A COMPARISON OF ADULT CHILDREN OF ALCOHOLIC FAMILIES
WITH ADULT CHILDREN FROM NON-ALCOHOLIC FAMILIES
ON DEPRESSION, SELF-ESTEEM, AND ANXIETY

DISSERTATION

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By

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The problem of this study was to test the differences between adult children from alcoholic families with adult children from non-alcoholic families on levels of depression, self-esteem, and anxiety. The sample consisted of 203 volunteers, all from the Counselor Education Department, 150 females and 53 males, ages 19 and older. Volunteers who were noted as being adult children of alcoholic families numbered 60. Measures used were the 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). Multivariate Analysis of Variance was used to test for differences between groups. In addition, a secondary analysis using a one-way MANOVA was used to test for differences between dysfunctional and functional family of origin status on the dependent variables of depression, self-esteem, and anxiety.

No significance was found on levels of depression, self-esteem, and anxiety between adult children of alcoholic
families and non-alcoholic families. However, secondary analysis did show significant differences (< .05) between functional and dysfunctional family of origin status on the dependent variables.
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CHAPTER I

INTRODUCTION

The National Association for Children of Alcoholics (NACA, 1982) estimates that more than 20 million Americans have at least one alcoholic parent. Awareness and research continues to expand concerning alcoholism's impact on the family, and conversely, the family's impact on alcoholism (Black, 1981; Brown, 1988; Steinglass, Bennett, Wolin, & Reiss, 1987). Alcoholism's impact on children of alcoholics (COAs), likewise, is receiving significant attention, much more so than as little as two decades ago (Cork, 1969; Fox, 1962). Through the work of clinicians and the acknowledged needs of COAs, the National Association for Children of Alcoholics (NACA) was established in 1982. The formation of the NACA marked this population as a treatment group in its own right, even apart from the alcoholic.

With the formation of the NACA, a child of an alcoholic was designated as a COA and an adult child of an alcoholic was designated as an ACA whenever the full spelling was not used. Before 1982, no specific, generalized designation was extant in the literature. In this research COA refers to a person from an alcoholic family, whether the person is an adult or a child. If a
specific distinction between adult or child needs to be made, it will be clearly noted.

Because COAs constitute one of the highest risk groups for substance abuse, and other psychosocial and medical problems (El-Guebaly Offord, 1977; Kumpfer, 1986; Tharinger and Koranek, 1988), a continued need exists for empirical research (Kumpfer, 1986; Settle, 1989) that expands the knowledge about this population. To date, however, much of the literature concerning COAs has been gathered through persons seeking treatment and has primarily been documented through clinical reports. In addition, much of the research that has accumulated about COAs has been descriptive in nature (Brown, 1988).

While what has been found to be valid for the clinical population of COAs is indeed valuable, Settle (1989) noted that the same conclusions may not be true of the COA population at large, and thus may not be generalized to everyone in this population. Even so, Black (1981), who has done extensive work with this population, has generalized the data. Black (1981) stated that "ALL CHILDREN RAISED IN ALCOHOLIC HOMES NEED TO BE ADDRESSED. ALL CHILDREN ARE AFFECTED" (p. 23).

Other clinicians support Black's (1981) conclusions. Through his clinical work, Kritsberg (1986) concluded that adult COAs "share the same underlying emotional states," which allow them "to recognize and identify with each other.
even though the behavior may be different" (p. 36). In addition, the NACA stated that COAs "of all ages have a common bond" (Charter Statement, 1982). The NACA reported that COAs often adapt to the "chaos and inconsistency of an alcoholic home by developing an inability to trust, and [an] extreme need for control, excessive sense of responsibility, and denial of feelings, all of which result in low self-esteem, depression, isolation, guilt, and difficulty maintaining satisfying relationships" (Charter Statement, 1982). Additionally, besides depression and low self-esteem, anxiety difficulties have been considered the norm for this population (Cermak, 1986; Kritsberg, 1986). These problems, and others, according to the NACA often persist into adulthood (1982). Other clinicians who have significantly contributed to information in the area of chemical dependency and the family concur with the abovementioned conclusions (Black, 1981; Brown, 1988; Cermak, 1986; Fossum & Mason, 1986; Hecht, 1977; Subby, 1987; Wegscheider, 1981; Whitfield, 1987; Wotitz, 1983).

Research concerning COAs indicates that a disproportionate number of this population enter the juvenile justice system and mental health facilities, are referred to school authorities, and receive attention from other special services (Kumpfer, 1986). Moreover, other clinicians have noted that many difficulties of COAs go unnoticed because their adaptive behavior tends to be
approval seeking and socially acceptable (Black, 1981; Cermak, 1986; Wegscheider, 1981). Black (1981) suggested that the majority of COAs are not involved in the difficulties mentioned above for this very reason, which leaves them open to carrying unresolved and ultimately dysfunctional ways of coping into adulthood. Research suggests that COAs are at "increased risk for most of the serious psychosocial illnesses of adulthood" (El-Guebaly & Offord, 1977, p. 364), on both an intrapersonal and an interpersonal level.

Concerning adult COAs, 40 to 60 percent of them become alcoholics themselves (Black, 1981). They have a 4 to 5 times greater chance of becoming alcoholic than persons from nonalcoholic families (Goodwin, 1988). An estimated 30 percent of COAs marry alcoholics (Black, 1981), thus creating the probability of forming or continuing a multigenerational cycle (Steinglass et al., 1987). A large proportion of persons served by Employment Assistance Programs (EAP) are adult COAS (NACA, 1982). In a recent study of EAP figures, the New England Telephone Company reported that 31 percent of its EAP general counseling cases were COAs, and 50 percent of its employees in rehabilitative treatment were also COAs (Scott, 1987). In a survey of 500 randomly selected records of 54 companies across the country, results showed that COAs who contacted EAPs were more likely than other employees seeking assistance "to have
low self-esteem, be overly responsible, inflexible, have an excessive need for approval, and often feel depressed" (Scott, 1987).

Therefore, the conclusion that many clinicians have drawn is that while many COAs appear to adapt with apparent resiliency and functionality (Werner, 1985), all persons who develop within the context of parental alcoholism and its concommitant influences face negative consequences in their development. The negative developmental consequences occur as a result of the need to adapt to the dysfunction in the family (Ackerman, 1978; Black, 1981; Brown, 1988; Cermak & Brown, 1982; Deutsch 1982; Gravitz & Bowden, 1984; Sexias & Youcha, 1985; Wegscheider, 1981; Woititz, 1983). Three of the most common problems noted for COAs, which this study considers, are difficulties with low self-esteem, depression, and anxiety. While the reporting of clinical data may be valid and indeed valuable, little research has been done with an at large population of adult COAS, i.e., a population that is not studied within the context of some form of treatment.

Statement of the Problem

Clinical data and case reporting has allowed clinicians to conclude that adult COAs suffer from low self-esteem, depression, and anxiety difficulties. Although few studies have used nonclinical samples of adult COAs to verify the findings, the problems associated with COAs have been
generalized to all COAs. The problem is that gaps in the research that validates clinicians' conclusions about COAs still exist. Before generalizations can be made about low self-esteem, depression, and anxiety in the COA population at large, more research is needed. The purpose of this research was to determine if levels of self-esteem, depression, and anxiety in a sample of adult COAs differ from levels of self-esteem, depression, and anxiety in a sample of adult non-COAs.

Hypotheses

To carry out this study, the following hypotheses were tested:

1. There is a significant difference in levels of self-esteem between adult COAs and adult non-COAs as measured by the Coopersmith Self-Esteem Inventory: Adult Form.
2. There is a significant difference in levels of depression between adult COAs and adult non-COAs as measured by the Beck Depression Inventory.
3. There is a significant difference in levels of anxiety between adult COAs and adult non-COAs as measured by the State-Trait Anxiety Inventory.

