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INTIMATE RELATIONSHIPS OF ADULT CHILDREN OF ALCOHOLICS

DISSERTATION

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Difficulties developing and maintaining intimate relationships are often attributed to adult children of alcoholics (ACAs). However, the focus of the literature has been on those obtaining psychological treatment and has primarily involved clinical impressions. The purpose of this study was to examine intimacy in the close friendships and love relationships of ACAs. Autonomy and intimacy in respondents' families of origin were also analyzed. Comparisons were made between ACAs currently in ($n = 59$) and not in ($n = 53$) therapy, and comparisons who had ($n = 48$) and had not ($n = 77$) received therapy. Alcoholics were eliminated. It was hypothesized that ACAs would score significantly lower than comparisons on love and friendship intimacy and autonomy and intimacy in their families of origin. Among the ACAs, those in therapy would score lower than those not in therapy. Hypotheses were tested using MANOVAS. ANOVAs were administered where there were significant differences, and Newman-Keuls contrasts further delineated the divergence. Multiple regression analyses were conducted to obtain explanatory data.

The two ACA groups seem to represent distinct populations with those not in therapy failing to report intimacy differences previously ascribed to them. While all of the groups were similar in friendship closeness, only the ACAs in therapy had significantly less intimacy in love relationships. Furthermore, clinical ACAs differed from the other groups by having less family of origin health, more physical and sexual abuse, more maternal drinking, more depression, and more suicidal thoughts and behaviors.

Family of origin health predicted intimacy in a love relationship. Family characteristics encompassing honesty, empathy and respect, which may or may not involve alcoholism, seemed to create an atmosphere of faulty parenting in the ACA clinical group which may have subsequently affected the child's intimacy in a love relationship. Results of the study support a developmental model and demonstrate the importance of including nonclinical ACAs as well as clinical comparisons in future research.

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CHAPTER I

INTRODUCTION

The purpose of the present study was to examine intimacy in the close friendships and love relationships of adult children of alcoholics (ACAs). Besides investigating clinical and nonclinical adults from nonalcoholic homes, a comparison of clinical and nonclinical groups of ACAs was conducted. This allowed previously neglected comparisons between ACAs seeking and those not presently seeking professional help for intimacy problems. Many adult children of alcoholics may be psychologically healthy in spite of their parent's pathology and may not have required psychotherapy. Thus, the suggestion of commonality of ACA intimacy difficulties will either be strengthened or weakened. Additionally, this study investigated the perceived autonomy and intimacy levels of childhood family relationships.

First, literature pertaining to children of alcoholic parents is presented. Most of this literature consists of clinical impressions, but research is reported where available. The limitations of this literature should be considered throughout the review. The construct intimacy is defined and discussed. Finally, the impact of parental

alcoholism on adult intimate relationships is explored, in part by extrapolating from the larger body of literature on children.

Introduction to the Problem

Historically, the impact of parental alcoholism on child development has been a neglected area of study. Although most of the literature has focused on children living in the alcoholic family system, no unifying theory currently explains the particular effects on their mental health (Lord, 1983). The literature strongly suggests that there are numerous negative effects on children's psychosocial status which may be enduring (Black, Bucky, & Wilder-Padilla, 1986; Fox, 1962; Harrigan, 1987; Lord, 1983). Interests are beginning to turn toward the long-term impact of parental alcoholism on the social and emotional adjustment of offspring during adulthood.

Professional interest in children from alcoholic homes has increased during the past 20 years. However, anecdotal reports and clinical impressions predominate in the literature. Early research focused on genetic and environmental influences on the etiology of alcoholism (Goodwin, Schulsinger, Hermansen, Guzi, & Winokur, 1973; Lucero, Jensen, & Ramsey, 1971; Roe, 1944). Recent investigations into the functioning of adults reared in alcoholic homes provide some insight into their special problems. These adults are becoming increasingly recognized

as a clinical population whose symptoms may be subject to misdiagnosis (Lord, 1983). Adult children of alcoholics have been identified as a group particularly at risk for the development of interpersonal problems and difficulties developing intimacy (Black, 1981; Black et al., 1986; Cermak & Brown, 1982; Downing & Walker, 1987; Woititz, 1983). Since the literature has primarily focused on young children of alcoholics (COAs), researchers have had to extrapolate from such data to help understand adult difficulties with interpersonal relationships.

When observations are presented, there is seldom an attempt to quantify the data, and statistical techniques are seldom employed to determinine the significance of the results. Experimental or quasi-experimental studies have been conducted, but they have been methodologically weak (Jacob, Favorini, Meisel, & Anderson, 1978; Nardi, 1981; Watters & Theimer, 1978). Critiques of this literature call for the use of independent variables such as age, sex, and clearly specified criteria for alcoholism (el-Guebaly & Offord, 1977). Researchers vary their definition of alcoholism from being identified as alcoholic by an adult child (Brown & Beletsis, 1986) to receiving inpatient psychiatric treatment for alcoholism (Becker & Miller, 1976; Goodwin, Schulsinger, Knop, Mednick, & Guze, 1977; Moos & Moos, 1984). Operational definitions of children of alcoholics have also varied across studies. A possible

implication of these definitional problems is that comparisons are being made between subjects whose backgrounds have been assumed, without adequate determination, to be similar. Moreover, comparisons across studies may generate spurious conclusions when they are based on different subject pools. Additional methodological weaknesses include small sample sizes and few analyses of intragroup variations. Thus, empirical evidence at this time is limited and should be considered suggestive. Issues related to characteristics of ACAs are far from resolved.

As pointed out, most of the research interest has focused on children. Studies have often found associations between parental alcoholism and childhood problems, such as self-esteem and identity (Baraga, 1977; Cermak & Brown, 1982; Cork, 1969; Woititz, 1977); avoidance and repression of feelings (Fine, Yudin, Holmes, & Heinemann, 1976); distrust and skepticism (Barnes, Benson, & Wilsnack, 1979); isolation from peers (Wilson & Orford, 1978); anxiety (Fine et al., 1976); and depression (Booz-Allen & Hamilton, Inc., 1974). Behavioral and school problems have also been reported (Farkasinszky, Simon, Wagner, & Szilard, 1973; Haberman, 1966; Miller & Jang, 1977; Nylander, 1979). It has been difficult to discern the impact of alcoholism on children because research has focused on samples of families seeking help. Usually the samples of children had come to the attention of legal or social authorities or had a parent

in treatment for alcoholism. When comparison groups were employed, they usually consisted of clinical subjects whose parents were not considered alcoholic. Since children from aberrant family situations were primarily studied and rarely were these children compared with those from more normally functioning homes, only the most detrimental effects of alcoholism may have been observed. Thus, these children have often been presented unfavorably, and problematic research has severely limited the generalizability of data.

Similar methodological weaknesses pervade findings on adult children of an alcoholic parent. Comparison groups are often absent, and characteristics of this population are generated from clinical observations (Ackerman, 1978; Black, 1981; Brown & Beletsis, 1986; Deutsch, 1982; Gravitz & Bowden, 1985; and Woititz, 1983). One of the few systematic studies of adults was by Black et al. (1986). Respondents were 409 ACAs and 179 adults from nonalcoholic homes solicited from national magazines. Results suggested that a number of issues characterize adult children of alcoholics. They have problems identifying and expressing feelings; difficulties with trust and dependency; problems with intimacy, expressing needs and putting the self first; and a tendency to assume excess responsibility. These results were consistent with clinical impressions and suggest the general conclusion that interpersonal relationships are problematic for ACAs. Utilizing nonclinical respondents was

a strength of this study, but the self-selection from alcohol-related journals may have biased the results. Additionally, no validating instrument confirmed a respondent's self-identification as a child of an alcoholic parent. Finally, it appeared that some findings were generated by one-sentence questions and, therefore, should be interpreted with caution.

Given such childhood and adult characteristics, it is not surprising that difficulties with interpersonal, especially intimate relationships, are frequently identified as major problems in their adult lives (Woititz, 1983; 1985). While clinical impressions support this idea, limitations in the research have significantly hampered a clear understanding of the unique characteristics of adult children of alcoholics. Furthermore, negative stereotypes regarding this population have been formulated by professionals (Burk, 1987). These stereotypes may be due to biases resulting from reports based on clinical or self-identified samples. For example, mental health professionals rated an adolescent COA presented as a class leader or a behavior problem as more pathological than a child from a nonalcoholic home (Burk, 1987). This is problematic because a favorable treatment prognosis is contingent upon accurate assessment of the problems, and unvalidated, negative stereotypes on the part of clinicians could bias their interventions. On the other hand, if a

cluster of symptoms, however negative, is relevant, the clinician would benefit from an accurate understanding of possible familial influences on the client's present interpersonal difficulties. More systematic research is clearly needed.

Prevalence of the Problem

A recent national survey found that one out of every three Americans comes from a home where alcohol caused familial problems (U. S. Department of Health and Human Services, 1983). Notably, a very large number of children are affected by alcohol. The most recent statistics are based on 1985 surveys and suggest that one-third of American adults abstain from alcoholic beverages, one-third are light drinkers, and the final third are moderate to heavy drinkers (U. S. Department of Health and Human Services, 1987). Heavy use means more frequent use than is true of American consumers generally, and the heaviest drinkers (8%) consume an average of 14 drinks per week. However, per capita consumption of alcohol has declined since reaching its peak in 1980-1981. The male-to-female ratio for moderate drinking is almost 2:1 and for heavy drinking is almost 5:1.

One out of every eight Americans comes from an alcoholic home. An estimated 7 million of this population are youngsters and 21 million are adults (Woodside, 1986). In 1955, alcoholism was recognized as a disease by the American Medical Association. In the 1960s and 1970s, it

became increasingly accepted that the family develops a parallel disease of its own. During the late 1970s and early 1980s, attention has been given to the adults from alcoholic homes. In 1983, the National Association for Children of Alcoholics was formed to address the issues of this group, regardless of age (Gravitz & Bowden, 1985). As children, they have been classified as "defenseless and tragic victims" (Chafetz, 1979, p. 23) and "at risk" for developing alcoholism as well as physical, emotional, social, academic, and interpersonal difficulties (Black, 1981; Deutsch, 1982).

Research points to the intergenerational continuity of alcoholism and suggests that COAs may be four times more likely to become future alcoholics than other individuals (Goodwin, 1985; Goodwin et al., 1977). Supportive evidence for a genetic component has been found (Cotton, 1979; Goodwin et al., 1973; Lucero et al., 1971). Recent research suggests that children with two alcoholic parents have a greater sensitivity to alcohol than those with nonalcoholic parents (McKenna & Richens, 1981). Further, they are more likely to be younger when first intoxicated, and if alcohol abuse occurs, they develop alcoholism more rapidly. Although environmental factors have also been implicated in the development of alcoholism (Roe, 1944; Cahalan, 1970), a genetic contribution is now recognized (Cloninger, 1983).

Additionally, interactions between genetic and environmental factors have been found.

Family Environment

Functional families differ from those with an alcoholic parent. The former provide security, love, and warmth necessary for adequate development of children (Fox, 1962). They are relatively consistent and predictable, minimally arbitrary, and rarely chaotic. Family members freely discuss their experiences, listen to each other, and accept one anothers' feelings. There are appropriate roles in the family where parents assume adult responsibilities. Children trust that their needs will be met, and new roles are not abruptly thrust upon them. Since parents are emotionally and physically available, children feel secure and do not fear abandonment (Gravitz & Bowden, 1985).

The parent-child relationship is critical in determining an offspring's personality and social development (Harrigan, 1987). Moreover, there is agreement that living with a problem drinker results in a dysfunctional family and problems for the members (Ackerman, 1978; Black, 1986; Dulfano, 1981; Ellwood, 1980; Hanson & Estes, 1977; Jackson, 1954; Johnson, 1980; Schaef, 1986; Wegscheider, 1981; Woodside, 1983). Forrest (1980) suggests that those living with a problem drinker become emotionally disturbed due to the impact of the alcoholic on the family's life style. A similar view is expressed by Straussner,

Weinstein and Hernandez (1979) from a family system's perspective. In addition to being classified as dysfunctional, alcoholic families have demonstrated more difficulties with overt power, parental coalition, and empathy when compared with nonalcoholic clinic families and a nonalcoholic comparison group (Watson & Hulgus, 1988). These findings support the need to further investigate interactional patterns of alcoholic families and the impact of such patterns on offspring. As a result of her clinical experience with ACAs, Woititz (1983) surmised that although specific events may vary, in general alcoholic home environments are similar. The patterned way nonalcoholic family members relate to others has been termed "co-dependency" (Wegscheider-Cruse, 1985, p. 2). This condition, involving a centrality of focus and extreme dependence on a person or object (e.g., an addiction to the dysfunctional alcoholic family system), eventually interferes with the co-dependent's other interpersonal relationships.

Anecdotal reports indicate that children living with an alcoholic parent are almost, but not quite, misled into thinking that their household is like any other (Seixas & Youcha, 1985). Alcoholic homes appear to have the rule "don't talk about what's really going on" (Harrigan, 1987, p. 140). Family members cannot admit problems to each other or to outsiders because such revelation could threaten the

alcoholic's belief that drinking is not a problem. Denial is learned and reinforced when family members do not discuss honestly what is happening. The result is that family members become suspicious and angry (Seixas & Youcha, 1985). Moreover, this lack of communication reinforces children's feelings of isolation, making it more difficult for them to function in society (Harrigan, 1987).

Marital Discord and Instability

Alcoholism clearly seems to have an adverse effect on familial interactions. Approximately one-third of problem drinkers describe marital discord to be a major problem associated with their drinking (Jacob, 1980). Furthermore, 40 percent of problems presented to family court involve alcoholism. Investigations using unstructured interviews have consistently documented the tension-filled atmosphere of the alcoholic home (Booz-Allen & Hamilton, Inc., 1974; Cork, 1969; Miketic, 1972; Wilson & Orford, 1978). However, lack of comparison groups and statistical analyses limit the generalizability of these studies.

A program of research on family environment has been conducted by Moos and his associates. Using the Family Environment Scale, consisting of 10 dimensions, Moos and Moos (1976) conducted a cluster analysis on a variety of family types which included "frequent drinkers." Although the criteria for determining this group is unclear, they were overrepresented in the "conflict-oriented" cluster and

underrepresented in the "structure-oriented" and "moral/religious-oriented" clusters. Thus, the frequent drinkers were often characterized by conflictual interaction and open expression of anger and aggression. Additionally, the families tended to deemphasize organization and order as well as ethical and religious values.

Since violence is often reported in alcoholic families (Hamilton & Collins, 1981; Wilson & Orford, 1978), it is not surprising to note that marital conflict as evidenced by separation or divorce is more prevalent in alcoholic than nonalcoholic families (Black et al., 1986; Kammeier, 1971; Miller & Jang, 1977; Swiecicki, 1970; Wilson & Orford, 1978). A study by Chafetz, Blane, and Hill (1971) found family structure and stability differences in alcoholic and nonalcoholic families. Most children of alcoholics were living with only one parent. Moreover, a child in an alcoholic family was more likely to have suffered a prolonged separation from one parent by mid-adolescence. It seems likely that these structural and stability problems could contribute to interpersonal distrust which may affect the intimate and other relationships of children from these families.

Parent-child Interactions

Alcoholic families have been characterized as arbitrary and chaotic (Gravitz & Bowden, 1985), with inconsistency and unpredictability as the hallmarks (Black, 1981). The

clinical work of Gravitz and Bowden (1985), who were psychotherapists for over 1500 ACAs, provides insight into difficulties experienced in these families. For example, a conversation with a drunken parent which is not remembered by the parent the next day can be confusing to a child. Alcoholics frequently experience "blackouts" which are a type of chemical amnesia where one cannot remember what was said or done. Even the alcoholic parent may not be aware that he or she has experienced a blackout (Gravitz & Bowden, 1985).

Healthy families provide fairly consistent parental guidance with predictable consequences for behavior. In alcoholic families inconsistency of personality and behavior is more common with parental responses sometimes oscillating between seductiveness and rages (Arentzen, 1978). A parent can change from being quite gentle and loving while sober to the opposite when drinking. Consequently, the child never knows which personality will be encountered and, therefore, suppresses spontaneity, waiting first to decide if the parent is sober (Gravitz & Bowden, 1985). Family life is arbitrary as a result of the impulsive attitudinal and behavioral changes that occur (Gravitz & Bowden, 1985). For example, parents often are unable to agree on the rules for their children. One week a teenager might be permitted to date without a curfew; the following week, the parents may not allow any dating. In an early review article, Fox

(1962) suggested that these parents often argue over how to discipline their children, occasionally using the child as a pawn. Such disagreement may leave the child confused over what is expected of him or her. A possible consequence of parental inconsistency is that the child will realize the injustice and severity of the punishment meted out to him or her for misdemeanors contrasts glaringly with the violent speech or acts of the parent when drunk, which go largely unpunished. The child may learn that one is not held responsible for what one does when drinking and may eventually use the same tactic.

In addition to inconsistencies in the content of communication, there are also problems involving communication patterns. Several authors agree that certain communicational maneuvers characterize alcoholic families (Gorad, McCourt & Cobb, 1971; Hanson & Estes, 1977; Hecht, 1973; Straussner, Weinstein, & Hernandez, 1979). After alcoholism has become an established phenomenon in the family, there is usually little willingness to communicate on a level of constructive exchange of feelings. Instead, communication efforts are mainly attempts to control behavior through means such as downgrading, avoidance or blaming. Often negative emotions with highly judgmental overtones are expressed (Hanson & Estes, 1977). Drunkenness may affect others through indirect responsibility-avoidance rather than direct communication. The intoxicated person

exercises considerable control in interpersonal relationships since drunken behavior is generally regarded as being out of control. Typically, the person trying to communicate eventually ceases and withdraws (Hanson & Estes, 1977). Thus, children in such situations are unlikely to learn communicational patterns necessary for positive intimate relationships.

