 6 to 8 on the FDS have self-esteem scores significantly lower than those scoring 0 to 5. The subjects reporting more dysfunctionality within their homes have means of 66.57 to 76.48, indicating lower levels of self-esteem than the other group.

What is readily apparent after analyzing the three dependent variables against the FDS is that subjects who suffer more dysfunctionality within their homes experience greater depression, higher levels of anxiety, and lower levels of self-esteem than do subjects suffering less dysfunctionality.

Second, a comparison of subjects from alcoholic versus non-alcoholic families is presented in Table II which compares the relationship between self-reported parental alcoholism and self-reported familial dysfunctionality.
The results in Table II show a strong relationship between the CAST and FDS. Subjects from high dysfunctional families were much more likely to be children of alcoholics than subjects from low dysfunctional families. For example, 70% of subjects from low dysfunctional families were not likely to have an alcoholic parent versus 31% of subjects from high dysfunctional families. Similarly, 61% of children from high dysfunctional families had an alcoholic parent versus 17% of subjects from low dysfunctional families.

Table II
A Comparison on Levels of Parental Drinking Versus Low and High Dysfunctionality

<table>
<thead>
<tr>
<th>CAST</th>
<th>FDS Low</th>
<th>FDS High</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Not Likely</td>
<td>101</td>
<td>70</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Drinker</td>
<td>20</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>Alcoholic</td>
<td>24</td>
<td>17</td>
<td>41</td>
</tr>
<tr>
<td>Total</td>
<td>145</td>
<td>67</td>
<td>212</td>
</tr>
</tbody>
</table>

When comparing scores of the FDS against those of the CAST, it is seen that of the total 212 subjects who completed both measures, 101 subjects who scored in the low end of dysfunctionality (0 to 5) reported that they likely
did not have an alcoholic parent. Twenty subjects who scored on the low end for dysfunctionality reported a parental problem drinker, and 24 subjects reported an alcoholic parent.

Table III presents the subjects’ scores as measured by the BDI, the SEI, the STAI, and the FDS. The numbers of subjects who identified themselves in this study as ACOAs and/or as ACDFs are as follows: out of 730 subjects, 71 were raised in alcoholic families, and 67 were raised in highly dysfunctional families.

Looking at specific numbers of subjects as they are represented in each category, of the 71 alcoholic families in the study, 55 ACOAs scored in the normal range (0-9) for depression, as measured by the BDI; 16 ACOAs scored in the higher range for depression. Regarding self-esteem, 34 ACOAs scored below 79 on the SEI, and 33 scored 80 or above (range being 70-80). Regarding anxiety, 22 ACOAs scored in the lower range (below 30), and 49 ACOAs scored 30 or more (indicating high levels of anxiety).

On the factor of variability, family dysfunctionality, 67 subjects out of 230 scored on the high end for dysfunctionality. Of those 67, 48 subjects scored in the low end for depression, and 19 scored in the higher end. On levels of self-esteem, 36 subjects scored on the low end, and 27 scored 80 or more (indicating high self-esteem). Regarding anxiety, 90 subjects scored 30 or less, and 139
Table III

A Comparison of Parental Alcoholism and Dysfunctionalit

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Depression</th>
<th>Self-Esteem</th>
<th>Anxiety</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low (0-9)</td>
<td>High (10 or H)</td>
<td>Low (1-79)</td>
<td>High (80-H)</td>
</tr>
<tr>
<td>Alcoholic Families</td>
<td>55</td>
<td>16</td>
<td>37</td>
<td>34</td>
</tr>
<tr>
<td>Highly Dysfunctional Families</td>
<td>48</td>
<td>19</td>
<td>39</td>
<td>28</td>
</tr>
<tr>
<td>Total</td>
<td>188</td>
<td>42</td>
<td>78</td>
<td>148</td>
</tr>
</tbody>
</table>

Note: Four subjects did not complete the SEI, and one subject did not complete the STAI.
subjects scored more than 30, indicating a high level of anxiety in these subjects who identified their families as being highly dysfunctional.

T-tests on the data presented in Table III are presented in Table IV in order to compare the differences between groups on alcoholic versus non-alcoholic and less versus more dysfunctional families. The t-test compares the means on each dependent variable in each group to determine the differences that existed between the two groups.