Definition of Terms

Adult Children of Alcoholics: Operationally defined by measures on the Children of Alcoholics Screening Test (CAST). A score of 12 or above on the CAST indicates that a subject is an adult COA.
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 adult COA.

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

This research was limited by certain conditions beyond this researcher's control. The limitations are noted as follows:

1. The voluntary nature of the sample may have limited the results of the study.

2. The attitudes of persons who chose not to participate in the research may have differed significantly from the attitudes of the persons who participated.

3. The subjects were restricted to a university population. Though a range of ages were included, the attitudes of university students may have differed significantly from persons not involved in the university as students.

4. The instruments used for this research were self-report measures; therefore, subjects may have chosen not to answer with as much clarity or honesty as possible.
5. The instruments also report at a specific period of time, which also may have affected the results.

Review of Relevant Literature

Overview of Empirical Studies

In 1956 the American Medical Association accepted alcoholism as a disease that has its own characteristic chain of symptoms. Approximately 10 to 14 percent of the adult population in the United States is alcoholic (Steinglass, et al., 1987). These persons suffer from an array of psychosocial and physical symptoms that indicate alcohol dependence. It is estimated that for every one alcoholic, there are at least 3 to 5 other people directly involved in the alcoholic's life (U.S. Department of Health and Human Services, 1987).

Approximately 1 in 8 Americans comes from a family in which one or both parents is alcoholic (Woodside, 1986). Early research related to COAs focused upon cataloging behavioral characteristics (El-Guebaly & Offord, 1977). In a review of literature concerning COAs, Kumpfer (1986) noted that COAs have multiple problems, and that they are likely to be overrepresented in the following special services in our society: intensive care services for birth defects and fetal alcohol syndrome; children's attention deficit disorder or hyperactivity treatment programs, particularly those focused on aggressive conduct disorders; classes for emotionally disturbed or handicapped children in public
schools; child abuse counseling programs; adolescent inpatient and outpatient psychiatric programs; hospital treatment for somatic complaints; teenage mother pregnancy programs; juvenile court case loads; and adolescent and adult substance abuse programs. In addition, Kumpfer (1986) noted that a large number of incest victims are offspring of alcoholics. Many adults seeking treatment for general psychiatric problems also indicate parental alcoholism in their backgrounds (Cermak & Brown, 1982).

Other research with COAs has indicated the following: COAs have shown a higher incidence of school problems, and have been noted as more likely to suffer from physical and emotional problems such as nightmares, insomnia, depression, and anxiety (Tharinger & Koranek, 1988). Also, COAs tend "to exhibit disturbances in personality, peer relationships, and behavior, including low self-esteem, ... hyperactivity, ... and to visit physicians more frequently than children of moderate drinking or abstaining parents" (p. 174). Wegscheider (1978) noted, too, that depression, suicide, and school problems were related to having an alcoholic parent(s).

In a seminal study that raised public and professional awareness concerning COAs, Cork (1969) started with a sample of 1,005 parents among current and former alcoholic parents. Their 115 children (59 male and 56 female, ages 10-16) were interviewed and then completed a questionnaire concerning
their subjective impressions of their family situation. Most of the children were from upper or middle class homes, and 90 percent of the sample lived in maritally intact homes. Cork (1969) found that 90 percent of the COAs lacked self-confidence, felt rejected by parents, and felt that their parents' behavior was unpredictable. Also, 70 percent of the respondents reported that the nonalcoholic spouse was frequently upset and had lost respect for the alcoholic parent; 50 percent of the COAs felt angry or anxious. She concluded that in many cases COAs exhibited significant difficulties in psychological, social, and family functioning.

In a similar study (Chafetz, Blane, & Hill, 1971) findings indicated that COAs suffered more deleterious developmental and social consequences, as opposed to severe problems of psychopathology and health consequences, though these difficulties were present. Family disruption acted as an obstacle for becoming socialized adults, according to the researchers. In a more recent exploratory study of pathological symptoms in COAs (N < 30), Hibbard (1989) indicated that adult COAs showed more moderate pathological symptoms related to developmental parent-attachment deficits than controls from nonalcoholic families.

Using a sample of adolescents, Kammier (1971) tested a population of 371 students in a Catholic high school after they completed an alcohol education and counseling program.
Of the 371 students, 20 males and 45 females came from families with identifiable alcohol problems, which were rated by two school counselors. A control group of 65 students from nonalcoholic families were matched for sex. They were selected from the remaining students. The most significant finding was the lack of differences in these adolescent populations. However, significant differences did occur in four areas: COAs had more school absenteeism, parents' marriages were less stable, occupational levels of fathers were lower, and female COAs showed more distress in areas of emotional stability, family relationships, conformity, and mood.

In a study of the personality characteristics of young adult COAs (N = 860), researchers (Berkowitz & Perkins, 1988) found that COAs were more likely to be self-depreciating than non-COA controls. Female COAs were more likely to be self-depreciating than male COAs; male and female COAs reported greater self-depreciation than male and female non-COA s. Female COAs whose fathers were alcoholic were significantly more likely to report self-depreciation than those whose mothers were alcoholic. Male COAs, however, "rated themselves significantly higher on autonomy than did their male controls" (p. 206), regardless of the gender of the alcoholic parent. The researchers suggested that the male COA's autonomy was influenced by "an ambivalence about relying on others" (p. 206). Though the
difference was not significant, female COAs, also, rated themselves higher on autonomy than their male and female controls. Thus, the same reasoning concerning male autonomy, likewise, might apply to female COAs.

Concerning self-depreciation, the researchers (Berkowitz & Perkins, 1986) suggested that female COAs' self-depreciation may reflect gender differences in society at large: "Women characteristically show a greater sensitivity to ... interpersonal relationships than men" (p. 209). Men, on the other hand, more often exhibit a task orientation that focuses on dealing with concrete situations (Gilligan, 1982).

Hibbard (1989), likewise, found differences between male and female COAs (N < 30), unrelated to the gender of the alcoholic parent. He concluded that males seem to "make a more externalized, expansive adaptation, while females a more internalized, inhibited one" (p. 507). Though behavioral adaptations differed by gender, Hibbard (1989) viewed the purpose of behavior as a method to manage attachment deficits with parents.

This research appears to support clinical findings about COAs' difficulty trusting others and their focus on a need for control, regardless of gender (Cermak & Brown, 1982; Sexias & Youcha, 1985). Brown (1988) suggested that the appearance of autonomy and self-depreciation acts as a form of protecting one's self from excessive feelings of
responsibility, from difficulties asking for help, and from feelings associated with depression and low self-esteem. Kritsberg (1986), through his clinical impressions, concluded that underlying feelings remain consistent for each gender, though behavioral adaptation may be different as affected by gender, family, and social expectations and perceptions.

Other research that has focused on psychosocial difficulties of COAs has noted the following: avoidance, repression of feelings, and anxiety (Fine, Yudin, Holmes, & Heinemann, 1976); isolation from peers (Wilson & Offord, 1978); and depression (Booz-Allen & Hamilton, Inc., 1974). Using a research sample of 409 self-identified adult COAs who completed a questionnaire, Black, Bicky, and Wilder (1986) concluded that the following problems were associated with adult COAs: they have problems identifying and expressing feelings; difficulties with trust and dependency; problems with intimacy; problems expressing needs and putting the self first; and they have a tendency to assume excess responsibility.

A twenty year longitudinal study (Miller & Jang, 1977) that investigated COAs from lower-class, multi-problem families reported that parental alcoholism increased the likelihood of COAs becoming problem drinkers: 36 percent of adult COAs in their study drank heavily, while only 16 percent of non-COAs drank heavily. COAs were more likely to
have faced concerns about mental health problems and were more likely to have engaged in suicidal acts. Also, COAs were more likely to have divorced, and were more likely to have failed in their ability to support themselves and their families.