A study of 20 couples with alcoholic husbands compared to 20 married controls matched on socio-demographic variables indicated that alcoholics possess a responsibility-avoiding communicational style (Gorad, 1971). Nevertheless, the alcoholic couples were highly competitive, showing much conflict over control and lack of cooperation for mutual benefit. These findings are consonant with clinical observations.

Straussner et al. (1979) claim that individuals within the alcoholic family unit often have not learned common communication skills. Becker and Miller (1976) found that alcoholic couples interrupted each other more frequently than did nonalcoholic couples. Moreover, the ever-present state of tension in these families makes it difficult to share negative feedback appropriately, and the built-up anger is expressed primarily during major outbursts of rage (Straussner et al. 1979). Children observe and absorb the family's feelings, attitudes and methods of dealing with others. According to Hecht (1973),

> Children, however, soon begin to perceive that parents don't always mean what they say and don't always say what they mean. They learn that certain kinds of communication precipitate quarrels, anger, and irritability. They learn the use of sarcasm and cutting, biting words. They are victimized by a desire to believe in their parents, particularly the one who is alcoholic, and by continued broken promises. They begin to place no reliance on verbal communications and begin to depend only upon actions and deeds. (p. 1765)

Given that intimacy has been related to mutual self-disclosure (Jourard, 1971), such communication problems in childhood may lead to later intimacy difficulties.

Abuse

It is not surprising that a disproportionate amount of physical and sexual abuse occurs in alcoholic families (Black et al., 1986; Seixas & Youcha, 1985; Yeary, 1982). When working at a naval hospital, Behling (1979) found a significant relationship between alcoholism and child abuse. He also found a high inter-generational transmission of child abuse. Of 51 instances of reported child abuse, 69 percent of the abusing parents additionally abused alcohol; 63 percent of the abused children had at least one grandparent who abused alcohol, and 92 percent of the parents who had been abused in childhood reported alcohol

abuse in their own parents. A review by Hamilton and Collins (1981) concluded that physical abuse toward children is more likely to occur among alcohol abusers than in the general population. A study by Black et al. (1986) found that 18.5 percent of the ACA group reported childhood sexual abuse by a family member, as contrasted with 9.6 percent of a comparison group with nonalcoholic parents. This study was limited somewhat, however, by utilizing unsubstantiated retrospective data.

The other common form of abuse to children of the alcoholic parent is neglect (Black, 1981; Chafetz, 1979; Cork, 1969; Fox, 1962; Lord, 1983; Morehouse & Richards, 1983). Alcoholic mothers may forget to feed them or leave them alone for long periods or even actively reject them (Fox, 1962). In addition, the alcoholic parent and the nonalcoholic spouse may be emotionally unresponsive and unavailable to their children (Black, 1981; Booz-Allen & Hamilton, Inc., 1974; Hanson & Estes, 1977). The nonabusing spouse may be divided between desiring to help the partner and desiring to support the other family members (Chafetz, 1979). When sober, the parent might continue to be emotionally unavailable or the parent's irritability might alternate with periods of overindulgence (Seixas & Youcha, 1985). According to Hanson and Estes (1977), this neglect means the child cannot communicate or obtain emotional support. The child does not feel valued or understood. His

or her basic emotional needs are not met. Among ACAs, unexpected outbursts of tears can be triggered in reaction to kindness from someone (Seixas & Youcha, 1985).

In summary, children from alcoholic homes seem to be vulnerable to physical, sexual, and emotional abuse. The child may feel frustrated and confused by inconsistencies and arbitrary behaviors enacted by the parents. Communication in the family is restricted, and parents often withdraw from each other until tension and anger builds to the point of rage and violence. Emotional neglect may be debilitating, with effects extending into adulthood.

Thus far, this review has contrasted alcoholic families with functional families. Marital as well as parent-child interactions have been explored. Now that the general characteristics of alcoholic families have been discussed, the more specific immediate and continuous effects of alcoholism on children will be addressed.

Specific Effects on Children

COAs may have difficulty trusting others as well as conceptualizing normal interpersonal roles. Thus, they may have difficulty developing and maintaining intimate relationships. Further impediments to intimacy are low self-esteem, constriction of affect and emotional disturbances. Problem behaviors would also tend to interfere with close interpersonal relationships.

Impaired Reality Testing and Lack of Trust

The alcoholic and those closest to him or her all have impaired judgment, only differing in degree of impairment (Johnson, 1980; Macdonald & Blume, 1986). Children learn not to trust their own perceptions and judgments (Cermak & Brown, 1982; Seixas & Youcha, 1985). They are told one thing, but something else happens. For example, Mom might say that she feels great and soon goes and vomits in the toilet. Thus, a small child may deny his or her own experience in order to agree with the parent. Since to make a parent right requires a child to sometimes consider himself or herself wrong, the child is left with questions of what is real.

COAs have learned that they cannot depend on the alcoholic; therefore, they fear trusting this parent (Seixas & Youcha, 1985). It is difficult to trust someone who frequently embarrasses, disappoints and humiliates the child or puts him or her in physical jeopardy (Black, 1981). Moreover, trust is impaired when family members do not discuss the incidents occurring in the home or when their communication is contradictory and inconsistent. These children may learn early that no one is dependable. A related lesson could be to depend on themselves and to be protective of their autonomy. They learn to idealize control since being out of control is seen as being victimized and helpless (Seixas & Youcha, 1985). Even if

the alcoholism subsides, the child may remain suspicious and apprehensive (Harrigan, 1987). This suspiciousness and lack of trust would certainly be a barrier to the development of intimacy in a relationship.

Inadequate Role Models

There is widespread agreement that an alcoholic parent is a poor model for healthy adult behavior (Chafetz, 1979; Fox, 1962; Hanson & Estes, 1977; Hecht, 1973; Nardi, 1981; Tuchfeld, 1986). Children have difficulty identifying with an alcoholic parent who is often passive, uninvolved in family decisions, and inconsistent in moods and behaviors (Barnes et al., 1979; Hecht, 1973). Fox (1962) claims that both parents, not just the drinking spouse, present inappropriate models. In a healthy family, a young child views the parents working cooperatively, with each having the right and responsibility to make certain kinds of decisions in the home. However, this partnership is missing in the alcoholic home (Hecht, 1973), and parents do not demonstrate healthy ways of coping with stress (Hanson & Estes, 1977).

The family has to adjust to the alcoholic's inability to perform his or her roles. In an effort to compensate and maintain family functioning, nonalcoholic members alter their role performance. The spouse often assumes many aspects of the alcoholic partner's roles, and children may

assist in bearing these responsibilities (Hanson & Estes, 1977).

When the father is alcoholic, the mother may eventually relinquish her role as wife, which then passes to the daughter. If the father gives the daughter extra attention or gifts, she may become confused about her relationships with the opposite sex. The daughter may develop a distorted view of her power with males, believing that she is capable of curing others' problems with her love (Hanson & Estes, 1977). Another potential consequence is that the daughter may come to equate masculinity and independence with alcoholism (Woititz, 1978). Both effects could contribute to the high percentage of daughters of alcoholics who marry alcoholic or potentially alcoholic spouses (Black et al, 1986; Hanson & Estes, 1977; Nici, 1979). Sons of a nonalcoholic mother and alcoholic father may have no strong masculine father with whom to identify. They may worry about their masculinity and may become aggressive and antisocial (Fox, 1962).

Thus, inappropriate parental models can alter the role that the child assumes in the family. Nardi (1981) speculates that socialization and modeling processes are affected by family alcoholism, and these processes may be critical to the development of self-esteem, identity, locus of control and sexual orientation in the offspring. Additionally, confusion about what constitutes a normal role

model can impair present as well as future interpersonal interactions with peers of one or both sexes (Chafetz, 1979).

Low Self-Esteem

Despite their efforts, nonalcoholic family members are seldom successful in improving the environment, and their feelings of inadequacy grow. Clinical impressions have supported the hypothesis that COAs suffer from low self-esteem (Ackerman, 1978; Hindman, 1975-1976; Schaef, 1986). Both research with (Baraga, 1977; Woititz, 1977) and without comparison groups (Cork, 1969) has demonstrated that these children have poor self-concepts. This finding may result from not trusting themselves, not knowing their own feelings, and reserving credit for accomplishments unless they are perfect. It could also derive from having their needs minimized or ignored as well as believing that they were responsible for the family's problems (Gravitz & Bowden, 1985). Moreover, in comparison to nonalcoholic homes, children from alcoholic families were lower in self-actualization, which characterizes one living a self-developing life, free of emotional turmoil and inhibition (Kammeier, 1971). A recent study utilizing college students found that self-identified female COAs had significantly higher self-depreciation scores than a comparison group, and these findings seemed attributable to having an alcoholic

father, but not an alcoholic mother (Berkowitz & Perkins, 1988).

Constriction of Affect

Perhaps in an effort to maintain the status quo, no one discusses family experiences with others and they do not reveal their true feelings. Children develop a set of rules about not talking or feeling in order to protect themselves from pain and to avoid upsetting others (Gravitz & Bowden, 1985). By age nine, these children have a well-developed denial system about what is occurring at home which is their most protective defense (Harrigan, 1987).

In addition to the link with pain, feelings are viewed as potentially dangerous. COAs often observe feelings leading directly to action. Since alcohol is a disinhibitor, a child is likely to witness expression of feelings in a violent and/or destructive way. Children come to view feelings as immediate causes of behavior; therefore, the thought of having a feeling is equated with acting out that feeling (Gravitz & Bowden, 1985).

Many children of alcoholics learn that it is not acceptable to show feelings of anger or sadness. When these are exhibited, no one comforts them and they are often ignored (Black, 1979). Therefore, they deny feelings of hostility, anger, fear, and frustration in order to survive (Black, 1981). This anger may continue into adulthood (Seixas & Youcha, 1985).

Despite their attempt to deny feelings, COAs evidence a common cluster of emotions. Feelings of humiliation, guilt, helplessness and chronic fatigue are common (Chafetz, 1979; Forrest, 1980; Macdonald & Blume, 1986). These children somehow come to feel that they are responsible for their parent's drinking and feel guilt over their causal role and their inability to change the alcoholism. Additionally, they are ashamed of their parents and do not bring friends into the home (Wilson & Orford, 1978).

One of the first empirical studies involving children of alcoholics was reported by Nylander (1960). He compared 229 children, age 4 to 12, of alcoholic fathers receiving outpatient treatment with 163 controls of nonalcoholic parents matched for gender, age, and father's socioeconomic status. Group comparisons were based on physical and mental examinations and interviews with mothers and teachers. Children with alcoholic fathers had more emotional disturbances than those with nonalcoholic fathers, with anxiety and depression being the most frequent symptoms. A limitation of this study is that those interviewing and testing the children were not blind to their classification (el-Guebaly & Offord, 1977).

Recent empirical studies have begun to investigate personality characteristics of children from alcoholic homes using objective measures. In addition to interviews and school records, Fine et al. (1976) gave children, age 8

to 18, the Devereux Child or Adolescent Behavior Rating Scale. They compared children of parents in treatment for alcohol-related problems with parents in treatment for a psychiatric disorder. Children with an alcoholic parent scored higher than the comparison group on emotional detachment, dependency, and social aggression. When compared to a normative sample, they were significantly more impulsive, distractible, emotionally and socially detached, anxious/fearful, and aggressive. Adolescent COAs rated higher than the psychiatric group on unethical behavior and paranoid thinking and were more disturbed than normals in 7 of 15 behavioral areas (e.g., schizoid withdrawal, poor emotional control, and domineering). The comparison group showed more disturbance only in emotional distance when compared to the normative sample. Based on these results, the authors concluded that having an alcoholic parent is a serious deterrant to healthy personality development. The quality of these emotional and behavioral disturbances suggests that these offspring would have problems forming and maintaining intimate interpersonal relationships.

Using the State Trait Anxiety Inventory for Children and the Children's Depression Inventory, Kamstra (1986) found latency-age children of an alcoholic parent in treatment to evidence more anxiety and depression than either children of nonalcoholic parents in psychotherapy or community controls. This is one of the few studies which

has used clinical and nonclinical comparison groups. The results suggest that alcohol-related family problems may have a more deleterious impact on latency-age children's emotional well-being than nonalcohol-related difficulties.

Another study employed the MMPI with teenage delinquents (Tarter, Hegedus, Goldstein, Shelly, & Alterman, 1984). These researchers found children of an alcoholic parent to present a more neurotic personality, evidenced by elevations on scales measuring anxiety, depression, and psychosomatic concerns. A degree of caution is required when interpreting these results, however, due to the select sample and the fact that alcoholism was diagnosed by informants.

In summary, emotional disturbances seem to be more prevalent among children with an alcoholic parent than those from families suffering a psychiatric disorder or a nonalcoholic comparison group. Clinicians claim that COAs deny and repress feelings as a defense against emotional pain. Empirical studies support the idea of emotional detachment and suggest that predominant feelings which do emerge are those involving anxiety, fearfulness, depression, and anger. This pattern would certainly suggest difficulties when attempting to develop and maintain intimacy.

Problem Behaviors

Not only have internal difficulties been associated with being a COA, but also external problem behaviors have been observed in this group. Early research by Whalen (1953) showed children of alcoholics to be more withdrawn and rebellious, to get into trouble in school and with the law, and to generally exhibit more disturbed social behavior than other children. A study by Rimmer (1982) of children under 17 concurred that COAs had more behavior problems than children of a depressed or nonclinical parent. Discipline problems in school was the most striking distinguishing feature. Results were reported in percentages and tests of significance were not conducted; thus, interpretation of these findings are limited.

Haberman (1966) also used multiple comparison groups. He compared a community sample of COAs with children of parents with chronic stomach trouble and a control group with neither problem. Matching to the alcohol group was done using sex, age, marital status, education, and ethnicity. He interviewed the mothers and defined alcoholism in terms of problems in the areas of health, work, or interpersonal relationships due to excessive drinking. Results indicated that the COAs were most likely to be known to correctional or school authorities, engaged in more temper tantrums and fighting with peers, and got into trouble with the school more often for bad conduct or

truancy. Again, no tests of significance were reported and no objective method was used to corroborate interview reports.

A study by Chafetz et al. (1971) sought to observe differences in children of alcoholics and nonalcoholics at a child guidance clinic. Case histories of 100 children, ages 2 to 19, in each group were examined. The groups were matched on sex, with 60 boys and 40 girls in each group. The two groups presented with similar complaints. Significant differences emerged, with the alcoholic families reporting more parental absence and marital discord. Moreover, they had a higher lifetime frequency of serious illnesses or accidents, school problems, and problems involving the police or courts. The major dissimilarities of these groups related to the effects of alcoholism on family disruption and on appropriate socialization. Thus, it may be difficult for children from alcoholic families to become socially mature and responsible adults.

A study by Udayakumar, Mohan, Shariff, Sekar, and Chamundi (1984) compared 50 families with an alcoholic father to 50 controls matched for age, education, income, and nuclear family. Children (ages 6 to 15) from alcoholic homes demonstrated poorer educational performance, were more quarrelsome, had more neurotic traits, were irregular in school attendance and showed more deviant behaviors. The alcoholic fathers in this study tended to reject, ridicule

or adopt harsh methods in rearing their children while control fathers tended to utilize a more normal or esteem-building style. A strength of this research is that a screening instrument was used for alcoholism and a scale was used for parenting behaviors. Tests of significance were also employed. However, the source of some of the findings was unclear.

One of the few longitudinal studies was conducted by Miller and Jang (1977). Their 20-year study included 147 COAs and 112 children of a nonalcoholic parent who had either been institutionalized in a mental hospital or a prison or were welfare recipients. Subjects were predominately lower class. Retrospective interviews revealed that children from alcoholic homes were significantly less likely to graduate from high school, more likely to be suspended and expelled and to have been seen by social or legal agencies. A path analysis was utilized to trace the effects of parental alcoholism on a child's adult adaptation. Interestingly, the highest correlation was between adult adaptation and the presence or absence of parental alcoholism. Parental alcoholism was also related to both the type and extent of family crises during childhood and the child's school performance, home adjustment, and disadvantaged home life. The authors concluded that children raised in alcoholic multi-problem

families have more severe problems than do those raised in nonalcoholic multi-problem families.

In summary, alcoholic families, which have been reported to be inconsistent, neglectful, and often violent and unstable, tend to produce children who act out, rebel, get into trouble with the law, and have general difficulties becoming well adapted individuals. Even when compared with other multi-problem families, having an alcoholic parent tends to be related to behavior problems of more severity. Many of the findings described to this point would appear to be relevant to the development of intimacy. Difficulties with trust, self-esteem, communication, expressing feelings, and inappropriate behavior could affect intimate relationships.

Intimacy

Perhaps the most consistently held belief about children of alcoholics is that they experience significant difficulty with interpersonal relationships during both childhood and adulthood (Beletis & Brown, 1981; Black, 1981; Booz-Allen & Hamilton, Inc., 1974; Fine et al., 1976; Seixas, 1977; Wilson & Orford, 1978; Woititz, 1983, 1985). Becoming close with another individual seems especially difficult for this population. In order to assess the contribution of parental alcoholism and family relationships to intimacy among adult children of alcoholics, it is first necessary to explore the construct of intimacy.

Conceivably intimacy exists within several contexts: family, friendships and love relationships. Close relationships have been described as a particular class of relationship characterized as "one of strong, frequent, and diverse interdependence that lasts over a considerable period of time" (Kelley, Berscheid, Christensen, Harvey, Huston, Levinger, McClintock, Peplau, & Peterson, 1983, p. 38). Hatfield (1982) viewed intimate relationships between friends, lovers, spouses, parents, and children as generally characterized by the following: (a) intensity of feelings; (b) self-disclosure; (c) value of resources exchanged; (d) variety of resources exchanged; (e) substitutability of resources; (f) commitment; and (g) the conversion of "you" and "me" to "we." However, the literature is not clear as to how intimacy differs in various contexts.