In comparing the means for depression as measured by the BDI on non-alcoholic families and alcoholic families (5.63 to 6.62), the difference was .99. The t-test for BDI on alcoholic families was not significant. In comparing the means for depression between low versus high dysfunctional families (5.16 to 7.99), the mean difference was much higher, 2.83 points, significant at the .01 level. The hypothesis that there is a significant difference in levels of depression between ACOAs and non-ACOAs is rejected. The hypothesis that there is a significant difference in levels of depression between high dysfunctional and low dysfunctional families is accepted.

In comparing the means for self-esteem, as measured by the SEI, the mean for non-alcoholic families was 82.03 and 75.74 for alcoholic families. This shows a difference of 6.29 points in means between the two groups, statistically
### Table IV

**A Comparison of Parental Alcoholism and Dysfunctionality on All Variables**

<table>
<thead>
<tr>
<th></th>
<th>Non-Alcoholic Families</th>
<th>Alcoholic Families</th>
<th>Low Dysfunctionality</th>
<th>High Dysfunctionality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>S.D.</td>
<td>St.E.</td>
</tr>
<tr>
<td>BDI</td>
<td>230</td>
<td>5.61</td>
<td>5.95</td>
<td>0.472</td>
</tr>
<tr>
<td>SEI</td>
<td>226</td>
<td>82.03</td>
<td>17.61</td>
<td>1.401</td>
</tr>
<tr>
<td>STAI</td>
<td>229</td>
<td>34.73</td>
<td>10.39</td>
<td>0.820</td>
</tr>
<tr>
<td>CAST</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FDS</td>
<td>212</td>
<td>3.08</td>
<td>2.38</td>
<td>0.190</td>
</tr>
</tbody>
</table>

'Level of significance at .05
''Level of significance at .01
significant at the .05 level. In comparing the means for self-esteem between low and high dysfunctionality (83.94 to 70.72), significance is seen at the .01 level. The hypothesis that there is a significant difference in levels of self-esteem between ACOAs and non-ACOAs is accepted. The hypothesis that there is a significant difference in levels of self-esteem between low and high dysfunctional families is accepted.

Looking at the means for anxiety, as measured by the STAI, non-alcoholic families were 34.73 and 37.77 for alcoholic families. Again, the difference in means for the two groups is very high, 3.04, statistically significant at the .01 level. Regarding the means for low and high dysfunctional families on levels of anxiety, the means were 33.51 and 40.55, significant at the .01 level. The hypothesis that there is a significant difference in levels of anxiety between ACOAs and non-ACOAs is accepted. The hypothesis that there is a significant difference in levels of anxiety between low and high dysfunctional families is accepted.

In comparing the means between the low and high dysfunctionality on familial alcoholism, the means were 2.66 and 9.75, significant at the .01 level. In comparing the means between non-alcoholic families and alcoholic families on dysfunctionality, the non-alcoholic group mean was 3.08
and that for the alcoholic group was 5.72, the difference being significant at the .05 level.
CHAPTER V

CONCLUSIONS

This study began as a replication of the Dodd study (1990). The reason for replicating the study was to examine and to determine whether any results different from those found by Dodd would be found in this study as a result of changing one of the measures used by Dodd: the demographic questionnaire. The questionnaire used by Dodd asked some very general questions regarding the family history of each subject in the study. This writer discarded that questionnaire and developed another one. The questions posed on the second questionnaire were designed to elicit specific information regarding various issues in family dynamics that several writers in the field (Kitchens, 1991; Subby, 1987; Fossum & Mason, 1986) believe were germane to the subject of family dysfunctionality.

Dodd's (1990) findings were as follows: no statistical differences existed between ACOAs and non-ACOAs on levels of depression, anxiety, and self-esteem. Dodd did find that ACOAs scored lower in self-esteem and higher in depression and anxiety, but these differences were not statistically significant, significance being found at the .05 and .01 level.
Dodd (1990) did find a significant difference between functional and non-functional groups on each of the three dependent variables; however, the scores for the dependent variables fell within the norms for each instrument used in the study.