Accepting that COAs do face potential psychosocial and health difficulties, Werner (1985), in a longitudinal study, sought to differentiate COAs who have had or have not had serious problems by age 18. Among 49 COAs, 30 percent had records of repeated delinquency, 25 percent had mental health difficulties requiring inpatient or outpatient care, and 41 percent had serious difficulties that had created coping problems at home, school, work or in the community. Interesting to note, however, was that 59 percent of COAs had not developed such problems by age 18. Werner (1985) called this group the resilient population. He concluded, though, that this resilient group still faced the later adult years in which many psychosocial difficulties might arise. Also, many of those noted as resilient may have adapted in a socially acceptable fashion, yet still suffer intrapersonal and interpersonal problems as Black (1981) has suggested.

Werner’s (1985) findings point to the difficulty in making facile generalizations about parental alcoholism and about imminent psychosocial difficulties in the offspring of an alcoholic parent. While research has rather clearly
pointed to a high correlation between parental alcoholism and difficulties in the psychosocial development of COAs, studies have, likewise, pointed out the difficulties in attempting to understand the association in a linear-causal fashion. Many mediating influences, in addition to parental alcoholism, have been suggested as acting transactionally upon the COA.

Some of the mediating influences are noted below: the child’s temperament, birth order, communicational skills, locus of control, the presence of at least one nurturing caregiver, and traumatic family events before the age of two (Werner, 1985); the alcoholic’s alcoholism in terms of chronicity and family stage development (Steinglass, et al., 1987); family traditions and rituals (Wolin, Bennett, Noonan & Teitelbaum, 1980); and neglect of the father who drinks away from home (Booz-Allen & Hamilton, Inc., 1974). Also, families are transactionally impacted by the peer, economic, social, and political systems in which the family members live.

Some compensating factors that act as transactional influences, such as support groups like Alateen or Al-Anon, have been noted as influencing the COA in a beneficial fashion (Cutter & Cutter, 1987). Hughes (1977) found that while adolescent COAs were prone to negative emotional moods, low self-esteem, and poor social adjustment, she also noted that COAs in Alateen were much better off emotionally.
than COAs who did not attend meetings. COAs who have a
relapsed parent have shown more symptoms of emotional
disturbance, especially depression and anxiety, than have
controls (Moos & Billings, 1982). However, children from
recovery families in Moos and Billings' study were
functioning as well as controls, suggesting, as Hughes
(1977) has concluded, that when the problem is recognized
and treated, improvement occurs.

A study that considered differences among children of
alcoholic fathers, depressed fathers, and controls (social
drinkers and not depressed) (Jacob & Leonard, 1986)
indicated that sons of both alcoholics and depressives were
experiencing more emotional and social competency problems
than were controls. These conclusions suggest that parental
alcoholism may be related to other psychosocial difficulties
and types of family dysfunction, and that many transactional
influences from social setting to the alcoholic's
alcoholism, for example, impact the COA. While COAs'
tendencies toward psychosocial difficulties cannot be
understood in a causal-linear fashion, conclusions still
rather conclusively show that COAs do indeed show a very
high incidence of difficulties, with the constant of
parental alcoholism being a predictor of problems. El-
Quebaly and Offord (1977) concluded their review of the
literature concerning COAs with the statement that this
population does appear to be "at increased risk for most of
the serious psychosocial illnesses of adulthood" (p. 364).

Other research appears to support El-Guebaly and Offord's (1977) conclusions. Approximately 40 to 60 percent of alcoholics had at least one alcoholic parent (Black, 1981). COAs have a 4 to 5 times greater chance of becoming chemically dependent than non-COAs (Goodwin, 1988). An estimated 30 percent of COAs marry alcoholics (Black, 1981). Concerning COAs and the workplace, Scott (1987) reported on a survey of 500 randomly selected records of 54 companies in this country. He noted that COAs who have sought EAP services were more likely than other employees seeking assistance "to have low self-esteem, be overly responsible, inflexible, and have an excessive need for approval, and often feel depressed" (p. 23).

Conclusions from Clinical Data and Case Reporting

While the more overt expressions of COA difficulties are more clearly documented, clinical reporting has suggested that many COAs' psychosocial and developmental difficulties may not be recognized until adulthood because their adaptational adjustments have fit so well in a social-occupational context (Black, 1984; Brown, 1988; Woititz, 1983). Kumpfer (1986) stated that many COAs who show little vulnerability early in life may become prone to substance abuse in adulthood because of depression and stress, especially for high-achieving, bright, overly responsible COAs. She stated that "their constant attempts to control
their environment, take care of families, and please others eventually decrease their emotional resources, and result in depression and substance abuse" (p. 48).

Also, many adult COAs continue inflexibly to adhere to adaptational roles formed in the alcoholic family. The rigid maintenance of these survival roles into adulthood creates communicational, intimacy, and occupational difficulties (Black, 1981; Scott, 1987; Wegscheider-Cruse, 1985). The adaptational roles are thought to impede emotional intimacy, honest sharing, emotional expression, feelings of self-worth; to foster depression, promote avoidance of confrontation, increase anxiety; and to lead to neglect of fun and pleasure (Tharinger & Koranek, 1988).

Through her clinical work with a heterogeneous population of adult COAs, Woititz (1983) characterized this population as possessing some or all of the following characteristics: they guess at normal behavior; they have difficulty following a project through from beginning to end; they often lie when telling the truth would be just as easy; they judge themselves without mercy; they have difficulty with intimate relationships; they overreact to changes over which they have no control; they constantly seek approval and affirmation; they feel that they are different from others; they become either super-responsible or super-irresponsible; they remain extremely loyal when loyalty is undeserved; and they often behave impulsively.
Woititz (1983) also concluded that age is an insignificant factor as a determinant of COAs level of self-esteem. She stated that COAs "saw themselves essentially in the same way" (p. 3). While "they may behave differently, ... they don't have different feelings .... The way the self attitude manifests itself will change, but not the self-perception" (p. 3).

Cermak and Brown (1982) concluded from their long term (2 years) group therapy with adult COAs that five outstanding issues characterized the impact of the alcoholic family for the adult offspring. Their conclusions were drawn from weekly summations of their clinical case notes over the two year period. The researchers acknowledged the subjectivity of their analysis of the data, and their inability to generalize their results.

Of the five outstanding issues, Cermak and Brown noted intrapersonal and interpersonal control as primary, especially the fear of being out of control. Secondary to control were mistrust, over-reponsibility, unacknowledged personal needs, and constriction of emotion. The clinicians noted control to be the most significant source of anxiety, and the context in which arose the other four issues. The maintenance of control was seen in their subjects as a rigid defense created to protect themselves against acknowledging feelings of distrust, personal needs, a sense of responsibility, and repressed, avoided, or denied emotions.
For group members, distrust of others was associated with the unpredictability and unavailability of parents. Expression of personal needs was equated with being dependent and less capable. Constriction of emotion resulted from the association of the expression of affect with being wrong or responded to with anger or rejection. Intense feelings of anger, sadness, loss, and joy were experienced as feeling out of control, and they were accompanied by feelings of anxiety, panic, and vulnerability. The strong sense of responsibility was associated with the rigid, though misguided belief, that they were responsible for others' emotions and actions, including the alcoholic's drinking and the alcoholic's emotional and/or physical abandonment of the family.

Group members were noted to use "denial, suppression, and repression liberally," as well as rationalization and projection "in an effort to keep tight reins on the outward expression and inward awareness of emotions" (Cermak & Brown, 1982, p. 379). To release a hypervigilant focus on control for the COA meant "acknowledging the overwhelming threat of underlying neediness" (p. 380).