Chelune and Waring (1984) consider family closeness as "similar or related to intimacy" (p. 298). These authors describe a measure of healthy family functioning, the Beavers-Timberlawn Family Evaluation Scale (Lewis, Beavers, Gossett, and Phillips, 1976), which consists of 13 measures of family functioning, including "closeness," "range of feelings," and "mood and tone." Moos (1974) argues that relationships, personal growth, and system maintenance are important in family intimacy. The instrument he developed significantly correlated with the variables of compatibility and identity measured by the Victoria Hospital Intimacy

Interview (Waring, McElrath, Lefcoe, & Weisz, 1981), which assesses marital intimacy. Hovestadt, Anderson, Piercy, Cochran, and Fine's (1985) measure of family of origin health is based on the same aspects deemed important by Lewis et al. (1976) to developing capable, adaptive persons. The former scale, however, measures retrospective perceptions whereas the latter is based on therapist ratings of videotaped family interactions during five structured tasks. Furthermore, Hovestadt et al.'s (1985) instrument has an intimacy subscale consisting of several factors (i.e., expression of a wide range of feelings, creating a warm mood and tone, dealing with conflicts without undue stress, promoting empathy, and trusting in the goodness of human nature).

According to Chelune and Waring (1984), social or friendship intimacy and marital intimacy are primary types of intimacy. These types have been described as relationships where one fully accepts the other, permits the other the full range of emotion, and appreciates the other's separateness (McMahon, 1982). At least two instruments have been used to measure the construct in these contexts. The Personal Assessment of Intimacy in Relationships (Schaefer & Olson, 1981) is based on the idea that intimacy is a process and measures emotional, social, sexual, intellectual, and recreational intimacy. The Miller Social Intimacy Scale (Miller & Lefcourt, 1982) operationally defines intimacy by

addressing self-disclosure, feelings of closeness and affection, and listening and disagreement. These instruments are used to assess friendship and love intimacy which suggests that the relationships are conceptualized similarly. Thus, similar processes may occur in the development of friendship and love intimacy. However, love intimacy has received primary focus in the literature.

Traditionally, the definition of intimacy in love relationships has varied somewhat from a euphemism for sexual behavior (Kieffer, 1977) to being equated with self-disclosure (Jourard, 1971). However, more recently the constructs have been shown to be distinct, though related (Waring & Reddon, 1983; Waring & Chelune, 1983). Many investigators agree with Altman and Taylor's (1973) description of social penetration theory which defines intimacy as the extent to which one allows the other access to core areas of one's personality. Increases in intimacy are evidenced by communicating the content of progressively deeper, more vulnerable areas of their own personalities. Thus, the depth ranges from biographical characteristics, attitudes and opinions to fundamental beliefs about the world, self-identity, and self-worth. This model emphasizes the reciprocal nature of intimate relationships. Supporting this conceptualization, researchers have found that intimacy involves a closeness of several levels (Biddle, 1979; Safilios-Rothschild, 1977; White, Speisman, Jackson, Bartis,

& Bostos, 1986). Dahms (1972) suggested conceptualizing intimacy as a hierarchy with three interrelated levels. While intellectual intimacy was considered at the lowest level, physical intimacy was at a middle level and emotional intimacy represented the highest level.

One of the most commonly used measures of intimacy seems to be that developed by Orlofsky, Marcia, and Lesser (1973). Erikson's conceptualization of intimacy has been incorporated in their work to identify five forms of intimacy: Isolate, Stereotyped, Pseudointimate, Preintimate, and Intimate. Their semi-structured interview would classify most individuals as intimate provided they had several close same-sex friends and had made a loving in-depth commitment to a heterosexual partner. Thus, most married individuals would be classified as intimate if they had at least one close same-sex friend. What is missing from this measure are clear deliniations of dimensions which comprise in-depth relationships.

Other researchers have viewed intimacy from a nonhierarchical, multi-dimensional framework. For example, Olson (1975) identified seven different types of intimacy: emotional, intellectual, social, sexual, recreational, spiritual, and aesthetic. Waring, McElrath, Mitchell, and Derry (1981) operationalized intimacy as the major determinant of marital adjustment and a multi-faceted dimension of an interpersonal relationship. They viewed the

level of intimacy as composed of conflict resolution, affection, cohesion, sexuality, identity, compatibility, autonomy, and expressiveness. Their definition encompasses the breadth and width this construct seems to encompass, and the present study will focus on Waring et al.'s dimensions of the construct.

Intimacy may be an important predictor of healthy psychological and physiological functioning (Brown, Brolchain, & Harris, 1975; Hames & Waring, 1979; Henderson, Byrne, & Jones, 1980; Vaillant, 1978). Furthermore, intimacy may also serve as a resource against life's stresses and depression (Lowenthal & Haven, 1968). Given such findings, it is understandable that intimacy has been shown to be the primary dimension of marital adjustment in enduring relationships (Waring et al., 1981).

Much of the empirical work on intimacy has derived from Erikson's (1968) eight-stage theory which describes the construct as the capacity to commit oneself "to concrete affiliations and partnerships and to develop the ethical strength to abide by such commitments, even though they may call for significant sacrifices and compromises" (p. 263). Erikson's psychosocial theory of personality is consistent with attachment theory in basic assumptions and common roots in object relations theory (Kernberg, 1974; Morris, 1982). These perspectives emphasize the establishment of basic trust and autonomy in the child's early years, recognizing

that healthy individuals can move away and come back to an attachment figure. Further, attachment theory specifically deliniates a causal relationship between an individual's experiences with his or her parents and later life capacity to make affectional bonds (Bowlby, 1977). These affectional bonds are viewed as positive, and attachment is described as directed toward a specific individual, as enduring, and as associated with intense emotions. In contrast, dependency is viewed as negative, not directed toward a specific individual, not implying an enduring bond, and not necessarily associated with strong emotion. The overly-dependent person is likely to develop neurotic symptoms, depression or phobia when stressed, and this type of person is likely to have had pathogenic parenting. On the other hand, an individual with a secure base from which to explore, who was not fearful of being abandoned, and who was allowed to gradually extend relationships with peers and with other adults, is more likely to achieve the capacity for depth in relationships (Bowlby, 1977; Morris, 1982).

Erikson's developmental theory also suggests that a well formulated sense of identity is a precursor to the ability to establish intimate relationships. Researchers have frequently found the more advanced stages of identity development to be associated with higher levels of intimacy formation for men and women (Kacerguis & Adams, 1980; Raskin, 1985; Tesch & Whitbourne, 1982). However, the

literature is unclear on how the relationship between identity development and intimacy might differ for the sexes. Gilligan (1979) theorized that while men's identity precedes intimacy, sex role socialization dictates that they occur simultaneously for women. "Thus women not only define themselves in a context of human relationship but also judge themselves in terms of their ability to care" (p. 440). She also distinguished the sexes by claiming that males are threatened by intimacy, whereas females are threatened by individuation and separation. Although support has been shown for Gilligan's position (Hodgson & Fischer, 1979), others have demonstrated the importance of interpersonal relationships for men's identity development (Rogow, Marcia, & Slugoski, 1983).

Intimate Relationships of Children of Alcoholics

Some literature suggests that interactions with others, especially those between child and parent, have profound effects on later relationships (Bowlby, 1977; Erikson, 1950; Freud, 1933; Satir, 1967). Sullivan (1953) theorized that the first interpersonal experiences between the infant and primary caregiver have the potential to characterize future interactions as either comfortable or anxiety-producing. Hornik-Beer (1984) stated that initial knowledge of a relationship with a man or a woman originates from experiences at home. Unpleasant feelings between a child

and his or her family may affect the individual's attitude toward all people both in the present and in the future.

For the young person who has difficulty trusting others, who has lived with denial and secrecy, who has repressed feelings, and who has received limited emotional nurturance from parents, it is not surprising that forming close attachments may be problematic. Other possible barriers to intimacy are suggested by research which has demonstrated that families with an alcohol problem have difficulties communicating (Hecht, 1973) and rarely do activities together (Forrest, 1980; Wilson & Orford, 1978). Furthermore, the parents are poor models of successful relating, with more marital conflict, instability, and violence in alcoholic families than in nonalcoholic ones.

Although interpersonal difficulties are believed to characterize COAs at all age levels, the majority of empirical support is limited to studies of children. Among younger children, several correlates suggest interpersonal difficulties: emotional detachment (Fine et al., 1976), anxiety and depression (Kamstra, 1986; Tarter et al., 1984), difficult relationships outside and inside the family (Cork, 1969), problems reciprocating friendships (Wilson & Orford, 1978), disturbed social relationships (Kammeier, 1971), trouble in school due to behavior (Haberman, 1966), frequent arguments (Udayakumar et al., 1984), and aggression (Fine et al., 1976; Haberman, 1966). However, in a study of

adolescent COAs who were not in treatment, the lack of overall differences was the most distinct finding (Kammeier, 1971). Although these children scored significantly different from controls in difficulties with emotional stability, social relationships, conformity, mood and leadership, the groups were equivalent in self-regard and capacity for intimate contact. The study was considered methodologically and statistically sound (Watters & Theimer, 1978), but subjective screening for alcoholism by school counselors may not have accurately differentiated the groups.

Few empirical studies have examined issues germane to adult children of alcoholics, and even fewer have investigated intimate interpersonal relationships. Woititz (1983) and Beletis and Brown (1981) have extensive clinical experience with ACAs. Woititz observed several consistent patterns. Both sexes share relationship difficulties which stem from multi-faceted sources. Contributing factors include the following: a healthy, intimate relationship was not modeled; family members overreacted to disagreements; and inconsistent parenting (e.g., "come close, go away" p. 29), which left the child with a fear of abandonment which contributes to low self-confidence and low self-esteem. In addition, these adults exhibit a constellation of similar behaviors: guessing at what normal behavior is; lying; judging themselves without mercy; taking themselves

seriously and difficulty having fun; overreacting to changes over which they have no control; constantly seeking approval and affirmation; feeling different from others and sometimes becoming isolated; being very loyal and finding change difficult; and, finally, behaving impulsively. Moreover, all of these characteristics can affect intimate relationships.

Beletsis and Brown (1981) reported their experiences treating adult children of alcoholics at the Stanford Alcohol Clinic. They described problems unique to these children as they negotiate Erikson's (1968) developmental stages. The task of leaving the family of origin is strongly influenced by earlier developmental failures such as lack of trust in others and low sense of initiative and mastery. The clinicians stated that many ACAs had never been able to emotionally separate from home. Furthermore, they assumed responsibility for the caretaking decisions of the alcoholic parent and held high self-expectations for being able to maintain control of family emergencies. Many reported feeling depressed, lonely, isolated, and anxious about their ability to survive outside of the family. The authors cited the developmental basis for intimacy problems:

> For most of them, difficulty with intimacy sparked by the lack of trust, and compounded by their lack of autonomy and ego boundaries, makes interpersonal relationships threatening

> and dissatisfying. For those years when learning both intellectual and social skills increases comfort with peers and self-esteem, the children of alcoholics were mastering complex and shifting roles and relationships in a dysfunctional family system. (p. 200)

Moreover, these adults had little experience in early adolescence with close peer relationships. Without such experience, later close relationships may be made more difficult.

Beletsis and Brown's (1981) respondents seemed to be struggling with unresolved emotional bonds with their families. From the Eriksonian perspective, adult intimacy may not be possible for these people until such issues are resolved. Beletsis and Brown also reported fear and denial of feelings, poor communication skills, role confusion, and problems of identification. Although these clinicians reported from years of experience, their observations were based on therapeutic encounters and should not be assumed to characterize those not involved in therapy. However, their findings were consistent with those involving children of alcoholic parents: they often have emotional detachment (Fine et al., 1976), communication difficulties (Hecht, 1973), poor self-concept (Cork, 1969), dependency (Fine et al., 1976), and role confusion (Hanson & Estes, 1977).

Roe (1944) conducted one of the first empirical studies which compared adult children of an alcoholic parent with those of nonalcoholic parents. All of these offspring had been raised in foster homes since a time prior to the age of 10. The children in the alcoholic-parentage group were generally older than those in the normal-parentage group when first placed in foster homes. Interview data suggested that the groups were equivalent in overall personality adjustment, but there were some interesting interpersonal variations. Although not significant, ACAs had fewer close friends, less adequate personal relationships, and fewer happy marriages.

In 1974, Booz-Allen and Hamilton, Inc. conducted a study for the National Institute on Alcohol Abuse and Alcoholism. They interviewed 50 male and female children of an alcoholic parent, 74 percent of whom were over the age of 18. Respondents were volunteers from Alateen, youth drop-in centers, personal contacts, and newspaper solicitations. Thus, they were not limited to clinical settings but were self-selected. The authors found that the primary difficulty experienced by this sample was in relating to the opposite sex (64%), followed by problems in relating to the same sex (34%). When only adults were considered, 87 percent reportedly experienced inadequate interpersonal relationships. Both sexes expressed difficulties with

trust, risking rejection, and making conversation. Women were often attracted to men who resembled their alcoholic father; some men with alcoholic fathers were more comfortable with women; and two men were most at ease in a homosexual relationship. This study provides support for the idea that socialization and intimacy difficulties which arise in childhood (Chafetz et al., 1971; Cork, 1969; Fine et al., 1976; Kammeier, 1971) continue into adulthood. This study was limited by its small sample size and lack of comparison data. However, it did include nonclinical respondents and provided extensive exploratory data.

Jackson (1984) studied personality characteristics of 123 adult women between the ages of 21 and 50 years. She found those with alcoholic fathers scored significantly higher than daughters of nonalcoholic fathers on items reflecting the need to control relationships and situations, the tendency to feel responsible for the behavior of others, and an inclination toward guilt. Although this study was limited to women, it provided insight into possible personality characteristics associated with being raised in an alcoholic home.

An investigation involving young men and women in college found ACA men to be significantly higher on autonomy than comparison men. However, the women failed to differ on the measure (Berkowitz & Perkins, 1988). The authors concluded that men and women may react differently to

parental alcoholism. Men possibly seek emotional distance from the family by increasing their autonomy.

In her work with young and adult children of alcoholics, Black (1981) identified three primary rules, "Don't talk, don't trust, don't feel" (p. 29). As a result of these rules, she claimed that this population develops emotional and psychological gaps related to control, trust, dependency, identification, and expression. These deficits are likely to affect adults' involvement in relationships, especially intimate ones. Recently, Black et al. (1986) put some of these characteristics to empirical test. Their adult sample included both ACAs (n = 409) and people with nonalcoholic parents (n = 179) from nonclinical settings. A questionnaire assessed various issues including interpersonal differences. Adults raised in an alcoholic home were found to have significantly more difficulties with trust, dependency, intimacy, responsibility, resolving conflict, identifying and expressing feelings, expressing needs and putting self first. This study is to be commended for utilizing nonclinical respondents. On the other hand, it is limited in that a nonvalidated and possibly unreliable questionnaire was employed. Furthermore, no validating instrument confirmed respondents' self-identification as children of alcoholics.

A recent dissertation by Carey (1986) investigated intimacy adjustment among nonclinical respondents. The

female sample compared those with (n = 125) and without (n = 183) an alcoholic parent. A modified version of the Children of Alcoholics Screening Test was employed to differentiate the groups. Intimacy adjustment was measured by the Miller Social Intimacy Scale, which reflects closeness with friend; and the degree of discrepancy between wanted and expressed affection scores on the Fundamental Interpersonal Relations Orientation-Behavior was assessed. Results demonstrated that the daughters of alcoholics reported significantly greater discrepancy between expressed and desired affection scores. They wanted others to express more closeness toward them than they felt comfortable expressing. In contrast, the groups scored equivalently on friendship intimacy. However, results might have been different had the instructions been more explicit regarding the relationship they were to describe. Although this is not an explanation, possibly they could adequately maintain a friendship, but love relationships may have been more difficult for them.

Carey also used the Family Relationships Index to measure perception of childhood family relationships. Daughters of alcoholics reported more dysfunctional relationships, evidenced by less cohesion, less expressiveness, and more conflict. Having an alcoholic father as opposed to an alcoholic mother had no effect on the quality of family relationships, but having two

alcoholic parents was related to less family cohesion than having only one alcoholic parent. Neither the number of alcoholic parents nor the gender of the alcoholic parent was a distinguishing factor between groups on either intimacy measure. The study required respondents to have lived in intact families until age 12. Since alcoholic families have been shown to have more separation and divorce (Black et al., 1986; Chafetz et al., 1971; Kammeier, 1971; Miller & Jang, 1977) than nonalcoholic families, this restriction may have skewed the results. Further research is needed to explore intimacy and family of origin issues among males as well as females.

Rationale and Hypotheses

In summary, clinical impressions as well as empirical studies point to disturbed interpersonal relationships, especially intimate relationships, among adult children of alcoholics. However, researchers have tended to operationally define intimacy in rather simplistic terms (Orlofsky et al., 1973). Additionally, methodological and statistical limitations in the research have restricted a full understanding of the nature of these relationships. Since intimacy is a complex construct, a multi-dimensional approach to its assessment would provide a more thorough understanding of possible problematic areas for adult children of alcoholics. Including a measure of friendship intimacy would also help to differentiate between

difficulties in degrees of closeness of interpersonal relationships.

The proposed study will extend the existing literature by utilizing multi-dimentional measures and investigating retrospective levels of autonomy and intimacy in respondents' families of origin. Intragroup comparisons of adult children of alcoholics in therapy with those not in therapy will provide much needed insight to help dispell or strengthen negative characteristics attributed to this population.