In contrast to Dodd’s (1990) study, this study, through use of a different questionnaire, did find statistical differences that existed between alcoholic and non-alcoholic families and between low and high dysfunctional families on the three dependent variables: depression, anxiety, and self-esteem. These differences are noted in Table III in the Results and Discussion chapter.

The issue of what constitutes dysfunctionality within families and the degree to which that dysfunctionality adversely affects children growing up in such families has been recently and continues to be explored by many writers in this field. For example, Subby (1987) writes about dysfunctionality in terms of family rules that prohibit expression of feeling, thus prompting depression and anxiety in children.

Werner (1985) believes the constitutional strength and early care-giving of a child can often overcome the effects of later even severe dysfunctionality. Werner’s work supports that of the developmental psychologist Erikson (1985), who maintains that if a child does not learn trust in infancy through an attentive and caring caregiver,
development of personality for that child is skewed, and that child is at risk for severe psychological, life-long problems.

Hadley et al. (1993) believes that the lack of parental emotional availability and parental failure to respond to children’s needs define dysfunctionality at an elemental level and cause the developmental problems many writers have ascribed to ACOAs.

Kitchens (1994) identifies a dysfunctional home as simply one in which important needs of the child are not met: love, acceptance, boundaries, guidance, discipline, and positive role-modeling.

Wolin and Wolin (1993) believe that if children possess certain strengths (insight, independence, health other relationships), it is possible to overcome the dysfunctionality that emotionally cripples many and that it is possible for those children to lead happy, healthy lives.

Higgins (1992) writes that it is the locus of hope in childhood, followed by the role of faith and vision, that enables these children to develop resilience (strength to overcome severe dysfunctionality) as adults.

Williams and Corrigan (1992) view severe mental illness of a parent as being a distinctive form of dysfunctionality that causes children to have more depression, more anxiety, and lower self-esteem than ACOAs and other ACDFs.
Neff (1994) also reports severe mental illness in parents much more than parental alcoholism results in higher levels of depression and anxiety.

Churchill et al. (1990) and Werner and Broida (1991) show that family dysfunction, whether alcohol abuse is present or not, is a strong predictor for lower self-esteem and more external locus of control. These writers believe that parental alcoholism by itself is simply not enough to produce the personality deficiencies and emotional problems ascribed to the ACOA population by writers such as Woititz (1983), Brown (1988), Cermak (1988), Ackerman (1983), and others.

In this study, in attempting to define less dysfunctionality versus more dysfunctionality, the results appear to show that more dysfunctionality is highly associated with several issues: repression of feeling that is generally believed to result in depression and anxiety; consistency (kind but firm treatment rather than chaotic family management, also associated with the ability of parents to resolve conflict; and a family history of depression and anxiety.

Keeping secrets (denial of one's own perceptions and, thus, reality) and parental rigidity (non-willingness to acknowledge wrong-doing) were also associated with higher levels of dysfunctionality in this study.
What these results mean is that specific issues may have more impact on healthy personality development than other issues usually assumed by many to have equal impact. This study indicates that parental drinking is but one type of dysfunctionality that is associated with depression, anxiety, and low self-esteem. Family dysfunctionality, not parental alcoholism, is the factor of variability in this study.

Although no one can really be certain what distinguishes less from more dysfunctionality and the degree to which children in homes are hindered from developing normally, it is generally agreed that children who are forced to focus on psychological survival rather than psychological development function at a much lower level than do children who are generally getting their needs met. This low level of functioning in formative years would seem to contribute to the development of emotional problems such as those examined in this study.

Conversely, children whose needs for love, acceptance, guidance, and discipline are met well enough (no one knows how much "enough" is) usually function at a much higher level, and their personality development is thought to be stronger than those children who are struggling merely to survive.

Going back to early infancy, Erikson (1985) wrote at length about the importance of the child’s developing trust.
Trust is the first and primary prerequisite for healthy personality development, according to Erikson, and that development of trust is dependent upon the early parental bond and the strength of that bond. Lacking enough closeness (no one is quite sure how much is "enough") leads to an internal sense of self as unworthy that, in turn, leads to other psychological problems that prevent healthy personality development. What this comes to is that lacking adequate care-giving in the first few months of life, a child can be set up for depression, anxiety, and self-doubt. In adulthood, these unresolved issues often manifest themselves in many self-defeating behaviors and serious emotional problems.