The researchers concluded that COAs often continued to experience distress and pain as adults, which impeded adult self-growth. They also noted that a secondary gain associated with control was a sense of pride that group members had acquired in being able to maintain control.
Control had worked to maintain a sense of security and self-worth. Letting go of control, therefore, was associated with losing security and self-worth. While rigidly maintaining the coping styles resulted in multiple problems, the secondary gain in the sense of control was equated with the individual's worth, which made change difficult.

Black (1981) and Wegscheider (1981), who have focused on the rules and roles, respectively, for the alcoholic family, have concluded that the development of a focus on control for the COA arises as a coping response to three dysfunctional rules for family members: (1) don't talk about family problems, especially where drinking is concerned; (2) don't express feelings, especially those associated with the difficulties of drinking; and (3) don't trust, especially in relation to depending upon consistent behavior from the alcoholic and/or non-alcoholic parent (Black, 1981).

The rules, which develop around the alcoholism, act as impetus for the formation of the roles of hero, scapegoat, mascot, and lost child (Wegscheider, 1981). Each of the roles is seen as a survival style. The roles serve the dual purpose of adhering to the dysfunctional needs of the alcoholic family, which supports the denial of the disease, and protecting one's self from revealing inner-turmoil (Wegscheider, 1981). To adhere to the rules and to fulfill the needs of the alcoholic family, the COA develops a false
Concerning the COA's inner-turmoil, Kritsberg (1986) concluded that adult COAs share the same underlying emotional states of abandonment, fear, anger, hurt, grief, shame, and guilt, even though their behavior may be quite different. Other clinicians have agreed with this conclusion (Black, 1981; Brown, 1988; Deutsch, 1982; Sexias & Youcha, 1985; Wegscheider, 1981; Whitfield, 1987). They have noted that control functions as a protective mechanism to defend against the acknowledgement of these emotions. Control also acts as a major precipitant influence in the formation of a reactive facade or false self that is often rigidly maintained into adulthood (Cermak, 1986; Whitfield, 1987).

**Alcoholic Family Dynamics and the Individual**

Functional families have been found to differ from those families that have an alcoholic parent (Black, 1981; Brown, 1988; Harrigan, 1987; Sexias & Youcha, 1985). The functional family's attitude is marked by parental warmth and affection, clearly defined limits, consistency, and respectful treatment. Family members discuss their experiences, listen to each other, and accept one another's feelings. Appropriate roles in which parents assume adult responsibilities allow children to acquire a sense of security in believing that their needs will be met. New roles are not abruptly placed on them. Also, parents are
physically and emotionally available, and the threat of abandonment is not present (Beavers, 1987; Gravitz & Bowden, 1985). Difficulties that do arise during the developmental stages of the family are handled by being addressed.

Concerning the development of the individual in the family, whether the family is functional or dysfunctional, the parent-child relationship is noted as being critical in influencing the personality and social development of the child (Erikson, 1963; Harrigan, 1987). As to the importance of a secure caregiver, Bowlby (1980) stated that "intimate attachments to other human beings are the hub around which a person's life revolves, not only when he is an infant or toddler, but throughout his adolescence and his years of maturity as well" (p. 442). The key notion for the child's formation of identity is the perception of how acceptable or unacceptable the child is in the eyes of the caregiver(s). The development of self-knowledge is influenced greatly by significant others, especially parents, which evolves for the developing child into concrete, well-defined beliefs about the self. These beliefs regulate a person's behavior and a person's perception of self, others, and the world (Guidiano & Liotto, 1983).

The alcoholic family, on the other hand, is often marked by how it does not function and by how developmental needs are often not met. The need for the child to adapt to the dysfunction of alcoholism, with an emphasis on psychic
survival rather than on a growth focus, establishes the
ground for the development of low self-esteem, depression,
and anxiety problems (Cermak, 1986; Whitfield, 1987).

Rosellini and Worden (1985) reported that depending
upon the alcoholic parent's level of intoxication and mood,
family life can vary "from a hilariously happy atmosphere to
one of intolerable brutality—all in the same hour" (p. 13).
They reported, too, that anxiety, tension, and fear reside
in the family. "Every member of the family lives with
uncertainty, fear of emotional or physical abuse, anxiety
over their own well-being and for the safety of loved ones,
anger over their feelings of powerlessness, chronic
disappointment" (p. 13).

Kumpfer (1986) noted that as the disease progresses for
the alcoholic parent, the family likewise is negatively
impacted, and family members adjust to the alcoholic's
dysfunction. The family as a unit increases its social
isolation; its developmental expectancies of the child or
adolescent; its abdication of parental responsibilities; and
its need to deny the family secrets of alcoholism and the
connected effects. Also, family conflict, especially verbal
abuse, increases. At the same time, decreases occur in the
family's management skills, in the family's rituals and
marked traditions, and in the family's cohesion. The
dynamics involved in adapting to the alcoholic decrease the
potential for the developmental needs of the COA to be met.
As early as 1954, Jackson outlined stages in the destabilizing process of alcoholism for the spouse and the offspring of the alcoholic. She established that alcoholism created a cumulative crisis effect in which the family members shaped their behavior in a manner that they hoped would resolve the crisis of alcoholism and would permit a return to stability. She concluded that the adaptation to the alcoholic was shaped to lower anxiety. Jackson noted five stages in the cumulative crisis: (1) avoidance of marital difficulty not related to the drinking; (2) isolation of family, which magnifies the importance of family interactions; (3) increase of tension for family members; (4) seeking short-term goals to relieve tension; and (5) marital and parental hierarchical shifts. Throughout the process, the children are pulled into the disease through their need to shape their behaviors to maintain attachment to their caregivers. As a result of the adaptation, Fox (1962) stated that every member in an alcoholic family is "affected by it—emotionally, spiritually, and in most cases economically, socially, and often physically" (p. 72).

In considering alcoholism as a systemic dysfunction for the family, Bowen (1978) suggested that the adjustment to the alcoholic acts as an anxiety-reducer for individuals and for the family as a whole. The adjustment, however, leads to distorted relationships and to the false belief in the
ability to control another’s behavior:

Those members who are most dependent on the drinking patterns are more overtly anxious than is the one who drinks .... The more the family is threatened, the more anxious they get, the more they become critical, the greater the emotional isolation, the more the alcoholic drinks, the higher the anxiety, the greater the ... emotional distance, the more the drinking, et cetera, in an emotional escalation that makes the problem worse and both sides more rigidly self-righteous (p. 267).

Roles, which are shaped to control the alcoholic and to protect the self, form as a response to the spiraling anxiety. Any one significant family member who can 'cool' the anxiety, according to Bowen, receives significance in the family and receives personal relief because a step towards deescalation occurs for the family.

A significant characteristic of the alcoholic family, then, is chronic stress (Black, 1981; Harrigan, 1987). Stress develops in the alcoholic family as influenced by the predominance of inconsistency (Mendenhall, 1987). COAs learn to adapt to parental arbitrariness, unpredictability, indirect communication, and ill-defined limits. They also learn to adapt to boundary infringements in the forms of specific acute or chronic physical, psychological, emotional, and/or sexual abuse, which can become the norm (Black, 1981; Cermak, 1986; Whitfield, 1987).
Chaos, or the apprehension of the loss of control, precludes the development of a "safe, secure, and reliable foundation from which to learn about ourselves through risk-taking" (Whitfield, 1987, p. 38). Communication is often tense, quarrelsome, and conflictual (Moos & Moos, 1984), and spousal communication is often guided by an attempt to control the other person or to allocate blame in responsibility taking (Bepko & Krestan, 1985). With family attention focused increasingly upon the alcoholic, little energy remains to meet the vital needs of other family members.