Specifically, it is hypothesized that adult children of alcoholics will score significantly lower than comparisons on all dimensions of intimacy in a love relationship, friendship intimacy, and perceived family autonomy and intimacy in their families of origin. Among the ACAs, those in therapy will score lower on the above variables than those not in therapy.

CHAPTER II

METHOD

Subjects

Volunteers were recruited from clinical and nonclinical sources including (a) therapy settings such as ACA groups and individual therapists (*n* = 86); (b) churches (*n* = 202); and (3) personal contacts (*n* = 15). Respondents were recruited in the Dallas metropolitan area. Respondents scoring 5 and above on the MAST were eliminated due to probable alcoholism. CAST scores of 12 and above indicated the subject was an ACA. This group was further differentiated by examining two sets of items on the PIQ (i.e., whether in current psychological therapy and member of ACA group), yielding two groups: ACAs in therapy (ACA-T, *n* = 59) and ACAs not in therapy (ACA-NT, *n* = 53). Since many of the respondents had received psychological therapy at some time (a PIQ yes response to current or past psychological therapy), comparisons were divided into those who had received therapy (COMP-T, *n* = 48) and those who had not (COMP-NT, *n* = 77).

A total of 601 questionnaires were distributed, yielding a response rate of 50.4 percent (*N* = 303). Of the surveys returned, 48 were excluded due to personal

alcoholism, 8 belonged to an ACA group but failed to meet the criteria of this study, 4 did not meet the criteria for an ACA or a comparison (i.e., CAST score was between 6 and 11), 5 omitted data necessary for group classification, and 1 did not meet the age requirement.

Respondents ranged in age from 22 to 76 (M = 37.63, SD = 10.03). The majority were female (64.6%, n = 153), with males comprising 35.4 percent (n = 84) of the sample. Almost all respondents were caucasian (98.7%, n = 234). Dividing the sample by religion, 84.0 percent (n = 199) were Protestant, 7.3 percent (n = 17) Catholic, .4 percent (n = 1) Jewish, and 7.3 percent (n = 17) endorsed "other."

Materials

Two instruments were employed for screening of respondents. The Michigan Alcoholism Screening Test was used to eliminate alcoholics. The Children of Alcoholics Screening Test was used to differentiate comparison groups. Data from the Miller Social Intimacy Scale, Waring Intimacy Questionnaire, and Family-of-Origin Scale comprised the dependent variables related to the stated hypotheses. Dimensional and total scores of instruments were obtained by summing responses according to instructions. Appendix A lists the instruments and dimensions. The Personal Information Questionnaire provided further dependent variables (i.e., length of most recent intimate love relationship and satisfaction with this relationship,

drinking patterns of self and parents, abuse from spouse and parents, depression, past suicide planning and attempts, and demographic data).

Personal Information Questionnaire

The Personal Information Questionnaire was devised by the investigator in order to assess the respondent's current life and family of origin. (See Appendix B.) Information such as age, sex, socio-economic status, race, and religion were requested. Additionally, several factors were related to the family of origin, including the presence or absence of physical or sexual abuse, birth order, and whether the family was intact.

Michigan Alcoholism Screening Test

The MAST was used to exclude alcoholics from the sample. This instrument was originally developed as a structured interview to detect alcoholism (Selzer, 1971). Selzer, Vinokur, and van Rooijen (1975) modified the original format, resulting in a 24-item self-administered instrument. (See Appendix C.) Respondents answer "Yes" or "No" to the questions. Each item is assigned a predetermined numerical value of 1, 2, or 5 points, and the total score is determined by summing points for the alcoholic items. Sample items are "Have you ever lost friends or girlfriends/boyfriends because of drinking?" (2 points), and "Have you ever gone to anyone for help about your drinking?" (5 points). Scores range from a total of 0

to 53 points. A score of three points or less reflects nonalcoholism, a score of four points suggests alcoholism, and a score of 5 or more points indicates alcoholism. The 48 respondents who scored 5 or more points in the present study were dropped from analyses.

Selzer et al. explored the reliability and validity of the MAST by examining a sample of 501 males. One group (n = 273) were routine driver's license renewal applicants and court mandated Driver Safety School students. The second group (n = 228) consisted of either inpatient or outpatient alcoholics. Reliability was measured by computation of internal consistency. High alpha reliability coefficients (r = .83 and .87, respectively) were found with r = .95 for the sample as a whole.

Criterion validity was assessed by computation of a product-moment correlation coefficient between the total MAST score and the scores of the groups. The resulting validity coefficient of r = .79 indicated that the alcoholics scored higher than the other respondents. A more rigorous validity assessment using only the license office drivers and hospitalized alcoholics yielded a validity coefficient of r = .90.

Selzer et al. also compared scores on the MAST to scores on a Deny-Bad subscale of the Crowne-Marlowe Social Desirability Scale (1964, cited by Selzer et al., 1975). Although significant correlations of -.11 and -.18 ($p < .01$)

were found for Groups 1 and 2, respectively, the relationships were weak and had no effect on validity coefficients when the Deny-Bad tendency was statistically controlled. The researchers suggested that their results demonstrate the self-administered MAST to be generally reliable and valid, with scores relatively unaffected by social desirability.

Children of Alcoholics Screening Test

The CAST (Jones, 1981) was used to differentiate adults from alcoholic and nonalcoholic childhood homes. (See Appendix D.) Respondents indicate whether or not the 30 questions describe their feelings, behavior and experiences related to a parent's alcohol use by answering "Yes" or "No." CAST items sample emotional distress associated with parental drinking, perceptions of alcohol-related marital discord, efforts to control parental drinking, exposure to alcohol-related family violence, perception of parent(s) as alcoholic, a desire for help, and attempts to escape the alcoholic family system (Pilat & Jones, 1984-85). Possible scores ranged from a total of 0 to 30 points. According to Jones (1983), six or more "yes" responses indicate that the person is likely to have at least one alcoholic parent. In order to provide a more stringent screening criterion, the present study required a cutoff score of 12 or greater for classification as a COA. Based on estimates by Jones (1983), this cutoff reduces the false positive rate from 23

percent to 11.8 percent. In this study, those scoring 5 or less were classified as having nonalcoholic parents and comprised the comparison group. Only four scored from 6 to 11 and were dropped from the study.

Validity of the CAST was determined using contrast groups in two studies. The first study investigated latency-age and adolescent children. Responses of 82 children of clinically diagnosed alcoholics and 15 self-reported children of alcoholics were compared with responses of 118 children who were in a randomly selected control group of children of nonalcoholic parents (Jones, 1983). All 30 CAST items were found to significantly discriminate children of alcoholics from controls ($p < .05$). Moreover, correlation of group scores with total CAST scores yielded a validity coefficient of .78 ($p < .0001$).

In a study of concurrent validity, the CAST was administered to 81 adults ranging from 18 to 37 years old (Jones, 1983). Five of these respondents reported that a parent had received treatment for alcoholism. Total CAST scores were correlated with subject reports of parental alcohol consumption during a typical week, resulting in a significantly positive relationship ($r = .63$, $p < .01$). Further, the self-reported ACAs scored significantly higher on the CAST than did the controls (t (79) = 2.5, $p < .01$). A Spearman-Brown split-half reliability coefficient of .98 was obtained in each investigation (Pilat & Jones, 1984-85).

Thus, the CAST appears to be both a reasonably reliable and valid instrument.

Miller Social Intimacy Scale

The MSIS (Miller & Lefcourt, 1982) was used to assess friendship intimacy. It is a 17-item questionnaire devised to assess the maximum level of intimacy currently experienced in a close friendship or marriage. (See Appendix E.) The authors operationally define intimacy as the degree of closeness felt toward the person who the subject regards as his or her closest friend. This definition is consistent with social penetration theory. The items address issues of self-disclosure, feelings of closeness and affection, and listening and disagreement. Thus, friendship intimacy was operationalized as scores on the MSIS.

Respondents are instructed to describe the relationship with their closest friend. In the present study, they were asked to exclude their spouse or lover. All questions are answered using a 10-point Likert scale, with possible total scores ranging from 17 to 170. Six questions measure frequency of intimate contacts while 11 items measure intensity of intimacy. The test yields a score for each subscale and a total score.

Reliability and validity data were developed using subsets of a sample of 252 married and unmarried students and couples seeking conjoint marital therapy. Cronbach

alpha coefficients ranged from .86 to .91, and test-retest reliability coefficients obtained over one-month (r = .84) and two-month (r = .96) intervals were significant at the .001 level. Therefore, the MSIS appears to reflect stability in the level of friendship intimacy experienced.

Convergent validity was assessed by comparing scores on the MSIS to the Interpersonal Relationship Scale (IPR; Schlein, Guerney & Stover, 1971, as cited in Guerney, 1977) and the UCLA Loneliness Scale (Russell, Peplau, & Ferguson, 1978). A positive relationship was demonstrated between scores on the MSIS and trust and intimacy dimensions on the IPR (r = .71, p < .001), and a negative relationship was shown between low scores on the MSIS and descriptions of loneliness (r =-.65, p < .001). Construct validity was supported when respondents described significantly greater intimacy with closest friends than with casual friends (t = 9.18, p < .001). Since unmarried students reported significantly higher degrees of intimacy than married couples in therapy (t = 2.56, p < .02), the MSIS seems to measure intimacy status more precisely than marital status alone.

Waring Intimacy Questionnaire

The WIQ (Waring & Reddon, 1983) was employed to assess the quality and quantity of intimacy in a love relationship. Thus, intimacy is operationalized as scores on this measure. The WIQ is a 90 item self-report questionnaire designed to

measure eight dimensions of marital intimacy: (a) conflict resolution, ease with which conflicts are resolved; (b) affection, degree to which feelings of emotional closeness are expressed; (c) cohesion, feeling of commitment to the relationship; (d) sexuality, degree to which sexual needs are communicated and fulfilled by the relationship; (e) identity, couple's level of self-confidence and self-esteem; (f) compatibility, degree to which the couple is able to work and play together comfortably; (g) autonomy, success with which the couple gains independence from their families of origin and from their own children; and (h) expressiveness, degree to which the couple shares thoughts, beliefs, attitudes and feelings (Hames & Waring, 1980). (See Appendix F.) In addition, the measure yields a total intimacy score based on summing 40 items across the scales and subtracting 10 items which reflect social desirability. Possible scores range from 10 to 20 for dimensions and 30 to 70 for total intimacy. This instrument has been modified for present purposes to describe love relationships rather than solely marriages, and respondents describe whether or not the items characterize their relationship by indicating "True" or "False."

Internal consistency has been demonstrated via Kuder-Richardson formula 20 using married individuals (Waring & Reddon, 1983). These reliability coefficients for the eight subscales ranged from .52 to .86 for males

(n = 76) and from .59 to .87 for females (n = 76). Test-retest reliability coefficients over a two-week interval ranged from .73 to .90 for males and from .76 to .88 for females. Total intimacy reliability coefficients of the WIQ for test-retest were .89 for males and .86 for females, and for Kuder Richardson formula 20 were .78 for males and .81 for females.

The validity of the WIQ has been investigated among both clinical and nonclinical samples (Chelune & Waring, 1984). When the 160-item precursor of the WIQ was administered to nonpsychotic psychiatric patients, it was found to be positively correlated (r = .77) with the Personal Assessment of Intimacy in Relationships scale (Schaefer & Olson, 1981), despite the WIQ precursor's containing an autonomy and identity scale which the PAIR did not contain. The former instrument was negatively related (r = -.62) to a measure of emotional illness, the General Health Questionnaire (Goldberg, 1972). Using nonclinical couples (Waring, McElrath, Mitchell, & Derry, 1981), the total WIQ intimacy score has been found to be positively correlated (r = .48) with marital adjustment on the Locke-Wallace Marital Adjustment Scale (1959). The relationship between marital intimacy and mood states has also been explored (Waring, Reddon, Corvinelli, Chalmers, & Vander Laan, 1983). Results of analyses of between-set redundancy showed that 17 percent of the variance in moods for husbands

and 28 percent of the variance in moods for wives was explained by intimacy.

A recent criterion validity study (Wood, Escaf, & Waring, in press) utilizing 25 married psychiatric patients and 5 spouses demonstrated that the WIQ total intimacy score was significantly correlated with the Dyadic Adjustment Scale (r = .67) and the Short Marital Adjustment Test (r = .58). This study also found the WIQ subscales: conflict resolution, affection, cohesion, compatibility and expressiveness to have moderate to high correlations (r = -.44 to r = -.79) with the Marital Satisfaction Inventory (MSI) subscales of global distress, problem solving communication, affective communication, and time together. The MSI measures marital distress along several dimensions. Chelune and Waring (1984) conclude that the WIQ, being highly reliable, relatively free from response bias and free of sex bias, appears to be a useful research measure of both the quantity and quality of marital intimacy.

Family-of-Origin Scale

The FOS is a 40-item self administered questionnaire developed to assess the perceived levels of autonomy or identity and intimacy in one's family of origin (Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985). (See Appendix G.) The constructs of autonomy and intimacy are operationalized as subscale scores on the FOS. The operational definition of intimacy provided by this instrument is consistent with

social penetration theory (W. T. Anderson, personal communication, April 21, 1988). Respondents apply statements to their families of origin using a 5-point Likert scale, ranging from 1 (Strongly agree) to 5 (Strongly disagree). Possible scores range from 4 to 20 for dimensions and 40 to 200 for total health. The FOS emphasizes autonomy and intimacy as two essential aspects of healthy family functioning. Items addressing autonomy include: clarity of expression, personal responsibility, respect for other family members, openness to family members, and acceptance of separation and loss. Intimacy items consist of expressing a wide range of feelings, family mood and tone, conflict resolution, empathy, and trust. In addition to these autonomy and intimacy subscales, the instrument renders a total score which indicates the degree of perceived health in the family of origin. Although validity has been provided for the total health score of this instrument, validity for dimensions and subscales has not been fully established (W. T. Anderson, personal communication, April 21, 1988).

The normative sample for the FOS was 278 college students. High reliability was demonstrated on a subsample by a test-retest coefficient of .97 ($p < .001$) over a two-week interval. Test-retest coefficients for the autonomy items ranged from .39 to .88 with a median of .77; test-retest coefficients for the intimacy items ranged from

.46 to .87 with a median of .73. An independent study of 116 undergraduates produced a Cronbach's alpha of .75 and a Standardized Item alpha of .97.

The FOS has been validated using single as well as married samples. Fine and Hovestadt (1984) assessed 184 single college freshmen and sophomores using the FOS, the Rational Behavior Inventory (Shorkey & Whiteman, 1977), and a semantic differential perception of marriage scale. The students who perceived their families of origin as healthier had a significantly more positive perception of marriage and scored higher on their level of rationality than did those who rated their families of origin as being low in health.

A study by Canfield (1984) administered the FOS, the Healthy Family Functioning Scale (Sennott, 1981), and a Personal Information Form to 171 married subjects who had at least one child under age 18. A significant correlation was found between FOS scores measuring levels of perceived health in the subjects' families of origin and self-reported health in their current families ($r = .48$, $p < .01$).

All three intimacy measures appear to operationalize the construct consistently with social penetration theory in regard to the depth of the relationship. However, the instruments differ in regard to how they define the breadth of the relationship. The WIQ, measuring love intimacy, encompasses the most dimensions, followed by the MSIS,

measuring social intimacy, then the FOS, reflecting family of origin intimacy.

Procedure

Volunteers were asked to read and sign a consent form. (See Appendix H.) They were given the option of obtaining a copy of the results by checking a line on the consent form. They were then given a pre-addressed and stamped envelope containing the instruments. All questionnaires were presented in the following order: Miller Social Intimacy Scale, Waring Intimacy Questionnaire, Family of Origin Scale, Children of Alcoholics Screening Test, Michigan Alcoholism Screening Test, and Personal Information Questionnaire. Upon receipt of the completed surveys, code numbers were assigned to each respondent.

CHAPTER III

RESULTS

The purpose of this study was to determine whether children of alcoholics differ from others in terms of friendship, love and family of origin intimacy. Dependent variables consisted of the friendship (MSIS) subscales (frequency and intensity) and total score; love (WIQ) subscales (conflict resolution, affection, cohesion, sexuality, identity, compatibility, autonomy, and expressiveness) and total score; and family of origin health (FOS) dimensions (clarity of expression, responsibility, respect, openness, acceptance of separation and loss, range of feelings, mood and tone, conflict resolution, empathy, and trust), subscales (autonomy and intimacy) and total. These variables are listed in Appendix A. Other dependent variables not directly related to the hypotheses addressed length of and satisfaction with most recent intimate love relationship, drinking patterns of self and parents, abuse from spouse and parents, depression, suicidal planning and attempts and demographic data.

MANOVAs were conducted on each of the measures (MSIS, WIQ and FOS) and a MANOVA included the three total scores. When significance was found, univariate procedures were used

to identify the particular dependent variables, and Newman-Keuls contrasts were used to determine differences between the specific groups. It was possible to use the same procedures for some data (e.g., abuse) from the PIQ. The groups were compared using chi-square analyses for nominal data from the PIQ (e.g., gender, race, and religion). Multiple regression analyses were conducted on the dependent variables as well as relationship satisfaction, depression and planning suicide using information from the PIQ, WIQ, MSIS and FOS as predictors. When multiple regression procedures were used, variables were allowed to enter in order of importance as explanation and are reported in that order. The results of statistical analyses are summarized in Tables 1-8. (See Appendix I.)