Children whose needs are not met and who aren’t allowed to develop normally learn instead to cope and to adapt in order to survive in unhealthy families. Coping and adapting usually involve adjusting oneself to a family system that is not designed to nourish children. Coping and adapting mean that the child’s needs are subverted and that he or she must learn to ignore his or her feelings and behave in ways acceptable to that particular family (usually playing a role well). Thus, the child develops a reactive rather than a proactive personality (Wegscheider-Cruise, 1989).

The results of this study generally support the findings of Williams and Corrigan (1992), Neff (1994), Sher (1990a), Churchill, Broida, and Nicholson (1990), Werner and
Broida (1991), Kitchens (1991), Hadley, Holloway, and Mallinckrodt (1993), and others who maintain that family dysfunctionality rather than parental alcoholism is the foundation of unhealthy personality development and emotional problems. In no way do these findings detract from the serious problems associated with heavy drinking in our society. However, it is important to understand the impact of various family dynamics upon children growing up in unhealthy homes.

Future Research

This study suggests the need for more knowledge and understanding regarding the impact upon developing children that the following issues have: parental alcoholism, negative and hostile parental communication, rigidity, blame, secrets, family roles, repression of feeling, and depression and anxiety within families.

Future research might additionally explore the questions, what exactly constitutes dysfunctionality and what types of dysfunctionality appear to be more harmful and destructive to the developing child than other types. The subject of resilience (strength to overcome adversity and function normally) is being studied and reported on currently and no doubt needs more study. As discussed in the review of the literature, age, gender, genetics and heredity, temperament, and other factors also need more
study so that we may better know and understand how to help individuals learn to overcome the effects of living in deficit, pain-filled families that are unable to meet the needs of their developing children.
APPENDIX A

INFORMED CONSENT
INFORMED CONSENT

The purpose of this research is to study and compares levels of depression, anxiety, and self-esteem among groups of people. Your participation is requested to complete the enclosed packet of measures. The measures are estimated to require 40 minutes of your time.

The following measures are contained within the packet:

1. The Beck Depression Inventory, the most widely used clinical self-report of depression.

2. The State-Trait Anxiety Inventory, a self-administered instrument measuring anxiety.

3. The Coopersmith Adult Self-Esteem Inventory, a self-report instrument designed to measure an individual's perception of his or her personal traits and characteristics.

4. The Children of Alcoholics Screening Test used to identify children of alcoholics.

5. A demographic questionnaire used in an effort to gather more information from participating subjects regarding family history that is related to conflicts and deprivation in childhood.

Any information that you choose to share will be strictly confidential, and no foreseeable risk is involved for anyone who chooses to participate. Do not write your
name on any measure. Participation is voluntary, and you may discontinue participation at any time during the testing. Whether or not you participate has no effect upon your class standing.

Results of this study will be available upon request by contracting Sandra Dooley, 6750 Hillcrest Plaza Drive, Dallas, Texas 75230, (214) 458-8333.
APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE
DEMOGRAPHIC QUESTIONNAIRE

Age: __________

Gender: 1. _________ Female  2. _________ Male

Race: 1. _________ Black  2. _________ White
      3. _________ Hispanic  3. _________ Asian
      4. _________ Native American
      5. _________ Other

Marital Status: 1. _________ Single  2. _________ Married
                3. _________ Divorced
                4. _________ Divorced/Remarried

Number of _________
Children:

1. Please answer the following questions by circling N for no or Y for yes.
   1. In my opinion, one or both my parents have experienced problems with alcohol.
      Y  N
   2. One or both of my parents always has to be right.
      Y  N
   3. One or both of my parents blames someone (self, other, child) when there are problems in the family.
      Y  N
   4. One or both of my parents keep secrets in the family.
      Y  N
5. One or both of my parents find it difficult or impossible to discuss feelings such as fear, sadness, or anger.

Y       N

6. One or both of my parents behave inconsistently: sometimes very angry, sometimes very calmly.

Y       N

7. My parents fight about the same things for years without resolution.

Y       N

8. A member of my immediately family suffers mental disability such as severe depression, anxiety, or other.

Y       N
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