Although specific events may vary, clinical work has supported the conclusion that alcoholic family's are related (Black, 1981; Brown, 1988; Cermak, 1986; Kritsberg; 1987; Whitfield, 1987). Organizationally, the parent's alcoholism often becomes the central unitary principle for the family, as does concomittantly the denial of such a focus (Brown, 1988). In the alcoholic family, individuals maintain their integral connections around the most inflexible and dysfunctional parts, i.e., the alcoholic (Wegscheider, 1978). It is the alcoholic who sets the unspoken rules for the family, because the alcoholic is the person to whom the family members must adapt (Tharinger & Koranek, 1988).

Brown (1988) stated that much like the alcoholic's primary defense is the denial that alcohol is creating problems for the family, the family members, likewise, adopt
denial as a primary defense. Denial acts as "the cornerstone that maintains the secret of alcoholism and secures it as the unacknowledged organizing principle in the family" (p. 37). Any individual who does not adhere to this defense raises the anxiety level in the family, and thus threatens the tenuous stability of the family.

Family members adopt denial as a form of avoiding, minimizing, rationalizing, delaying, or projecting the acknowledgement of the consequences of the alcohol use. As a result, "what the child sees as reality is denied, and a new model," a false belief system to maintain denial "is assumed true for every family member" (Whitfield, 1987, p. 40). Denial, then, acts as the short-term solution to the inconsistencies presented by the alcoholic. At the same time, denial becomes the problem that enables the alcoholism and its impact on family members to continue. Anything that threatens the beliefs that maintain denial is rejected. For the child to maintain a sense of significance and belonging in the family, the child shapes behavior around the alcoholic's rules, which are often covert (Black, 1981).

To deny alcoholism, then, yet at the same time to maintain a very real need for attachment to significant others, a child's attachment:

earily and ongoing—is based on denial of perceptions, which results in denial of affect, which results in developmental arrests and difficulties. The core
beliefs and patterns of behavior form to sustain attachment and denial within the family, then structure subsequent development of the self including cognitive, affective, and social development (Brown, 1988, p. 5).

Much of development, therefore, is shaped by the need to deny the very reality that the individual is experiencing.

To deny perceptions requires that the child suppress intrapsychic experience (Mendenhall, 1989). This denial and suppression establish the potential for the individual not to communicate needs or feelings. As a result, the awareness of needs and feelings go unacknowledged in one's self as a form of adaptation. Thus, while the family members may be faced with the chronic stress of the alcoholic's abusive potentials, they are, at the same time, "forbidden to articulate their fears" (Mendenhall, 1989, p. 7). The developing child, then, loses contact with primary needs, and the child shapes personality from a reactive basis as opposed to a proactive stance.

Woititz (1983) noted that COAs shape their personalities on a reactive basis. This development of an external locus of control leads to an internal sense of confusion, insecurity, a distorted sense of normality, and a concentration on the control of emotions to protect against unacceptable feelings of hurt, sadness, anger, guilt, shame and fear of abandonment (Ackerman, 1978; Kritsberg, 1986; Whitfield, 1987). In their reactivity, COAs invest their
self-esteem in the ability to control one's self and others because others control the self-esteem of the COA (Cermak, 1986).

Cermak (1986) maintained that the COA develops a codependent personality as a result of the dynamics around alcoholism. The COA becomes "co-dependent" upon another as to what his behaviors, feelings, and thoughts ought to be, having learned to give up on self-trust of the appropriateness of his own behaviors, feelings, and thoughts. Cermak (1986) noted low self-esteem, depression, and anxiety problems to be characteristic of those persons who have been significantly involved with a chemically dependent person.

Subby (1987), who discussed codependency in relation to COAs, stated that the family dysfunction creates the "denial or suppression of the real self based on the erroneous assumption that love, acceptance, security, success, [and] closeness are all dependent upon one's ability to do the 'right thing'" (p. 26). The false self or defensive facade is created to protect the real self from feelings of inadequacy, worthlessness, incapability, and unloveliness. The negative sense of self is produced by the parent's inability to take responsibility for acknowledging the reality of alcoholism (Subby, 1987; Whitfield, 1987). The child makes major decisions about the self based on little experience, insufficient knowledge, and restricted power.
While the behavior may change as one reaches adulthood, the early decisions about the worth, capability, adequacy, competence, and loveableness of one's self do not change (Brown, 1988; Wotitz, 1983).

While the trauma may be different, the underlying constant for the COA is the need for all family members to adjust their lives and thus their development "to cope with or survive the realities of alcoholism" (Brown, 1988, p. 29). The impact of the trauma for the individual precipitates disturbances in cognition, due to the denial of perceptions, which lead to disturbances in feeling and behavior. Anxiety and depression symptoms, as well as disturbances in self-esteem, are manifestations of coping mechanisms that are "directed by cognitive processes and cognitive defenses" (Brown, 1988, p. 98). These defenses are utilized by both the alcoholic parent and the nonalcoholic parent to deny, maintain, and control the drinking behavior. The disturbances in self-esteem, anxiety, and depression are expressions for the COA of the distortions required "to deny both the perception of reality and the affect congruent with it" (Brown, 1988, p. 98).

In conclusion, the need to look more closely, in empirical fashion, at COAs is evident, especially indicated by clinicians' data reporting of impressions and assessments. Brown (1988) noted that not until the mid 1970s and early 1980s were persons from alcoholic families
focused on as a distinct population, and as a population in need of specific therapeutic intervention from the mental health field. During this time, many clinicians became interested in COAs (Ackerman, 1978; Black, 1981; Cermak & Brown, 1982; Wegscheider, 1978, 1981; Woititz, 1983). Many of these clinicians took part in forming the NACA in 1982, and since that time, the NACA has "legitimized and served the needs of millions of children of alcoholics" (Brown, 1988, p. xiv).

While the spread of therapeutic assistance, self-help groups, lay literature, and media exposure has indeed brought much needed attention and aid to COAs, the empirical research in this area is still in its infancy (Brown, 1988; Settle, 1989). The majority of the literature of the mid-1970s and early 1980s focused heavily on establishing similarities among COAs and their families (Black, 1981; Cermak & Brown, 1982; Sexias & Youcha, 1985; Wegscheider, 1978, 1981; Woititz, 1983). While the clinical data may indeed be valuable and valid, much more empirical research needs to be conducted (Settle, 1989) to further elucidate our understanding of COAs. The literature's predominant view is that COAs have a propensity for psychosocial difficulties, prominent of which are low self-esteem, depression, and anxiety. This research offers a needed empirical consideration of levels of self-esteem, depression, and anxiety in adult COAs.
CHAPTER II

PROCEDURES

Selection of Subjects

The data for this study were gathered from volunteer subjects in the undergraduate and graduate courses in the Department of Counselor Education at the University of North Texas. All sampling was conducted with adults 19 years of age and older. An individual does not enter undergraduate Counselor Education courses until the junior year; therefore, no subject was below the age of 19. The rationale for using subjects in the undergraduate and graduate courses was to insure heterogeneity of age. Also, the subjects were likely to be heterogeneous in terms of socioeconomic background, marital status, child status, gender, and race, although the majority of subjects were white as is consistent with the student population. The only criterion for exclusion from the research was the subject's choice not to participate in the study.

To recruit subjects, this researcher, with the permission of individual instructors, entered the classes and requested the help of the students. The purpose of the research was stated verbally and repeated in a cover letter of consent (See Appendix A). Total anonymity was assured.
At that time, packets of measures were distributed to the subjects. The estimated time for completion of the measures was 45 minutes. However, most subjects completed the packet within 20 to 30 minutes.

A total of 226 packets of measures were distributed. The minimum desired number of adult children of alcoholics (COAs) in the study was 60. Identification of adult COAs was assessed by the Children of Alcoholics Screening Test. More non-COAs took the measures—as is consistent with the national population estimates of adult COAs (Woodside, 1986).