Sample Description

Because the categories for education and income approximated interval level data, differences on these variables and age were included in a MANOVA, Pillais F (9, 693) = 2.37, $p < .02$. Univariate analyses indicated that the difference was found for income, $F(3, 231) = 5.41$, $p < .001$, with a borderline effect for education, $F(3, 231) = 2.57$, $p < .06$. To view these data differently, the frequencies and percentages are presented in Table 1. (See Appendix I.) Planned comparisons demonstrated that the ACA-T group had significantly lower income (M = 3.49) than did the other groups (Comp-NT, M = 4.43; Comp-T, M = 4.13;

ACA-NT, $M = 4.17$). Just over 20 percent of the ACA-T group had incomes over $50,000, but approximately one-half of the other groups had high incomes. The ACA-T group also had significantly lower educational levels ($M = 3.64$) than the remaining groups (Comp-NT $M = 4.08$; Comp-T $M = 3.92$; ACA-NT $M = 3.87$). A three on this item indicated some college and a four indicated a college degree.

Table 2 describes the parents' marital status during the subject's childhood. (See Appendix I.) While the majority of the sample had parents who were married, it is striking that 97.4 percent of the Comp-NT group and 91.3 percent of the Comp-T group had married parents. Approximately 24 percent of the ACA groups had divorced parents, but few (2.6% to 6.5%) in the comparison groups had parents who were divorced. Comparisons of birth order across groups yielded nonsignificant results, chi-square (6, $N = 234$) = 4.26. Overall, the highest percent (43.9%) of the subjects were oldest or only children in the families in which they were raised. The middle child and the youngest child comprised 26.6 percent and 28.3 percent of the sample, respectively.

Respondents' relationships are described in Table 3. (See Appendix I.) The groups differed in marital status, chi-square (6, $N = 236$) = 27.35, $p < .001$. Most (69.7%) of the Comp-NT group were married, and only 42.4 percent of the ACA-T group were married. The Comp-T group (58.3%) and

ACA-NT group (58.5%) had similar percentages of married respondents. Separation or divorce was reported by 35.6 percent of the ACA-T group, 13.2 percent of the ACA-NT group, and 18.8 percent of the COMP-T group. Only 2.6 percent of the Comp-NT group were separated or divorced. The Comp-T and ACA-NT groups were similarly distributed across the marital status categories, but the Comp-NT and ACA-T distributions were discrepant.

The groups also differed regarding their most recent love relationship, chi-square (3, $\underline{N}$ = 211) = 7.87, $\underline{p}$ < .05, with 88.2 percent of the Comp-NT group cohabitating or married as compared to 79.1 percent of the Comp-T group, 69.2 percent of the ACA-T group, and 70.8 percent of the ACA-NT group. Few (11.8%) in the Comp-NT group were dating, but 20.9 percent of the Comp-T group, 30.8 percent of the ACA-T group and 29.2 percent of the ACA-NT group reported such a relationship. Thus, both ACA groups reported similar recent relationships.

There was no significant difference between the groups for sex preference for a friend, chi-square (3, $\underline{N}$ = 235) = 1.73 or for a love relationship, chi-square (3, $\underline{N}$ = 237) = 5.94. Most of the subjects (Comp-NT = 68.4%, Comp-T = 72.9%, ACA-T = 71.2%, ACA-NT = 78.8%) preferred someone of the same sex for a friendship. Almost all respondents (Comp-NT = 92.2%, Comp-T = 83.3%, ACA-T = 96.6%, ACA-NT = 90.6%) preferred the opposite sex for a love relationship.

The literature suggests that the groups would possibly differ in relationship stability. Therefore, a MANOVA with number of times divorced, time since last relationship, length of relationship, and satisfaction with this relationship was performed, Pillais F (12, 513) = 3.38, $p < .001$. Univariate analyses revealed that the groups differed on all items: number of divorces, $F(3, 172) = 7.57$, $p < .001$; time since last relationship, $F(3, 172) = 4.56$, $p < .01$; length of relationship, $F(3, 172) = 3.19$, $p < .05$; and satisfaction, $F(3, 172) = 6.43$, $p < .001$. Planned comparisons indicated that the ACA-T group ($M = .68$) had significantly more divorces than Comp-NT ($M = .16$), Comp-T ($M = .39$), or ACA-NT ($M = .35$). Ratings showed that most in three of the groups were still in relationships (Comp-NT $M = 1.57$; Comp-T $M = 1.69$; ACA-NT $M = 1.76$), but the ACA-T group's relationships ($M = 2.45$) had ended within the past two to six months. Finally, the ACA-T group reported significantly less satisfaction ($M = 4.40$) than the Comp-NT ($M = 6.04$), Comp-T ($M = 5.67$), and ACA-NT ($M = 5.52$) groups who did not differ from each other. Both ACA groups had shorter relationships ($M = 8.24$ years ACA-T and 9.29 years ACA-NT) than the Comp-NT group ($M = 14.02$), but did not differ from the Comp-T group ($M = 10.86$).

Drinking Patterns

Although alcoholics, as determined by the MAST, were excluded from analysis, self-reported alcohol use was

assessed to determine whether the groups differed within normal drinking patterns. A MANOVA with items related to the frequency and amount of drinking was not significant, Pillais F (9, 687) = 1.50. Thus, the groups did not differ in their usage of alcohol as adults. Overall, the sample drank on occasions between once every other month to two times a month (M = 3.54). Additionally, the sample drank from one to two drinks (M = 2.58) on these occasions.

Although the CAST provided information concerning respondents' thoughts and feelings about their parents' drinking behaviors, it is possible that the groups differed in regard to the drinking behaviors of each parent. Therefore, a MANOVA was conducted with variables related to the mother, Pillais $F(12, 684) = 8.59$, $p < .001$. Univariate analyses indicated significant differences on all of the items: how often she drank, $F(3, 229) = 32.27$, $p < .001$; days per week she drank, $F(3, 229) = 24.93$, $p < .001$; amount she drank, $F(3, 229) = 32.98$, $p < .001$; and years she drank heavily, $F(3, 229) = 27.02$, $p < .001$. Planned comparisons showed that on each item, the two ACA groups significantly differed from the comparisons as well as from each other. The ACA-T group reported mothers drinking more frequently (M = 2.83), more days (M = 3.19), more alcohol (M = 3.47), and longer (M = 3.24) than did ACA-NTs (M = 2.37, 2.35, 2.71, and 2.54, respectively). Mothers of the Comp-NT group and Comp-T group drank less frequently (M = 1.53 and 1.56),

fewer days per week (M = 1.53 and 1.27), less alcohol (M = 1.68 and 1.42), and for a shorter period (M = 1.06 and 1.00) than both ACA groups. ACA-Ts reported that their mothers drank about four drinks, more than two or three days per week for more than two years. In contrast, mothers of COMP-NTs reportedly drank less than one drink, less than one day per week with no period of heavy drinking. Furthermore, mothers of the ACA-T group drank more frequently, consumed more alcohol when they did drink, and drank for more years than did mothers of the ACA-NT group.

Similar items were utilized in a MANOVA for respondents' fathers' drinking patterns, Pillais $F(12, 690) = 21.88$, $p < .001$. Again differences were found on all of the variables: often drank, $F(3, 231) = 128.28$, $p < .001$; days drank, $F(3, 231) = 104.74$, $p < .001$; amount drank, $F(3, 231) = 152.36$, $p < .001$, and years drank heavily, $F(3, 231) = 257.96$, $p < .001$. Planned comparisons indicated that on each item, the ACAs differed from the comparison groups but not from each other. That is, the ACA-T group did not report fathers drinking more frequently (M = 3.64), more days per week (M = 4.33), more alcohol (M = 5.00), or for a longer period (M = 5.53) than did the ACA-NT group (M = 3.49, 4.11, 4.77, and 5.19, respectively). However, fathers of the Comp-NT group and Comp-T group were reported to drink less frequently (M = 1.75 and 1.81), fewer days per week (M = 1.71 and 1.50), less alcohol (M = 1.94 and 1.92), and for

a shorter period (M = 1.06 and 1.18) than both ACA groups. Fathers of the ACA groups reportedly drank about 7 drinks, more than 4 or 5 days per week for more than five or six years. On the other hand, fathers of comparisons drank less than one drink, less than one day per week, with no period of heavy drinking. Since all ACAs differed from comparisons when mother's as well as fathers's drinking patterns were analyzed, further validation for the CAST was found. Interestingly, these comparisons show that mothers of ACA-Ts drank more often, larger amounts, and for more years than did mothers of ACA-NTs; but the fathers' drinking patterns were similar.

Because there were differences between the ACA groups, other aspects of parental drinking were compared for these groups. Conceivably, something about parental drinking patterns could suggest hypotheses for understanding differences between these groups. To compare drinking behaviors of mothers with fathers, t-tests were employed. First, within each group, comparisons were made of mothers' and fathers' drinking. The ACA-T group perceived their fathers as drinking more often (M = 3.64), $t(58) = -5.23$, $p < .001$; more days a week (M = 4.32), $t(55) = -3.96$, $p < .001$; larger amounts (M = 4.98), $t(56) = -5.48$, $p < .001$ and as drinking for more years (M = 5.53) than their mothers (M = 2.83, 3.23, 3.47, and 3.19), $t(57) = -5.75$, $p < .001$. The ACA-NT group had similar patterns on frequency (M = 3.49,

father; $M = 2.37$, mother), $t(50) = -6.04$, $p < .001$; days a week ($M = 4.12$, father; $M = 2.35$, mother), $t(51) = -6.88$, $p < .001$; amounts ($M = 4.79$, father; $M = 2.71$, mother), $t(51) = -7.35$, $p < .001$; and period of heavy drinking ($M = 5.17$, father; $M = 2.54$, mother), $t(51) = 6.24$, $p < .001$. Thus, in addition to ACA fathers drinking similarly, in both ACA groups fathers used alcohol more than mothers.

Further investigation of items related to parental drinking yielded no difference between ACA groups. The ACA-T ($M = 3.07$) and the ACA-NT ($M = 3.31$) groups were about the same age (between 7 and 8 years old) when the heavy drinking began, $F(1,104) = .64$. Moreover, the age of both groups ($M = 2.43$, ACA-T and 2.33, ACA-NT) when a parent quit drinking heavily was similar, $F(1,105) = .05$, 6 to 7 years of age. Clearly, there is some problem with these items. The results suggest that respondents reported they were younger when drinking ended than when it began.

The literature suggests that drinking patterns are often transgenerational. Therefore, ACA groups were compared on items which assessed drinking behaviors of grandparents. Maternal grandparents of ACA-Ts reportedly drank more often ($M = 2.34$) than did those of ACA-NTs ($M = 1.83$), $F(1,99) = 7.06$, $p < .01$. In contrast, ACA-T paternal grandparents ($M = 2.20$) did not differ significantly from ACA-NT paternal grandparents ($M = 2.09$) in frequency of drinking, $F(1, 98) = .30$. Thus, for both parents and

grandparents, the pattern is similar in that ACA-Ts viewed mothers and maternal grandparents drinking as more pronounced than did the ACA-NTs.

The ACA-T group had significantly higher scores on the CAST (M = 21.56) than the ACA-NT group (M = 18.66), $F(1, 110) = 10.34$, $p < .01$. Those receiving therapy apparently felt more adversely affected by parental drinking. Since the ACA groups currently differ in help-seeking behaviors, it is possible that they have previously differed in membership in Alcoholics Anonymous-related groups. Consequently, the two groups were compared on such memberships. Results of chi-square analyses were significant for Alanon, chi-square (1, N = 110) = 19.15, $p < .001$, with 43.9 percent of the ACA-T and 5.7 percent of the ACA-NT group having belonged to Alanon at some time. Differences were not shown for Alateen, chi-square (1, N = 110) = 1.23, p = n.s., with some of the ACA-T (5.3%) but none of the ACA-NT group having belonged. As expected, more ACA-Ts (80.7%) than ACA-NTs (3.8%) had at some time belonged to an ACA group, chi-square (1, N = 110) = 62.99, $p < .001$. Not surprisingly, the ACA-T group (M = 5.85) was also more knowledgeable about children of alcoholic's issues than the ACA-NT group (M = 3.23), $F(1, 110) = 71.06$, $p < .001$.

Hypotheses Testing

A MANOVA with total scores for friendship, love and family of origin health was conducted to determine whether

the groups differed on these overall descriptions of their relationships, Pillais $\underline{F}(9, 684) = 14.80$, $\underline{p} < .001$. The means for these total scores are listed in Tables 4 through 6. (See Appendix I.) Univariate analyses found differences on the WIQ, $\underline{F}(3, 228) = 16.79$, $\underline{p} < .001$ and FOS, $\underline{F}(3, 228) = 61.05$, $\underline{p} < .001$, but not on the MSIS, $\underline{F}(3, 228) = 1.04$. The comparisons revealed that the ACA-T group differed from the other groups by reporting the least love intimacy. All four groups significantly differed from each other on reports of their family of origin. The Comp-NT group reported the most health in their family, followed by Comp-Ts, ACA-NTs, then ACA-Ts. MANOVAs were used to directly test the hypotheses, using dimensions of the instruments with means and standard deviations are reported in Tables 4-6. To better understand these results, several additional analyses were conducted using scores on each instrument.

Friendship

Before testing the hypothesis regarding friendship intimacy, data on the MSIS were examined. Initial tests for internal consistency yielded reliability coefficient alphas of .83 for the frequency subscale, and .897 for the intensity subscale. Thus, items on these subscales seem to be reasonably related to each other. The total score for social intimacy was not significantly correlated with the total score for love intimacy (WIQ), $\underline{r} = .10$ or family of origin health (FOS), $\underline{r} = .07$. While this suggests little

relationship between the instruments, the low correlations do not yield information about their validity.

It was hypothesized that ACAs would score significantly lower than comparisons on friendship intimacy and that ACAs in therapy would score lower than their counterparts not in therapy. The MSIS frequency, intensity and total scores served as dependent measures for this hypothesis. A MANOVA on the frequency and intensity of behavior with friends was significant, Pillais F (6, 460) = 3.04, $p < .01$, but univariate analyses found no difference for frequency, $F(3, 230) = 2.01$, or intensity, $F(3, 230) = .76$. The multivariate results may have been due to the combined effects of these subscales. Therefore, the first hypothesis was not supported; no significant pattern emerged although there were overall differences. Table 4 lists means and standard deviations for friendship intimacy scales (total score, intensity and frequency). (See Appendix I.) Although not significant, the highest mean score for total friendship intimacy was reported by the ACA-T group.

In order to determine the relevance of sex and 8 dimensions of love intimacy (WIQ) to friendships, step-wise multiple regressions were conducted, using the total friendship intimacy score as the dependent variable. When the variables were allowed to enter in order of importance, no variables emerged for the ACA-NT group, but sex (i.e., being a female) emerged as an explanatory variable for

friendship's descriptions in all the other groups. Gender was entered as 1 = male and 2 = female. Specifically, sex and expressiveness helped explain friendship intimacy in the Comp-NT group, $R = .54$, $F(2, 74) = 15.00$, $p < .001$. Sex was the only predictor for the Comp-T group, $R = .49$, $F(1,46) = 14.32$, $p < .001$. Within the ACA-T group, identity and sex emerged, $R = .48$, $F(2, 53) = 7.99$, $p < .001$.

A second series of regressions utilized sex preference for a friend, WIQ total, sex, FOS total, and whether they had ever been seriously depressed on friendship intimacy. These variables were chosen to help determine whether past or present relationships are important for friendship closeness. Explanatory variables for the Comp-NT group were sex and family of origin health, $R = .58$, $F(2, 73) = 18.10$, $p < .001$. For the Comp-T group, only sex emerged, $R = .49$, $F(1, 46) = 14.32$, $p < .001$. Among the ACA-T group, love intimacy and sex, $R = .43$, $F(2, 53) = 6.12$, $p < .01$, were partial explanations. For the ACA-NT group, preference for a same sex friend emerged, $R = .10$, $F(1, 47) = 6.52$, $p < .02$. Looking at these results, being female was the most frequent and often the strongest explanation for social intimacy across groups. The intimacy of a love relationship was important for friendships only among the ACA-Ts, and family of origin health was important only among the Comp-NT group.

Love Relationships

The WIQ internal consistency and validity data were assessed prior to testing the hypothesis. Tests for internal relatedness produced acceptable Cronbach alphas for the dimensions: conflict resolution r = .80, affection r = .65, cohesion r = .67, sexuality r = .63, identity r = .76, compatability r = .79, autonomy r = .69, expressiveness r = .76, and social desirability r = .86. These moderate to high correlations support the interrelatedness of subscale items. Although the WIQ was not correlated with the MSIS, r = .10, it was moderately correlated with the FOS, r = .52, $p < .001$.

Since the literature suggests that the WIQ is correlated with marital satisfaction, such a relationship was investigated to provide further information on the WIQ and the relationships of these groups. It is also possible that sex and duration of a relationship are important to satisfaction. Therefore, a set of multiple regression procedures was performed using the 8 WIQ dimensions, length of relationship and sex as independent variables to explain relationship satisfaction. Affection was a significant explanatory variable for the Comp-NT group, R = .24, $F(1, 74) = 4.69$, $p < .05$. Compatibility and identity emerged for the Comp-T group, R = .59, $F(2, 41) = 11.14$, $p < .001$. Satisfaction for the ACA-T group was partially explained by compatibility, conflict resolution, and cohesion, R = .75,

$F(3, 53) = 23.16$, $p < .001$. Among the ACA-NT group, cohesion and conflict resolution $R = .69$, $F(2, 46) = 20.28$, $p < .001$ were explanatory variables. Interestingly, compatibility was important to both groups which had received psychological therapy (Comp-T and ACA-T), accounting for 21 percent and 41 percent of the variance, respectively. Further, conflict resolution and cohesion were important only to the ACA groups, accounting for 13 percent of the ACA-T group variance and 45 percent of the ACA-NT variance.