The packet included the following measures: a demographic questionnaire (See Appendix B); the Beck Depression Inventory; the State-Trait Anxiety Inventory; the Coopersmith Self-Esteem Inventory; and the Children of Alcoholics Screening Test. Following the letter of consent, was the Beck Depression Inventory, the State-Trait Anxiety Inventory, and the Coopersmith Self-Esteem Inventory. The Children of Alcoholics Screening Test and the demographic questionnaire followed the above mentioned scales. Placing the Children of Alcoholics Screening Test and the demographic questionnaire at the end of the packet protected against contamination of results.
Methods

Instruments

Identification of Children of Alcoholics: The Children of Alcoholics Screening Test (CAST) was used to differentiate comparison groups. The CAST contains 30 items that describe behaviors, feelings, and experiences in relation to a parent's alcohol use. "Yes" or "no" answers are given in response to the items. The CAST items measure a child or adult's emotional distress associated with a parent's alcohol use or misuse; perception of drinking-related marital discord between parents; attempts to control parental drinking; efforts to escape from alcoholism; exposure to drinking-related family violence; and tendencies to see parents as alcoholic; and desire to help (Pilat & Jones, 1984-85).

Six or more "yes" items indicate that a person is likely to have at least one alcoholic parent. Five or less "yes" items indicate that a person is unlikely to have at least one alcoholic parent. To insure a higher level of accurate screening, the study required a cutoff score of 12 or greater. In Jones' (1983) research, this cutoff level reduced the false positive from 23 percent to 11.8 percent.

The CAST appears to be a reasonably reliable and valid instrument. The validity of the CAST was measured by using contrast groups in two studies. A study using 82 children of clinically diagnosed alcoholics and 15 self-reported COAs
were compared to 118 randomly selected controls from nonalcoholic families. All 30 CAST items were found to discriminate significantly from control group children, and COAs scored significantly higher on the CAST than control group subjects. Groups were correlated with the total CAST scores and yielded a validity coefficient of .78 (p < .0001). In a study of concurrent validity, the CAST was given to 81 adults, ages 18 to 37. The self-reported adult COAs scored significantly higher on the CAST than did controls (p < .01). A Spearman-Brown split half reliability coefficient of .98 was obtained in both studies (Pilat & Jones, 1984-85).

Identification of Depression: The Beck Depression Inventory (BDI) is a widely used 21 item self-report measure of the intensity of depressive symptomatology. Since its origination (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the BDI has been used in over 500 reported studies. There is a world-wide trend for the BDI's inclusion within routine psychological test batteries and as a touchstone against which to compare assessments derived from other measures (Steer, Beck & Garrison, 1985). The BDI has also grown from its beginning as a brief psychiatric screening instrument to its employment as a powerful assessment tool (Steer, et al., 1985). While the BDI was specifically developed to assess depression in psychiatric patients, it has also been noted as appropriate for detecting the presence of depressive

The 21 item measure takes approximately 10 to 15 minutes to complete, and it can be self-administered. Items consist of a graded series of four self-evaluative statements ranked to reflect the range of severity of symptoms from normal to severe. Numerical values of 0 to 3 are assigned to each statement to indicate the degree of depression. Scores are found by totaling responses. The higher the total score, the more depressed the subject. A score of 0 to 9 indicates no or minimal depression; 10 to 14 indicates borderline depression; 15 to 20 mild depression; 21 to 30 moderate depression; 31 to 40 severe depression; and 41 to 63 indicates very severe depression (Beck, 1967).

The BDI has been used on a wide range of groups, including clinical and nonclinical populations. Originally, the measure was standardized on a group of 598 psychiatric inpatients and outpatients at a large metropolitan hospital (Beck et al., 1961). Split-half reliabilities ranging from .78 to .93 have been reported, indicating sound internal consistency. Test-retest reliabilities ranging from .48 for psychiatric patients after three weeks have been reported,
and .74 for undergraduate university students after three months have been reported (Cocoran & Fischer, 1987). Research has shown significant correlations with a number of depression measures, indicating strong concurrent validity from .50 to .60 (Steer et al., 1985). The BDI also correlates strongly with clinicians' ratings (r = .65 and .67) (Beck, et al., 1961). The measure has also been shown to be sensitive to clinical changes in several studies (Cocoran & Fischer, 1987).

**Identification of Anxiety:** The State-Trait Anxiety Inventory (STAI): "Self-Evaluation Questionnaire" has been used extensively in research and clinical practice. More than 2000 studies that have used the STAI have appeared in research literature since its publication in 1970 (Speilberger, 1983). Construction of the instrument began in 1964 with college students, and it was designed to be a self-administering scale. The intent of construction of the STAI was to develop a single, relatively brief scale that would provide objective self-report measures of both state and trait anxiety. The scale was later broadened to include adolescent and emotionally disturbed persons in both clinical and research contexts (Speilberger, 1983).

State anxiety is characterized by transitory "subjective feelings of tension, apprehension, nervousness, and worry and by activation or arousal of the autonomic nervous system" (Speilberger, 1983, p. 1). Trait anxiety
refers to "relatively stable individual differences in anxiety-proneness, that is, to differences between people in the tendency to perceive stressful situations as dangerous or threatening and to respond to such situations with elevations in the intensity of their state anxiety ... reactions" (p. 1).

The STAI consists of 40 brief items, and college students on average require 10 minutes to take the inventory. Half of the items notes state anxiety, the other half notes trait anxiety. To respondents, the scale is referred to as the "Self-Evaluation Questionnaire". Respondents are asked to read the directions carefully since the State scale is answered in the present sense, whereas the Trait scale is answered as to how one generally feels (Speilberger, 1983). Respondents answer on a 1 to 4 scale, with 1 being "not at all"; 2 being "somewhat"; 3 being "moderately so"; and 4 being "very much so". A high score suggests high state or trait anxiety. A respondent may measure high on one scale and not the other.

Normative data for the STAI were gathered from large samples of college and high school students, working adults, military recruits, medical and surgical patients, psychiatric patients, and prison inmates. More than 5,000 subjects were tested (Speilberger, 1983).

Test-retest reliabilities for the trait scale for male and female college undergraduates over a six month period
were .73 and .77 respectively, indicating the Trait scale to be quite stable. Internal consistency of the State scale as measured by the Kuder-Richardson 20 ranged from .83 to .92. Alpha reliability coefficients for normative samples (high school juniors, college freshmen, and introductory psychology students) ranged from .83 to .92 for State scores and .86 to .92 for Trait scores (Katkin, 1978).

Concurrent validities for the Trait-anxiety scores were obtained by correlating scores with the IPAT Anxiety Scale and the Manifest Anxiety Scale. Correlations were high, ranging from .73 to .85 (Katkin, 1978). Validity for the State-anxiety scale was gathered by contrasting results with norming groups, with the criterion being different degrees of stress within each group. Scores on the State-anxiety scale increased dramatically under stress compared to normal conditions, indicating that the State scale measures changes in subjects' subjective experience of anxiety (Speilberger, 1983).

In this research only the Trait scale was used as a relevant measurement of anxiety. Because each class was tested under different, uncontrolled situations, e.g., tests being given, tests being completed, etc., the present status of anxiety presented a variable that had no relevance. No criterion of consistency existed to which it could be compared. The Trait scale, however, is a relatively stable measure of how one "generally" feels in
terms of anxiety, thus making test conditions less of a concern. The STAI was created in such a fashion as to make either scale usable apart from the other.

The STAI appears to be a reliable and valid instrument. Katkin (1978) stated that the "STAI scale represents a relatively efficient, reliable, and valid way to assess individual differences in both anxiety-proneness and phenomenological experience" (p. 684).

Identification of Self-Esteem: The Coopersmith Adult Self-Esteem Inventory (SEI) is a self-report, 25 item questionnaire that requires marking "like me" or "unlike me" responses. The adult form was adopted from the extensively used school form and is for ages 15 and over. The scale provides a total score as a measure of self-esteem. The higher the score, the higher the self-esteem ratings; the highest a respondent can score is 100. Coopersmith (1987) defines self-esteem as a "set of attitudes and beliefs that a person brings with him- or herself when facing the world .... Self-esteem provides a mental set that prepares the person to respond according to the expectations of success, acceptance, and personal strength" (p. 1).

The total score correlation of the school form with the adult form exceeded .80 for three samples of high school and college students (n = 647) (Coopersmith, 1987). The adult form was administered to 226 college students. The reliabilities ranged from .78 to .85.
Peterson and Austin (1985) stated that the Coopersmith Inventories, both the School and Adult Forms, have much to recommend them, and that they are among the best known and most widely used of the various self-esteem measures. They also reported that the Adult Form of the SEI possesses enough reliability and validity to recommend its use in research.

Demographics

The demographic data sheet noted gender, age, marital status, child status, and race. It also included questions about the functioning of the subject's family of origin, and it requested information about the types of mental health treatment, if any, that the subjects have received.

Analysis of Data

To analyze the data for this study, a 2 X 2 (Group X Gender) multivariate analysis of variance (MANOVA) was computed. The three dependent variables—self-esteem, depression, and anxiety—used in this research are considered areas of primary dysfunction in COAs (Cermak, 1986; Kritsberg, 1986).

The hypotheses for this research stated that a significant difference exists between COAs and non-COAs on levels of self-esteem, depression, and anxiety. In addition, further research was conducted to consider differences between those individuals from functional families and those individuals from dysfunctional families,
regardless of parental alcoholism status. The .05 level of significance was used to evaluate all relevant F-ratios.
CHAPTER III

RESULTS AND DISCUSSION

Analysis of Data

To determine whether significant differences existed at the omnibus level, a 2 X 2 Multivariate Analysis of Variance (MANOVA) was conducted 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 means and standard deviations for each dependent variable (Y1 = self-esteem, Y2 = depression, and Y3 = anxiety) for the four cells of the design are presented in Table 1.

Table 1
Means and Standard Deviations on Dependent Variables

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Y1</td>
<td>Y2</td>
</tr>
<tr>
<td>NON-COA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=30 M</td>
<td>81.73</td>
<td>4.07</td>
</tr>
<tr>
<td>SD</td>
<td>19.04</td>
<td>6.54</td>
</tr>
<tr>
<td>COA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=23 M</td>
<td>72.35</td>
<td>6.83</td>
</tr>
<tr>
<td>SD</td>
<td>20.85</td>
<td>6.35</td>
</tr>
</tbody>
</table>
The Hottelling-Lawley trace, Wilks's Lambda (\(\lambda\)), and Philhali's trace (\(V\)) were used to approximate the F-ratios in this and all subsequent multivariate analysis.

The first analysis compared children of alcoholics (COA) and non-COA groups without regard to gender differences. Table 2 shows that no significant difference exists—multivariate F (3,199) = 1.898, n.s. A second design was done comparing males against females without regard to group affiliation. Again, no significance was found—multivariate F (3,199) = .976, n.s. A third design examined interaction between group and gender, and again no significance was found—multivariate F (3,197) = .591, n.s.

Table 2

<table>
<thead>
<tr>
<th></th>
<th>df</th>
<th>F</th>
<th>Sig. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>3/199</td>
<td>1.89826</td>
<td>.131</td>
</tr>
<tr>
<td>Gender</td>
<td>3/199</td>
<td>.97616</td>
<td>.405</td>
</tr>
<tr>
<td>Group X Gender</td>
<td>3/197</td>
<td>.59136</td>
<td>.621</td>
</tr>
</tbody>
</table>

p < .05.

Therefore, the hypothesis that significant differences exist between COAs and non-COAs on levels of self-esteem, depression, and anxiety is rejected, and the null hypothesis is accepted. Had the hypothesis been accepted, appropriate
post-hoc procedures (e.g., discriminant analysis, completely partialed F tests) would have been employed to provide a method of investigating the question of the relative importance of the dependent variables to the MANOVA effect.

While no significance was found related to the hypothesis, two factors concerning the results are worth noting. Firstly, though no significance was found in testing, the COA scores did prove to be lower in self-esteem, and higher in depression and anxiety, which supports the literature concerning this population. Secondly, Woodside (1986) has estimated that 1 in 8 adult Americans, or 12 percent of the adult population, are from alcoholic families of origin. In this study, however, of the 203 subjects tested, 60 subjects, or 29 percent, were noted as being from alcoholic families of origin. This number is more than double the national estimate. This result appears even more remarkable when considering the male subjects only. Of the 53 male volunteers, 23 subjects, or 43 percent, are COAs.

In order to facilitate future research in this area, a secondary analysis was conducted on the same data. It compared differences between individuals from functional families and those from dysfunctional families by group only. Table 3 shows the means and standard deviations of the two groups along the dependent variables.
Table 3

Means and Standard Deviations for Functional and Dysfunctional Groups

<table>
<thead>
<tr>
<th>Functional</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>n=92</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>79.17</td>
<td>4.92</td>
<td>34.77</td>
</tr>
<tr>
<td>SD</td>
<td>17.75</td>
<td>4.798</td>
<td>8.89</td>
</tr>
<tr>
<td>Dysfunctional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=111</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>70.74</td>
<td>7.12</td>
<td>39.86</td>
</tr>
<tr>
<td>SD</td>
<td>19.15</td>
<td>6.57</td>
<td>9.32</td>
</tr>
</tbody>
</table>

A significant difference exists between the functional and dysfunctional groups on each of the dependent variables. The Hotelling-Lawley trace, Wilks's Lambda (Λ), and Pillai's trace (V) all indicate significance—multivariate F (3, 199) = 5.364, p < .01 (cf. Table 4).

Table 4

F Value for One-Way MANOVA on Group Comparisons of Functional and Dysfunctional Groups

<table>
<thead>
<tr>
<th>df</th>
<th>F</th>
<th>Sig. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group</td>
<td>3/199</td>
<td>5.36412*</td>
</tr>
</tbody>
</table>

* p < .01.
Univariate ANOVAs (cf. Table 5) show the locus of effect to be in all three variables: Self-esteem multivariate F (1,201) = 10.425, p < .01; Depression multivariate F (1,201) = 7.102, p < .01; and Anxiety multivariate F (1,201) = 15.506, p < .001.

Table 5

F Values for the ANOVAs on the Dependent Variables of Functional and Dysfunctional Groups

<table>
<thead>
<tr>
<th></th>
<th>df</th>
<th>F</th>
<th>Sig. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Esteem</td>
<td>1/201</td>
<td>10.42547*</td>
<td>.001</td>
</tr>
<tr>
<td>Depression</td>
<td>1/201</td>
<td>7.10246*</td>
<td>.008</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1/201</td>
<td>15.50612**</td>
<td>.000</td>
</tr>
</tbody>
</table>

* p < .01. ** p < .001.

Though the results showed significance between the dysfunctional and functional groups, the scores related to the measures for the dependent variables fall within the norms of each instrument used. A score between 0 and 9 for depression, measured by the BDI, indicates the normal or asymptomatic range for depression. The mean for each group related to depression falls within this score. Also, levels of Trait anxiety, measured by the STAI, and self-esteem, measured by the SEI, fall within the norms for each group. Therefore, while the dysfunctional and functional family of
origin groups did significantly differ, the results did not indicate severity of symptoms in either group.

Due to the secondary nature of the results that are noted above, further analysis was not pursued into tests regarding the extent to which the individual dependent variables contributed to the significant omnibus effect. Interesting to note, though, is that over half of the subjects tested noted themselves as having come from dysfunctional families of origin.