It was hypothesized that ACAs would score significantly lower than comparison groups on love intimacy and that ACAs in therapy would score lower than those not in therapy. The WIQ dimensions as well as total intimacy score served as dependent variables for this hypothesis. A MANOVA for love intimacy on the eight dimensions and social desirability was significant, Pillais $F(27, 672) = 3.33$, $p < .001$. Univariate analyses revealed significant differences at the .001 level for all dimensions except sexuality $F(3, 230) = 1.29$: conflict resolution $F(3, 230) = 5.89$, affection $F(3, 230) = 8.03$, cohesion $F(3, 230) = 13.58$, identity $F(3, 230) = 17.26$, compatibility $F(3, 230) = 10.06$, autonomy $F(3, 230) = 10.27$, expressiveness $F(3, 230) = 6.91$, and social desirability $F(3, 230) = 10.00$. The means and standard deviations for the scales are reported by group in Table 5. (See Appendix I.) Planned group comparisons indicated that

the ACA-T group scored significantly lower than all other groups on every scale except social desirability, where they differed from the Comp-NT group. Also on social desirablility, the Comp-T group scored lower than the Comp-NT group. Notably, the ACA-NT group did not differ from the comparison groups on any dimension. Therefore, the hypothesis received partial support. On all but one dimension (sexuality), the ACA-T group reported less intimacy than did the other groups. However, in contrast to expectations, The ACA-NT group was not significantly lower than the comparison groups on any dimension.

It is possible that love intimacy is affected by other personal and interpersonal variables. Sets of step-wise multiple regression procedures were performed using the total WIQ score as the dependent measure in order to determine the contribution of one's sex, drinking behaviors, experience with depression, abuse from a partner, family of origin health, and friendship intimacy. The items describing drinking were frequency, amount and feelings about their own drinking. A "partner abuse" variable was formed summing PIQ items related to ever having received abuse in a love relationship. For the Comp-NT group, FOS total score, amount (negative beta), and frequency of drinking, $R = .54$, $F(3, 71) = 9.87$, $p < .001$ emerged as explanatory variables for love intimacy. Partner abuse (negative beta), and FOS score, $R = .47$, $F(2, 44) = 6.23$,

$p < .01$ helped explain intimacy in the Comp-T group. The MSIS and FOS scores, $R = .44$, $F(2, 52) = 6.11$, $p < .01$ were the only predictors for the ACA-T group. Among the ACA-NT group, FOS score, sex (i.e., being male), and depression (negative beta), $R = .62$, $F(3, 45) = 9.24$, $p < .001$ were explanatory variables for love intimacy. Interestingly, family of origin health provided some explanatory power for love intimacy for each group. This suggests that relationships in the family of origin may affect intimacy in later love relationships.

Family of Origin

Before reporting results of hypothesis testing, data germane to the FOS will be presented. Tests for internal consistency resulted in high Cronbach alphas for the dimensions: clarity of expression $r = .87$, responsibility $r = .85$, respect for others $r = .90$, openness to others $r = .88$, acceptance of separation and loss $r = .92$, range of feelings $r = .899$, mood and tone $r = .92$, conflict resolution $r = .896$, empathy $r = .89$, trust $r = .87$. Cronbach alphas were especially high for the larger autonomy $r = .97$, and intimacy subscales $r = .97$. From these coefficients, items on the dimensions and subscales seem highly related.

The means and standard deviations and subscales of the FOS are reported in Table 6. (See Appendix I.) It was hypothesized that ACAs would score significantly lower than

comparisons on family of origin autonomy and intimacy and that ACAs in therapy would score lower than ACAs not in therapy. To test the hypothesis, a MANOVA with the subscales autonomy and intimacy was conducted, Pillais F (6, 466) = 22.91, $p < .001$. Differences were found on both autonomy $F(3, 233) = 57.36$, $p < .001$ and intimacy $F(3, 233) = 63.76$, $p < .001$. Planned comparisons revealed that the ACA-T group had significantly lower scores than others on both dimensions. The Comp-NT group scored significantly higher than the other three groups on autonomy. On intimacy, the Comp-NTs scored significantly highest, followed by Comp-Ts, ACA-NTs, and ACA-Ts.

Next, a MANOVA was utilized with all 10 FOS dimensions as dependent variables to determine whether some groups had higher levels of family health in certain areas than did others. This analysis yielded significant results, Pillais $F(30, 663) = 6.33$, $p < .001$. Univariate analyses indicated that differences were found on all dimensions at the .001 level: clarity of expression, $F(3, 228) = 42.79$; responsibility, $F(3, 228) = 51.82$; respect, $F(3, 228) = 42.84$; openness, $F(3, 228) = 45.63$; acceptance of separation and loss, $F(3, 228) = 28.27$; range of feelings, $F(3, 228) = 46.37$; mood and tone, $F(3, 228) = 66.14$; conflict resolution, $F(3, 228) = 64.00$; empathy, $F(3, 228) = 48.00$; and trust, $F(3, 228) = 29.84$. The groups all differed significantly from each other on clarity of expression,

responsibility and conflict resolution. On these scales, the Comp-NT group had the highest scores, followed by Comp-T, then ACA-NT, then ACA-T. A slightly different pattern emerged for respect, openness, range of feelings, empathy and trust in the family of origin. The ACA-T and Comp-NT groups were again different from the other groups, scoring lowest and highest. However, the Comp-T and the ACA-NT groups failed to differ from each other. On the dimension of acceptance of separation and loss, only the ACA-T group differed from the other three groups. On mood and tone, the ACA-T group was also significantly lower than the other three groups. The ACA-NT was next lowest and differed from the other groups.

The hypothesis was partially supported by the two MANOVAS. The ACA-T group was consistent, rating their families lowest on all dimensions, including the subscales of autonomy and intimacy. However, the ACA-NT group was next lowest only on the intimacy subscale and four dimensions (clarity of expression, responsibility, conflict resolution, and mood and tone). Furthermore, this group was similar to the Comp-T group on six of the subscales (respect, openness, range of feelings, empathy, trust, and separation).

Several of the PIQ items appeared relevant to family of origin health. Therefore, multiple regressions were performed with the FOS total as the dependent measure and

PIQ items related to childhood as predictors. To obtain overall measures, items related to physical abuse by each parent were summed. First, sex, how often you were sexually abused, abuse by mother and father, and birth order in family they lived with were allowed to enter in order of importance. No variable emerged for the Comp-T group. For the Comp-NT group, abuse from mother (negative beta) helped explain family of origin health, $\underline{R} = .31$, $\underline{F}(1, 74) = 7.84$, $\underline{p} < .01$. Abuse from mother (negative beta) and sexual abuse (negative beta) $\underline{R} = .41$, $\underline{F}(2, 55) = 5.38$, $\underline{p} < .01$ were explanatory variables for the ACA-T group. Abuse from father (negative beta) $\underline{R} = .47$, $\underline{F}(1, 47) = 13.52$, $\underline{p} < .001$, was an important predictor of family health for the ACA-NT group. In summary, lack of abuse from mother only accounted for about 8 percent of the variance for both the Comp-NT and ACA-T groups. However, a father's lack of abuse accounted for 21 percent of the variance for the ACA-NT group. Moreover, a lack of sexual abuse was an explanatory variable only for the ACA-T group.

Since the groups had distinctly different scores on family of origin health (i.e., total FOS score), the second set of multiple regressions were utilized to examine which parental drinking behaviors were most important in describing this health. The variables included sex as well as items related to parental drinking (i.e., how often, how many days a week, amount, and years mother and father drank,

and subject's age when heavy drinking began). As expected, no explanatory variables emerged for either comparison group. Age when drinking began helped explain family health for the ACA-T group, $R = .32$, $F(1, 53) = 6.07$, $p < .02$. Age and how often the father drank (negative beta) were important predictors for the ACA-NT group, $R = .48$, $F(2, 48) = 7.10$, $p < .01$. Age when drinking began was a predictor of family health for both ACA groups, accounting for slightly more variance in the ACA-NT group (12%) than in the ACA-T group (9%). Notably, the frequency of father's drinking was negatively related to family health in the ACA-NT group.

Related Results

Group differences were found on mood and tone of the family of origin. Possibly individual differences in mood also occurred. Therefore, the groups were examined to determine whether they differed in experiences of depression as well as suicide-related behavior.

Depression and Suicide

Three items in the PIQ pertained to depression or suicide (experience with depression and suicidal plans and attempts). These items were examined individually using chi-square procedures and are reported in Table 7. (See Appendix I.) A striking result was that 98.3 percent of the ACA-T group, 68.8 percent of the Comp-T group, 51.9 percent of the ACA-NT group, and only 28.6 percent of the Comp-NT

group reported having been depressed at some time in their lives, chi-square (3, N = 236) = 70.28, p < .001. When asked whether they had ever planned suicide, 55.9 percent of the ACA-T group answered in the affirmative, compared to 27.1 percent of the Comp-T group, 17.3 percent of the ACA-T group, and 10.4 percent of the Control-NT group, chi-square (3, N = 236) = 38.59, p < .001. The item assessing attempted suicide was also significant, chi-square (3, N = 236) = 12.57, p < .01. More in the ACA-T group (15.3%) than Comp-T (8.3%), ACA-NT (5.8%) or Comp-NT (0%) groups had tried to commit suicide. These findings indicate that the ACA-T group was more likely to have suffered depression than the other groups and more likely to have considered and even attempted suicide.

In order to try to understand these findings, a set of multiple regression procedures were conducted with partner and both forms of parental abuse, sex, friendship and love intimacy, and family of origin health. This procedure yielded no significant predictors of depression for Comp-NT or ACA-T groups. FOS total emerged as a predictor (negative beta) for the Comp-T group, R = .36, F(1, 44) = 6.36, p < .02. Love intimacy (negative beta) was the sole explanatory variable for the ACA-NT group, R = .44, F(1, 46) = 11.14, p < .01. Thus, where explanations for depression emerged, they reflected either lack of closeness in family of origin or a present love relationship.

Another multiple regression specified planning suicide as the dependent variable, but entered sex, partner abuse, parental abuse, love and friendship intimacy and family of origin health as predictors to help determine the weighted importance of such variables. Abuse from the father was significantly related for the Comp-NT, R =.45, $F(1, 75)$ = 18.62, $p < .001$ and Comp-T, R = .60, $F(1, 44)$ = 24.38, $p < .001$ groups. ACA-NT had no predictors, but family health (negative beta) emerged as an explanatory variable for the ACA-T group, R = .37, $F(1, 53)$ = 8.31, $p < .01$.

Conceivably, variables related to parental drinking as well as the repondent's sex and age when the parental drinking commenced could be related to suicidal ideation. Therefore, a set of multiple regressions with planned suicide as a dependent variable, employed these items to help determine significant predictors. No explanatory variables emerged for the comparison groups but amount the father drank was related to planning suicide for the ACA-T group, R = .36, $F(1, 53)$ = 7.64, $p < .01$; and frequency of the father's drinking was related for the ACA-NT group, R = .33, $F(1, 49)$ = 5.82, $p < .02$. Of interest, the father's, as opposed to the mother's, drinking was related to planning suicide. Therefore, while abuse from the father was related to planning suicide for the comparison groups, less family health and amount the father drank were related for the

ACA-Ts and frequency of father's drinking was related to planning suicide for the ACA-NTs.

Abuse

The literature suggests that alcoholism and abuse are related. Thus, ever having received physical abuse from a partner, father, or mother and having been sexually abused as a child were included in a MANOVA to determine whether the groups differed on these variables, Pillais $F(12, 672) = 5.41$, $p < .001$. Table 8 lists the means and standard deviations of each composite variable. (See Appendix I.) Univariate analyses revealed group differences occurred on partner abuse, $F(3, 225) = 5.98$, $p < .001$, abuse from father, $F(3, 225) = 9.50$, $p < .001$, abuse from mother, $F(3, 225) = 9.47$, $p < .001$, and sexual abuse, $F(3, 225) = 11.19$, $p < .001$. Planned comparisons indicated that on each variable, the ACA-T group was significantly higher in abuse than the other three groups, which did not differ from each other.

CHAPTER IV

DISCUSSION

This study makes a contribution by comparing ACAs to individuals who did not come from alcoholic homes, but more importantly, by examining differences between ACAs in therapy and those not in therapy. Comparisons between these groups have been strongly needed because most of the current literature reflects clinical impressions based on ACAs currently receiving psychological therapy. Those impressions have subsequently been generalized to the population of ACAs, resulting in negative stereotyping (Burk, 1987).

The purpose of this study was to determine whether adult ACAs do indeed have difficulty with intimacy (Black et al., 1986; Woititz, 1983, 1985) in both close friendships and love relationships and to assess the levels of autonomy and intimacy in their families of origin. The most striking findings are that the two ACA groups seem to be distinct populations and that those not in therapy fail to report intimacy difficulties which have previously been ascribed to them. Based on the results of this study, common characteristics of ACAs receiving therapy are not necessarily the same as those for ACAs not receiving

therapy. Furthermore, generalizing these characteristics could lead to the misunderstanding of nonclinical ACAs.

This study was limited in that the ratio of female to male respondents prevented analyses using sex as an independent variable. Since some researchers suggest that males and females differ in development of intimacy (Gilligan, 1979; Hodgson & Fischer, 1979), such comparisons would have augmented the present understanding of intimacy in ACAs. For hypothesis testing purposes, unequal cells varied too much. However, because regressions are based on correlations (rather than means), problems associated with the gender imbalance were deemed less severe. Consequently, it was logical to maintain gender as an explanatory variable. With such an imbalance, findings should be viewed as tentative.

Additionally, regarding comparisons, one group was distinguished by having ever had therapy. Although similar to the ACA-T group in that respondents had experienced therapy, this group was not equivalent to the ACAs in therapy since its members were not necessarily currently involved in therapy. A more precise comparison group would have been nonalcoholic nonACAs who were currently engaged in psychotherapy.

Another limitation is the source of respondents. While most of the ACA-T group came from ACA group therapy settings, the majority of the other respondents were

recruited from churches. It is possible that differences in religiosity somehow impacted the respondents' disclosures. For instance, perhaps those who attend church are more concerned with how they are perceived by others, or perhaps they are more committed toward maintaining a cohesive family structure.

In addition to limitations concerning the sample, the study contained limitations related to the instruments employed. The WIQ was modified to reflect intimacy in any love relationship, not limited to marriage. However, several of the items in the autonomy dimension concern relationships with in-laws or children. Thus, these items may not have applied to some of the respondents and may have been left unanswered. Furthermore, the identity dimension of the WIQ poses questions predominately related to self-esteem. Thus, the title, "identity," seems somewhat misleading.

There is also a methodological issue related to the FOS. Validity for dimensions and subscales has not been fully established (W. T. Anderson, personal communication, April 21, 1988). However, high reliability coefficients were found for this sample, indicating internal consistency. Thus, because the research was exploratory in nature, it was decided to address the dimensions and subscales where relevant. Caution should be used, however, in interpreting its results.

Some single-item questions were used to assess such factors as depression, attempted suicide, and relationship satisfaction. Utilization of validated instruments for such constructs would have added to the usefulness of these variables.

Finally, multiple regressions utilized a large number of predictors. Since the size of the groups is somewhat small for such number of predictors, caution should be exerted when interpreting results.

Given these limitations, this study was largely exploratory, seeking to obtain a large amount of information, much of which had previously been unexplored. The inclusion of several single-item questions as exploratory variables contributed considerably to the understanding of adults from alcoholic homes. Instruments were used which seemed to reflect the breadth and depth of the construct, intimacy, in various relationships. Although not ideal, these instruments did provide much-needed information regarding the multi-dimensional aspects of intimacy.

The predominance of females in the sample, especially in the ACA groups may be partially due to the elimination of alcoholics, many of which were males, from the study. Additionally, females seem to outnumber males in ACA therapy groups. The present study reflects such imbalances.

Respondents were solicited from churches in an effort to avoid self-selection, such as from ads in journals or newspapers. The hallmark of this study is that it includes ACAs not in therapy. Thus, it was necessary to find this group in a setting unrelated to their ACA status. In an attempt to counteract recruiting a skewed sample with characteristics typically ascribed to certain religious groups (e.g., political orientation, tolerance for variation in beliefs), respondents were recruited from seven churches of four different denominations. Moreover, these churches, as well as the ACA groups, were located in different sections of the city and included various socioeconomic groups. If belonging to a church in and of itself produced a particular response set, it would seem that the most likely response set would be to present oneself favorably. However, only the nonclinical comparison group differed from the other groups on social desirability on the WIQ. The other two groups which were primarily recruited from churches failed to differ from the ACAs in therapy, who were not recruited from churches. Therefore, the notion of a social desirability response set associated with religiosity does not seem to be supported.

The quasi-comparison groups were included to provide relevant and useful comparisons. Although not exactly the same in therapy experience, the ACA-T and Comp-T groups were comparable in that they had sought treatment for some form

of distress in their lives. Thus, the alcoholic family of origin was a distinguishing feature of these two groups.

Family of Origin

Research has shown that alcoholics probably differ from nonalcoholics in their family environment. Therefore, ACAs were expected to report that their families of origin were less healthy than families of other groups. "Less health" was operationalized as having lower scores than comparisons on family of origin autonomy and intimacy, as measured by the FOS. When considering the overall health of the family, intimacy, clarity of expression, responsibility, conflict resolution, and mood and tone of the family, ACAs reported the lowest levels of functioning, partially confirming this hypothesis. These findings provide support for alcoholic families being characterized by poor communication (Gorad et al, 1971; Hanson & Estes, 1977), conflict (Carey, 1986; Moos & Moos, 1976), tension-filled atmosphere (Booz-Allen & Hamilton, Inc., 1974), and responsibility avoidance (Gorad, 1971). In summary, ACAs reported a more negative atmosphere where family members exhibited more difficulty communicating, resolving conflict, and taking responsibility than did comparisons.