Discussion

This study explored the effects of group association with alcoholic family of origin, gender, and their combination on levels of self-esteem, depression, and anxiety. Although no significance was found at the omnibus level, several factors may have weakened the power of the test.

A Box-Plot analysis was done to determine possible outliers in the data. Extreme scores were found in all three dependent measures (3 standard deviations from the mean). These scores led to large within group variance that limited the ability of the MANOVA to detect differences. The outliers were checked for data entry errors, and none were detected. Another possibility is that while participation was voluntary, some participants may have skewed the data by attempting to finish quickly or by
marking measures carelessly. Also, some participants may have misunderstood the questions on the measures.

Another factor that may have weakened the power of the test concerned the secondary analysis. This analysis compared differences between subjects from functional and dysfunctional families of origin. Results indicated significance at the multivariate level. Factors that led to this significance, and may have led to the lack of variability in the initial analysis, are suggested as follows.

All but one subject in the COA group (N = 60) noted a dysfunctional family of origin, indicating a clear association and recognition of parental alcoholism as part of family dysfunction. When the COAs who noted family dysfunction were grouped with other subjects who noted family dysfunction, the result produced greater variability in the data. Significance was then found at the multivariate level. In as much, then, the initial analysis of COAs to non-COAs may have been comparing "likes to likes" more than assumed by this researcher. Thus, variability was minimized by comparing dysfunction to dysfunction.

Areas of dysfunction marked by the subjects (each subject was asked to choose one area of dysfunction) included the following: (1) inflexible and controlling parent(s), (2) physically abusive parent(s), (3) sexually abusive parents, (4) mentally disabled parent(s), (5)
physically disabled parent(s), and (6) parents were divorced. A total N of 111 subjects noted themselves as having been raised in a dysfunctional family; 59 of the 111 subjects were COAs who made up the first comparison group.

The significance of dysfunction compared to function showed that for this sample, persons who were from dysfunctional families of origin, with or without parental alcoholism, were significantly associated along lines of self-esteem, depression, and anxiety. Rather than parental alcoholism being the deciding factor of variability, family dysfunction proved to be the major factor of variability. The result suggests that commonalities exist among the subjects from dysfunctional families of origin. Concerning these commonalities, clinicians such as Whitfield (1987) and Bradshaw (1988), among many others, have noted common characteristics that make up dysfunctional families, both in structure and atmosphere. The need for a child to adapt to dysfunction, with an emphasis on psychic survival rather than upon a growth focus, forms the basis for the development of low self-esteem, depression, and anxiety difficulties. Roles develop, which often become rigid, to control the primary stressor person(s) and to protect the self. Rules, which likewise become rigid, in these dysfunctional families are often set by the primary stressor person(s).
The atmosphere is often predominated by stress in the dysfunctional family. Stress is often characterized by inconsistency, unpredictability, indirect communication, ill-defined or rigidly defined roles and rules, and acute or chronic boundary infringements. Chronic stress, then, precludes the development of a secure foundation from which a child can learn about the self through growth enhancing risk-taking (Whitfield, 1987).

The effect of this structure and atmosphere is that the potential for the healthy development of the parent-child relationship is diminished. A key notion of the formation of a child's identity is the perception of how acceptable or unacceptable the child is in the eyes of primary caregiver(s) (Bowlby, 1980). Researchers note that the development of self-knowledge is influenced greatly by significant others, which evolves into concrete, well-defined beliefs about the self. These beliefs regulate a person's behavior and a person's perception of self, others, and the world (Guidiano & Liotti, 1983).

If the child is in a family system that is supported by denial concerning the existence of a problem, as can be quite common in the areas of dysfunction noted above, then perceptions become shaped around the "secret" (Bradshaw, 1988). For the developing individual to be significant and to belong in the family, he must deny his own perceptions. The denial of one's own perceptions requires that the
individual, likewise, deny intrapsychic experiences (Mendenhall, 1989).

This denial establishes the potential for the person not to communicate needs or feelings. As a result, the awareness of needs and feelings go unacknowledged as a form of adaptation. The developing person, then, loses contact with primary needs (Mendenhall, 1989), and shapes the personality from a reactive basis as opposed to a proactive stance. The resulting reactive stance negatively impacts self-esteem, and can establish the basis for depression and anxiety problems (Bradshaw, 1988; Whitfield, 1987).

These purported commonalities of individuals from dysfunctional families may have influenced the results of this study by lessening the power of the initial test that compared COAs to non-COAs. They also offer a rationale for the significance found to exist when the dysfunctional family of origin group was compared to the functional family of origin group.

While COAs show a high incidence of problems and appear to be at "increased risk for most serious psychosocial illnesses of adulthood" (El-Guebaly & Offord, 1977, p. 364), seeing alcoholism from a linear-causal stance can create distinctions that do not necessarily exist. This factor does not diminish the impact that alcoholism does indeed have. It does suggest, however, that alcoholism needs to be seen as a transactional problem that has many
mediating factors (Werner, 1985). The data in this study suggest that alcoholism is related to other forms of family dysfunction and that family dysfunction is related to the dependent variables used in this study.

Results from this study suggest that family dysfunction needs continued study to discriminate among factors that are relevant in influencing the development of the individual. This study notes that persons in the sample from dysfunctional families of origin may be more susceptible to difficulties with self-esteem, depression, and anxiety than persons from functional families. Individuals from alcoholic families did not prove to be significantly different from the comparison group in relation to the dependent variables. However, being from a dysfunctional family of origin did prove to be significant in relation to the dependent variables when subjects from dysfunctional families were compared to subjects from functional families.

Implications for Further Research

Determining the factor(s) that contribute to the variability between functional and dysfunctional families of origin is indicated. For the subjects tested, those persons from dysfunctional families of origin had significantly lower levels of self-esteem, higher levels of depression, and higher levels of anxiety than those persons who indicated being from functional families of origin. Rather than parental alcoholism being a significant factor, the
family of origin status proved to be significant. While this research certainly does not disprove, nor can it be generalized to, the literature pertaining to COAs, research does indicate that family dysfunction, of which alcoholism can be a type, needs continued study. Future research could well focus on discriminating between types of dysfunction and determining which factors can be attributed to the variability between functional and dysfunctional families.
APPENDIX A

INFORMED CONSENT
Informed Consent

The purpose of this research is to study levels of depression, anxiety, and self-esteem between groups of people. Your participation is requested to complete the enclosed packet of measures. The measures are estimated to require 45 minutes of your time.

Any information 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 are available upon request by contacting David Dodd through the Counseling and Human Development Center, University of North Texas (817-565-2970). Thank you for your cooperation.
Information

Age: ___ Gender: 1. ___ Female 2. ___ Male

Race: 1. ___ Black  2. ___ White  3. ___ Hispanic
4. ___ Asian  5. ___ Native American  6. ___ Other

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

Number of Children: ___

Is or was one or both of your parents an alcoholic?
1. ___ Yes  2. ___ No

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

If you marked dysfunctional or very dysfunctional, please circle one of the numbers beside the statement that most closely applies to your situation.

1. Parent(s) was inflexible and controlling.
2. Parent(s) was physically abusive.
3. Parent(s) was sexually abusive.
4. Parent(s) was mentally disabled.
5. Parent(s) was physically disabled.
6. Parents were divorced.

Have you received or attended therapeutic assistance through one of the following. Please circle the number beside the types of therapy that you have received.
1. 12-step recovery program.
2. Family therapy
3. Individual therapy (not through the Counselor Education Program)

4. Required therapy sessions in the Counselor Education Program

5. Outpatient hospitalization treatment

6. Inpatient hospitalization treatment

Approximately how long ago did you receive treatment?

_________
REFERENCES


Black, C., Bucky, S., & Wilder, P. S. (1986). The interpersonal and emotional consequences of being an