However, ACAs not in therapy failed to differ from the comparisons who had had therapy regarding their families' respect for others, openness to others, range of feelings, empathy, trust, and acceptance of separation and loss. They

did differ from comparisons with no therapy, though. These findings highlight the contribution of subdividing the original comparison group. Since the ACAs not in therapy and comparisons who had had therapy failed to differ on six of the dimensions, the possibility is suggested that alcoholic homes may be similar, at least along certain dimensions, to homes with other problematic patterns. Alternatively, perhaps neither group had significant difficulties. Nevertheless, these findings contradict previously held assumptions that alcoholic families typically are characterized by distrust (Cermak & Brown, 1982; Hecht, 1973), lack of respect (Black, 1981), passivity and lack of responsiveness (Barnes et al., 1979), emotional neglect (Hanson & Estes, 1977; Seixas & Youcha, 1985), constriction of feelings (Gravitz & Bowden, 1985), and difficulties with separation (Beletsis & Brown, 1981).

As expected, ACAs in therapy scored lower than those not in therapy. ACAs in therapy reported less overall family health and were lower on all dimensions than the other groups. Since responses reflected perceptions of the respondents, the question must be raised as to whether or not ACAs in therapy have more negative perceptions regarding their family of origin than do the other groups. Perhaps as a result of currently being involved in therapy, their attention has focused on negative family of origin issues which may have been exaggerated or at least brought to mind.

ACAs not in therapy may either be denying a comparable degree of dysfunction or may have merely repressed these memories. Alternately, it may be possible that not all alcoholic families are dysfunctional, at least not more so than other families who have offspring who eventually seek treatment.

As reported in Chapter I, more separations and divorces are reported in alcoholic homes than in nonalcoholic homes (Black et al., 1986; Kammeier, 1971; Miller & Jang, 1977). Family of origin structure of the present groups was similar to previous findings with ACAs reporting more divorces than comparisons. Moreover, the ACA groups were similar to each other in parental divorces.

Examination of the parental drinking behaviors as reported by the subjects, indicates that ACA fathers drank more often than mothers, larger amounts and for more years than mothers. However, the mother's drinking differentiated the groups, with mothers of clinical ACAs drinking more than mothers of ACAs not in therapy. The literature supports the possibility that negative effects of having an alcoholic mother are worse than those of having an alcoholic father (Cork, 1969; Miller & Jang, 1977). A study by Obuchowska (1974) found that when children had an alcoholic father and were able to find emotional satisfaction through contact with their mothers, this gratification compensated in achievement motivation in school and social behaviors.

Booz-Allen & Hamilton, Inc. (1974) also found that the negative effects of alcoholism on children are reduced when the nonalcoholic parent is supportive. It may be then that it is not an alcoholic home per se that has negative effects, but rather having a mother who also drinks heavily and may fail to provide adequate nurturing for the child. Thus, perhaps ACAs not in treatment were somehow protected from some of the negative effects of alcoholism in a family because their mothers' resources were not depleted by drinking.

Reports of higher incidences of parental physical and sexual abuse in alcoholic families than nonalcoholic families are consistent with the literature (Behling, 1979; Black et al., 1986; Seixas & Youcha, 1985; Yeary, 1982). However, the ACAs in therapy were the only group to significantly differ on these issues, reporting more abuse. Perhaps the mother's drinking made this abuse possible. If a mother is drinking heavily or frequently, she may be less likely to be aware of what is happening to her child and/or unable to stop abuse.

This study explored other variables which may have affected family of origin health. As would be expected, physical and sexual abuse are negatively associated with family health. Having had a nonphysically abusive mother was related to family health for the nonclinical comparisons as well as the ACAs in therapy. Not having had sexual abuse

was related to family health for the ACAs in therapy. The lack of physical abuse from the father was the only predictor for the nonclinical ACA group. These results support the notion that with abuse, less family health or intimacy is a likely result.

Since the presence of alcoholism in families has been linked with marital instability, parental drinking behaviors were also considered as possible predictors of family of origin health. The subject's age when the heavy drinking began was predictive for both ACA groups, suggesting that a later age for onset of parental drinking predicted higher levels of family health. These findings are consistent with Booz-Allen and Hamilton, Inc. (1974), who found that the younger the child at the onset of parental alcoholism, the greater the emotional damage. Lower levels of family health may produce emotional damage in children. Caution should be used when interpreting childhood age when drinking commenced since there may have been a problem with responses to this item. Although the fathers in both ACA groups drank equivalently, the less frequently a father drank also partially explained family health for ACAs not in therapy. It is noteworthy that the ACAs in therapy had no parental drinking behaviors significantly predictive of family health although they reported heavier maternal drinking than the other ACA group. Interestingly, family health of the ACAs in therapy seems more impacted by maternal physical abuse

and by sexual abuse than by parental drinking while family health of the nonclinical ACAs seems more impacted by abuse and drinking related to the father.

Current Relationships

Friendship

This study hypothesized that ACAs would have less intimate friendships than others because research has suggested that children of alcoholics have poor role models for communicating as well as emotional and behavioral difficulties which might interfere with forming and maintaining intimate interpersonal relationships. This hypothesis was not supported. Differences did not emerge on friendship intimacy, and no pattern was discernable from the comparisons on the frequency and intensity dimensions. The implication is that the groups are equally able to form and maintain close friendships, which is consistent with Carey's dissertation (1986) findings with females. Although both studies excluded alcoholics, the present research augments previous findings by including males and by comparing ACAs in treatment to those not in treatment.

The literature describes alcoholics as having communication (Gorad, 1971) and interpersonal difficulties (Fox, 1962). However, including alcoholics may have biased previous results on ACAs (Beletsis & Brown, 1981; Black et al., 1986) so that they appeared to have difficulty with

friendship intimacy. Thus, perhaps alcoholism is a confound which has been eliminated from this study.

Gender was a predictor of friendship intimacy except for the group of ACAs not in therapy. Females apparently reported more intimacy than males. This result may be partially due to an artifact of the instrument. The MSIS primarily consists of items assessing self-disclosure and expression of feelings, and females have been shown to be higher in self-disclosure (Cozby, 1973; Hendrick, 1981; Ickes & Barnes, 1978; Jourard, 1971) and to have fewer but more intimate friendships (Booth, 1972; Maccoby & Jacklin, 1974; Waldrop & Halverson, 1975) than males. It follows then that being female would be important for friendship intimacy as measured by the MSIS.

Love Relationships

As a result of clinical observations and limited existing research, ACAs were expected to have less intimate love relationships than comparisons. If this hypothesis were true, one would expect those in therapy to have the least intimate relationships since they were experiencing difficulties which required treatment. However, the ACAs as a whole did not differ from comparisons. This finding suggests that intimacy in a love relationship is not perceived differently just because one comes from an alcoholic home.

The second part of this two-part hypothesis was generally supported by the data. ACAs who were receiving treatment reported the least intimacy, and this was found on all dimensions except sexuality and social desirability. Sexuality has been shown to be one of the three dimensions least related to total intimacy (Wood et al., 1988; Waring, 1984). Thus, it is not surprising that the groups reported equivalent sexual intimacy while diverging in other areas.

On social desirability, the comparison group which had not had therapy scored higher than the comparison group which had received therapy and the ACAs who were receiving therapy. A possible explanation is that the individuals who had not had therapy do not have the level of introspection that is gained through therapy. Those who have had treatment may have been taught to view themselves and their relationships in positive as well as negative terms.

The finding that ACAs in treatment were distinguishable from comparisons in terms of their intimacy, provides support for clinical impressions (Brown & Beletsis, 1986; Deutsch, 1982; Gravitz & Bowden, 1985; Woititz, 1983) and research (Black et al., 1986; Carey, 1986) that intimate love relationships are particularly problematic for adults who grew up in alcoholic homes. This group was less able to express affection, thoughts, and feelings, resolve conflict, play and work with a partner, achieve autonomy, commit to a relationship, and feel a sense of self-esteem than the other

groups. Findings by Black et al, (1986) of ACAs having difficulties with resolving conflict, expressing feelings and needs, and putting self first are strengthened by this study.

However, the fact that ACAs not in therapy scored no differently from either comparison group on any dimension of intimacy suggests either that intimacy in a love relationship is not perceived differently by this group than by the comparisons or that ACAs not in therapy tend to deny intimacy related problems that do exist. Social desirability should have distinguished the two ACA groups if those not in therapy were denying such problems. However, they did not differ on this measure of presenting themselves favorably. Thus, the latter explanation seems less plausible.

These findings make a marked contribution by discriminating between two distinct groups. The nonclinical ACAs were similar to the comparison groups on all intimacy dimensions. Since the majority of the literature consists of clinical impressions, ACAs who have not sought treatment have been overlooked. This study demonstrates the necessity of including nonclinical respondents when exploring characteristics of a specific population such as children of alcoholics.

According to attachment theory, early childhood experiences affect subsequent personality development and

interpersonal relationships (Bowlby, 1977; Morris, 1982). Thus, one would expect a relationship between family of origin health and adult intimacy. If this were true, family of origin autonomy and intimacy should predict intimacy achievement in adulthood. This expectation was confirmed for all groups in regard to love intimacy. Family of origin health accounted for 6 percent of the variance for the ACAs in therapy, 10 and 16 percent of the variance for the comparisons having had therapy and not having had therapy, respectively, and 19 percent of the variance for the nonclinical ACAs. In contrast, the family of origin apparently has less effect on intimacy with friends. It made a contribution only for the comparisons without treatment, accounting for 10 percent of the variance. These results suggest that dynamics in one's family of origin affect later intimacy. This explanation is logical since modeling effects should exert considerable influence on one's future interactions. Furthermore, such modeling effects could be positive or negative. Not only does family of origin health relate to love intimacy, but with increased levels, it appears to affect friendships as well, as shown in the nonclinical comparison group. Thus, when a critical level of family health is reached, spillover effects may influence friendships.

While for the ACAs in therapy, love intimacy was a predictor of friendship intimacy, the reverse was also

shown. That is, this group's ability to form and maintain closeness with a friend is related to their ability to develop romantic closeness, and romantic intimacy predicts friendship intimacy. A practical application would be for therapists to facilitate friendship closeness which, in turn, could affect romantic relationships. The reverse would then apply for those wishing to increase friendship closeness.

Other Interpersonal Factors

As has been suggested in the literature (Gravitz & Bowden, 1985; Woititz, 1983, 1985), at least some ACAs appear to have problems with love relationships. Although the ACAs tended to come from families with similar levels of instability (divorces), current relationships differed. When marital status was examined, fewer ACAs in therapy were married, but nonclinical ACAs and the clinical comparisons were similar. In addition, ACAs in therapy reported more divorces and longer latencies since their last relationship, less satisfaction with their most recent relationship, and more spouse abuse than the other groups. Based on correlations of the WIQ with marital adjustment (Waring et al., 1981) and satisfaction (Wood et al., in press), one would expect lower levels of satisfaction to be associated with more divorces. This expectation was confirmed with ACAs in therapy reporting the lowest intimacy, the least satisfaction, and more divorces. Thus, these results

provide some criterion validity for the WIQ and strengthen the findings of the study.

Little research has explored the variables which might provide explanation for satisfaction in love relationships of ACAs. One would expect certain dimensions of intimacy to be more strongly related to satisfaction than others. Therefore, the data were examined in order to further understand the interrelatedness of such concepts. For the comparisons who had not received therapy, the degree of affection expressed by the couple predicted satisfaction, and for the comparisons who had received therapy, working and playing together compatibly, followed by the couple's level of self-esteem predicted satisfaction. However, compatibility, conflict resolution, and cohesion or commitment to the relationship were predictors for the clinical ACAs. Satisfaction was predicted by cohesion and conflict resolution for the nonclinical ACAs. The ACA groups, with common predictors which would help insure staying together and resolving difficulties (i.e., conflict resolution and cohesion), were more similar to each other than to comparisons. Results for all of the groups suggests that Maslow's (1954) hierarchy of needs may apply to relationship satisfaction. While satisfaction is predicted by more basic needs of maintaining the relationship for ACAs, it is predicted by higher needs of affection and esteem for the comparisons.

Other Intrapersonal Factors

Given the interpersonal differences between groups described above, it is not unreasonable to assume there may be intrapersonal differences as well. For example, the groups differed on reported mood in the family of origin. It may be that individual and family mood were not related. However, if the mood and emotional tone of the family were related to mood of the individual, one would expect those from families with a lower mood to possibly have more depression than those from families with higher moods, as was found here.

Investigating suicidal thoughts can offer further information as to the possible severity of a mood disturbance and degree of hopelessness involved. Both ACA groups reported less positive family mood than comparisons, with the ACAs in therapy describing even lower levels than ACAs not in therapy. However, only the ACAs in therapy were found to have experienced depression, planned suicide and attempted suicide at a higher rate than the other groups. In fact, the comparisons who had had therapy reported slightly more depression, suicide planning and suicide attempts than the ACAs not in therapy. Although research has suggested that alcoholism in the home is related to depression (Kamstra, 1986; Tarter et al., 1984), current results suggest that this may not necessarily be true.

Information from the CAST might provide relevant information for differences in mood and suicidal behaviors between the ACA groups. In contrast to those not in therapy, ACAs in therapy reported more emotional effects of parental alcoholism (i.e., higher CAST scores). Many of the items reflect loneliness (e.g., "Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?" "Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?") and emotional distress (e.g., "Did you ever feel responsible for and guilty about a parent's drinking?"). Perhaps the depression was affected by these early feelings of loneliness, anxiety, and guilt. Thus, a plausible explanation for group differences in depression and suicide is that there may be factors distinguishing the groups other than alcoholism. These differences could have created an atmosphere that accounted for the variations in individual moods.

These findings regarding depression and suicide support attachment theory which argues that depression can be related to faulty parenting (Bowlby, 1977). Faulty parenting may be more likely in the presence of heavy drinking, and clearly, abuse qualifies as faulty parenting. Thus, one would expect abuse and heavy drinking to help explain depression and/or suicide. The only explanatory

variables of depression to emerge were lower levels of family of origin health for the comparisons who have had therapy (11% of the variance) and less love intimacy (18% of the variance) for the ACAs not in therapy. The effect of the family was direct for clinical comparisons who were more likely to suffer depression if their childhood family environment was less healthy. ACAs not in therapy were more likely to have depression with low levels of intimacy in a love relationship. This shows an indirect effect since family health accounts for 19 percent of the variance for explaining intimacy in a love relationship.

When examining explanatory variables for planning suicide, amount of paternal drinking and less family of origin health accounted for 11 and 12 percent, respectively, of the variance for the ACAs in therapy. Frequency of paternal drinking accounted for 9 percent of the variance for ACAs not in therapy. Paternal abuse was a predictor for both comparison groups, accounting for 19 percent of the variance for comparisons with no treatment and 34 percent of the variance for comparisons with therapy experience. The implication of these findings is that for the few comparisons who do plan suicide, such a plan may be precipitated by physical abuse from the father. However, planning suicide was explained by the father's drinking for both ACA groups but by less family health only for the ACAs in therapy. Since there is a significant difference between

the ACA groups in depression and suicide, family health as a distinguishing explanatory variable deserves further exploration. When predictors of family of origin health were examined, lack of sexual abuse and lack of maternal abuse helped describe ACAs in therapy and lack of paternal abuse and less frequency of paternal drinking characterized ACAs not in therapy. Since the clinical ACA group reported more sexual and physical abuse than the nonclinical ACAs, since these abuse factors are predictive of family health, and since family health predicts planning suicide for this group, the abuse factors should be considered as germane to thoughts of suicide.

Taken as a whole, ACAs cannot be said to have difficulties with intimate relationships. They failed to differ from comparisons on friendship intimacy, and only the ACAs in therapy differed on love intimacy. Clearly, not all ACAs are alike. Although those not in treatment are similar to ACAs in treatment in that they differ from comparisons on family of origin intimacy and overall health, the number of areas in which they fail to differ from comparisons are noteworthy. Moos, Finney, & Gamble (1982) found that when spouses of alcoholics seek treatment, they tend to be more dependent, lower in self-esteem and to function less well than those who do not seek help. Possibly the same can be said of ACAs. Those who sought treatment report lower autonomy and self-esteem (i.e., identity) and report more

problems associated with their families, less intimacy in their love relationships, more divorces, a greater impact from their parent's alcoholism, more abuse and depression, and more suicide planning and attempts than the other groups. As mentioned in Chapter I, Bowlby (1977) classified the overly-dependent person as one who had experienced faulty parenting and who currently has difficulty with affectional attachments. This description seems to better characterize the ACAs in therapy due to their lower levels of family of origin health and higher levels of maternal drinking and abuse than those not in therapy.

On the other hand, the clinical ACAs may have negative perceptions regarding their mothers, having reported more drinking by their mothers and maternal grandparents and as evidenced by their lower ratings of family health. It may be that their negative perceptions are partly a function of being in psychological treatment. In ACA groups, they often discuss how their parent's drinking affected them. Further, because most were females, it would not be unreasonable to speculate that much of their discussion would focus on their mothers. Perhaps anger associated with their upbringing has been channeled toward their primary caretaker, and they have become disillusioned with her perceived lack of support during the growing-up years. Thus, they may be perceiving her more negatively at present than they had previously.

Another possible explanation for these results is that the ACAs not in treatment are still denying the impact of parental drinking (Black, 1981; Harrigan, 1987; Seixas & Youcha, 1985). It is possible that their families of origin were just as unhealthy, the abuse just as frequent, and the current intimacy relationships just as functional as ACAs in treatment. However, the ACAs in treatment may have broken through the denial and and have begun to face the pain associated with growing up in such aversive circumstances as well as the inadequacies in their present relationships. The family denial may be different from individual denial, however. If individual denial were occurring, one would expect responses on the CAST to have been less than the present cutoff, which was even more stringent than the standard cutoff for a COA. Their social desirability scores would also be expected to differ from the ACAs in therapy if they were denying individual difficulties. However, since those in therapy reported higher CAST scores and the ACA groups failed to differ on social desirability, more support is found for the argument that subgroups of ACAs exist than for the assertion that the differences are a function of denial.

The finding that ACAs not in therapy failed to differ from comparisons who had received therapy on love intimacy and several family of origin dimensions has an implication. Watters and Theimer (1978) surmised that COAs are similar to

children of parents in treatment for other emotional or social problems. Nonclinical comparisons were not considered by these writers; nevertheless, the underlying premise may apply. Perhaps the nonclinical ACAs and clinical comparisons had similarly healthy families, whether that health was in the positive or negative direction. Level of dysfunction was not assessed so that determination cannot be assumed. Possibly the similar family of origin factors for these two groups (i.e., respect, openness, range of feelings, empathy, trust, acceptance of separation and loss) are especially crucial in avoiding some of the deleterious effects of what Bowlby (1977) calls faulty parenting.

Further research is clearly needed to determine the explanations for these results. However, the practical implication at the present time is that the previously held beliefs about ACAs, which are founded primarily on clinical impressions, do not seem to generalize to all ACAs. Those in treatment seem to be having much more difficulty in current love relationships as well as more trauma in previous years. However, they have maintained levels of friendship intimacy similar to the other groups in this study. While family of origin health seems related to intimacy in a love relationship, ACAs not in treatment have been able to maintain intimate relationships comparable to comparisons.

ACAs differ on family of origin dimensions primarily encompassing honesty, empathy and respect. These differences are consistent with the higher levels of sexual and physical abuse in the clinical group. Such findings, therefore, suggest that lack of respect for a child as evidenced by dishonesty, lack of openness and abusive behaviors which may or may not be associated with alcoholism create an atmosphere of faulty parenting which affects the child's subsequent intimacy in a love relationship. Thus, not all ACAs can be described as having difficulties with intimate relationships.

APPENDIX A

Dimensions of Instruments

Appendix A

Dimensions of Instruments

Miller Social Intimacy Scale

Frequency of intimate contacts

Intensity of intimacy

Waring Intimacy Questionnaire

Conflict resolution

Affection

Cohesion

Sexuality

Identity

Compatability

Autonomy

Expressiveness

Family-of-Origin Scale

Autonomy:

- Clarity of expression
- Responsibility
- Respect for others
- Openness to others
- Acceptance of separation and loss

Intimacy

- Range of feelings
- Mood and tone
- Conflict resolution
- Empathy
- Trust

APPENDIX B

Personal Information Questionnaire

Appendix B

Personal Information Questionnaire

Directions: There are no right or wrong answers to these questions. Your honest feelings and thoughts are requested.

INFORMATION ABOUT YOU AS YOU ARE NOW

_____ 1. Age (in years)

_____ 2. Sex: 1 male 2 female

_____ 3. Race:

(1) Caucasian
(2) Mexican American
(3) Black
(4) Asian American
(5) American Indian
(6) Other (specify____________________)

_____ 4. Religious preference:

(1) Protestant
(2) Jewish
(3) Catholic
(4) Other (specify____________________)

_____ 5. How frequently do you attend church or church-related activities?

(1) never
(2) rarely
(3) monthly
(4) bimonthly
(5) weekly
(6) more than once a week

_____ 6. How religious do you consider yourself to be

(1) very religious
(2) moderately religious
(3) somewhat religious
(4) somewhat nonreligious
(5) moderately nonreligious
(6) not at all religious

_____ 7. Current marital status:

(1) never married
(2) married
(3) separated
(4) divorced
(5) widowed

_____ 8. Number of times you have been divorced?

_____ 9. Your education:

(1) did not complete high school
(2) high school
(3) some college
(4) graduated college
(5) graduate degree

_____ 10. What is the combined income for your present household?

(1) less then $10,000
(2) $10,000 but less than 20,000
(3) $20,000 but less than 35,000
(4) $35,000 but less than 50,000
(5) $50,000 but less than 75,000
(6) more than 75,000

_____ 11. Preference for a close friendship

(1) same sex
(2) opposite sex

_____ 12. Preference for an intimate love relationship

(1) same sex
(2) opposite sex

_____ 13. Are you currently involved in a love or marriage relationship?

(1) no
(2) yes

_____ 14. If you are not currently in a love/marriage relationship, when did your most recent relationship end?

(1) not applicable
(2) within the last month

(3) from 2 to 6 months ago
(4) from 6 months to 1 year ago
(5) more than a year ago

_____ 15. When thinking about your most recent love/ marriage relationship, how long did it or has it lasted? (answer both in numbers)

_____ months _____ years

_____ 16. How would you describe this current or recent relationship?

(1) dating
(2) dating exclusively
(3) living together
(4) married

_____ 17. How satisfied are you or were you with this love relationship?

(1) very satisfied
(2) moderately satisfied
(3) somewhat satisfied
(4) unsure
(5) somewhat dissatisfied
(6) moderately dissatisfied
(7) very dissatisfied

_____ 18. Have you ever received psychological therapy or professional counseling?

(1) no
(2) yes

_____ 19. What type of therapy did you receive

(1) None
(2) individual psychotherapy
(3) group psychotherapy
(4) both individual and group psychotherapy (5) other (please specify_________________)

_____ 20. How long did your therapy last?

(1) not applicable
(2) less than a month
(3) from one to six months
(4) from six months to a year

(5) from one to two years
(6) over two years

_____ 21. Are you presently receiving psychological therapy or professional counseling?

(1) no
(2) yes

_____ 22. What type of therapy are you receiving?

(1) none
(2) individual psychotherapy
(3) group psychotherapy
(4) both individual and group psychotherapy (5) other (please specify)

_____ 23. Which of the following best describes your drinking of alcoholic beverages?

(1) never
(2) less than 6 times a year
(3) 7 to 11 times a year
(4) once or twice a month
(5) every weekend
(6) several times a week
(7) every day

_____ 24. When you do drink, how much do you typically drink?

(1) not applicable
(2) 1 drink
(3) 2 drinks
(4) 3-6 drinks
(5) 7 or more drinks
(6) until drunk

_____ 25. How do you feel about your drinking?

(1) no problem at all
(2) I can control it and set limits on myself
(3) I can control myself, but my friends easily influence me
(4) I often feel bad about my drinking
(5) I need help to control myself
(6) I have had professional help to control my drinking

_____ 26. How much do you know about children of alcoholic`s issues?

1	2	3	4	5	6	7
nothing						very much

The next question asks about behaviors a spouse or love partner has EVER done to you. Use the following scale:

(1) never
(2) once or rarely
(3) a few times
(4) occasionally, quite a few times
(5) monthly
(6) more than monthly
(7) weekly or more

_____ 27. something was thrown at you

_____ 28. pushed

_____ 29. grabbed

_____ 30. shook

_____ 31. slapped

_____ 32. kicked

_____ 33. bit

_____ 34. hit with fist

_____ 35. hit with something

_____ 36. beat up

_____ 37. threatened with knife or gun

_____ 38. wounded by knife or gun

In the PAST YEAR, how often has a spouse or love partner done each of these behaviors to you? Use the following scale:

(1) never
(2) once or rarely
(3) a few times
(4) occasionally, quite a few times
(5) monthly

(6) more than monthly
(7) weekly or more

_____ 39. something was thrown at you
_____ 40. pushed

_____ 41. grabbed

_____ 42. shook

_____ 43. slapped

_____ 44. kicked

_____ 45. bit

_____ 46. hit with fist

_____ 47. hit with something

_____ 48. beat up

_____ 49. threatened with knife or gun

_____ 50. wounded by knife or gun

INFORMATION ABOUT YOUR CHILDHOOD FAMILY:

_____ 51. Before age 18, your parents

(1) were married to only each other
(2) separated for less than 6 months
(3) separated for more than 6 months
(4) divorced and neither remarried
(5) divorced and one parent remarried
(6) divorced and both parents remarried

_____ 52. In your biological family, were you the:

(1) oldest of the children
(2) middle of the children
(3) youngest of the children

_____ 53. In the family you lived with (including step or half-brothers or sisters), were you the:

(1) oldest of the children
(2) middle of the children
(3) youngest of the children

_____ 54. How often did your mother (or stepmother you lived with) drink alcohol?

(1) never
(2) not very often
(3) often
(4) very often

_____ 55. How often did your mother's mother or father drink?

(1) never
(2) not very often
(3) often
(4) very often

_____ 56. How many days a week did your mother (or step-mother you lived with) drink alcohol?

(1) not applicable
(2) 1 day
(3) 2-3 days
(4) 4-5 days
(5) 6-7 days

_____ 57. When she did drink, how much did your mother typically drink?

(1) not applicable
(2) 1 drink
(3) 2 drinks
(4) 3-6 drinks
(5) 7 or more drinks
(6) until drunk

_____ 58. How many years did your mother's heavy drinking (i.e., more than 14 drinks consumed per week) last?

(1) not applicable
(2) less than 1 year
(3) 1-2 years
(4) 3-4 years
(5) 5-6 years
(6) 7 or more years

_____ 59. How often did your father (or stepfather you lived with drink alcohol?

(1) never
(2) not very often

(3) often
(4) very often

_____ 60. How often did your father's mother or father drink?

(1) never
(2) not very often
(3) often
(4) very often

_____ 61. How many days a week did your father (or stepfather you lived with) drink alcohol?

(1) not applicable
(2) 1 day
(3) 2-3 days
(4) 4-5 days
(5) 6-7 days

_____ 62. When he did drink, how much did your father typically drink?

(1) not applicable
(2) 1 drink
(3) 2 drinks
(4) 3-6 drinks
(5) 7 or more drinks
(6) until drunk

_____ 63. How many years did your father's heavy drinking last?

(1) not applicable
(2) less than 1 year
(3) 1 to 2 years
(4) 3 to 4 years
(5) 5 to 6 years
(6) 7 or more years

_____ 64. How old were you when either parent began drinking heavily (i.e., more than 14 drinks consumed per week?

(1) not applicable
(2) under 6
(3) 7 to 8
(4) 9 to 10
(5) 11 to 12
(6) 13 or over

_____ 65. Did either parent quit drinking heavily (as defined above before you were 18?

(1) not applicable
(2) unsure
(3) yes, but one has continued drinking heavily
(4) yes, the heavy drinker(s) quit
(5) no

_____ 66. If either parent did quit drinking heavily (as defined above), how old were you at this time?

(1) not applicable
(2) under 6
(3) 7 to 8
(4) 9 to 10
(5) 11 to 12
(6) 13 or over

_____ 67. How often did a parent or step-parent touch your genitals or force you to touch their genitals prior to age 18?

(1) never
(2) once or rarely
(3) a few times
(4) occasionally, quite a few times
(5) monthly
(6) more than monthly
(7) weekly or more

_____ 68. Who touched your genitals or forced you to touch their genitals?

(1) no one
(2) father or step-father
(3) mother or step-mother
(4) brother or sister
(5) other (specify_______________________)

When you were growing up, how often did your father or step-father do each of the behaviors to you. Use the following scale:

(1) never
(2) once or rarely
(3) a few times
(4) occasionally, quite a few times
(5) monthly
(6) more than monthly
(7) weekly or more

_____ 69. something was thrown at you

_____ 70. pushed

_____ 71. grabbed

_____ 72. shook

_____ 73. slapped

_____ 74. kicked

_____ 75. bit

_____ 76. hit with fist

_____ 77. hit with something

_____ 78. beat up

_____ 79. threatened with a knife or gun

_____ 80. wounded with a knife or gun

When you were growing up, how often did your mother or step-mother do each of the behaviors to you? Use the following scale:

(1) never
(2) once or rarely
(3) a few times
(4) occasionally, quite a few times
(5) monthly
(6) more than monthly
(7) weekly or more

_____ 81. something was thrown at you

_____ 82. pushed

_____ 83. grabbed

_____ 84. shook

_____ 85. slapped

_____ 86. kicked

_____ 87. bit

_____ 88. hit with fist

_____ 89. hit with something

_____ 90. beat up

_____ 91. threatened with a knife or gun

_____ 92. wounded with a knife or gun

_____ 93. Have you ever planned suicide without attempting it?

(1) no
(2) yes

_____ 94. Have you ever attempted suicide?

(1) no
(2) yes

_____ 95. Have you ever been so depressed that it interfered with your life?

(1) no
(2) yes

Have you ever been a member of: 1 = no 2 = yes

_____ 96. A.A.

_____ 97. Al-Anon

_____ 98. Alateen

_____ 99. ACA group

Are you presently a member of: 1 = no 2 = yes

_____ 100. A.A.

_____ 101. Al-Anon

_____ 102. Alateen

_____ 103. ACA group

_____ 104. When you were growing up, did a parent or step-parent have a severe psychological or emotional problem which required treatment?

(1) no
(2) yes

____ 105. Was this parent or step-parent a heavy drinker (i.e., more than 14 drinks consumed per week)?

(1) no
(2) yes

APPENDIX C

Michigan Alcoholism Screening Test

Appendix C

Michigan Alcoholism Screening Test

Directions: Write the number from the scale that describes how you feel in regard to the following questions.

1 = No 2 = Yes

_____ 1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)

_____ 2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?

_____ 3. Does you wife, husband, a parent, or other near relative ever worry or complain about your drinking?

_____ 4. Can you stop drinking without a struggle after one or two drinks?

_____ 5. Do you ever feel guilty about your drinking?

_____ 6. Do friends or relatives think you are a normal drinker?

_____ 7. Are you able to stop drinking when you want to?

_____ 8. Have you ever attended a meeting of Alcoholics Anonymous?

_____ 9. Have you ever gotten into physical fights when drinking?

_____ 10. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?

_____ 11. Has your wife, husband, a parent, or other near relative ever gone to anyone for help about your drinking?

_____ 12. Have you ever lost friends or girl friends because of your drinking?

_____ 13. Have you ever gotten into trouble at work because of your drinking?

_____ 14. Have you ever lost a job because of drinking?

_____ 15. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?

_____ 16. Do you drink before noon fairly often?

_____ 17. Have you ever been told you have liver trouble? Cirrhosis?

_____ 18. After heavy drinking have you ever had delirium tremens (DTs) or severe shaking, or heard voices or seen things that weren't really there?

_____ 19. Have you ever gone to anyone for help about your drinking?

_____ 20. Have you ever been in a hospital because of drinking?

_____ 21. Have you ever been a patient in a psychiatric hospital where drinking was part of the problem that resulted in hospitalization?

_____ 22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?

_____ 23. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?

_____ 24. Have you ever been arrested, even for a few hours, because of other drunken behavior?

Appendix D

Children of Alcoholics Screening Test

Directions: Write the number from the scale that best describes your feelings, behavior, and experiences related to a parent or step-parent's alcohol use while you were growing up.

1 = No 2 = Yes

_____ 1. Have you ever thought that one of your parents had a drinking problem?

_____ 2. Have you ever lost sleep because of a parent's drinking?

_____ 3. Did you ever encourage one of your parents to quit drinking?

_____ 4. Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?

_____ 5. Did you ever argue or fight with a parent when he or she was drinking?

_____ 6. Did you ever threaten to run away from home because of a parent's drinking?

_____ 7. Has a parent ever yelled at or hit you or other family members when drinking?

_____ 8. Have you ever heard your parents fight when one of them was drunk?

APPENDIX D

Children of Alcoholics Screening Test

_____ 9. Did you ever protect another family member from a parent who was drinking?

_____ 10. Did you ever feel like hiding or emptying a parent's bottle of liquor?

_____ 11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?

_____ 12. Did you ever wish your parent would stop drinking?

_____ 13. Did you ever feel responsible for and guilty about a parent's drinking?

_____ 14. Did you ever fear that your parents would get divorced due to alcohol misuse?

_____ 15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?

_____ 16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?

_____ 17. Did you ever feel that you made a parent drink alcohol?

_____ 18. Have you ever felt that a problem drinking parent did not really love you?

_____ 19. Did you ever resent a parent`s drinking?

_____ 20. Have you ever worried about a parent's health because of his or her alcohol use?

_____ 21. Have you ever been blamed for a parent's drinking?

_____ 22. Did you ever think your father was an alcoholic?

_____ 23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?

_____ 24. Did a parent ever make promises to you that he or she did not keep because of drinking?

_____ 25. Did you ever think your mother was an alcoholic?

_____ 26. Did you ever wish you could talk to someone who could understand and help the alcohol related problems in your family?

_____ 27. Did you ever fight with your brothers and sisters about a parent's drinking?

_____ 28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?

_____ 29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?

_____ 30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

APPENDIX E

Miller Social Intimacy Scale

Appendix E

Miller Social Intimacy Scale

Directions: Describe the relationship with your closest friend, excluding your spouse or lover. Using the following scale, write the number that best describes this friendship.

Very Rarely				Some of the Time				Almost Always	
1	2	3	4	5	6	7	8	9	10

_____ 1. When you have leisure time how often do you choose to spend it with him/her alone?

_____ 2. How often do you keep very personal information to yourself and do not share it with him/her?

_____ 3. How often do you show him/her affection?

_____ 4. How often do you confide very personal information to him/her?

_____ 5. How often are you able to understand his/her feelings?

_____ 6. How often do you feel close to him/her?

Not Much				A Little				A Great Deal	
1	2	3	4	5	6	7	8	9	10

_____ 7. How much do you like to spend time alone with him/her?

_____ 8. How much do you feel like being encouraging and supportive to him/her when he/she is unhappy?

_____ 9. How close do you feel to him/her most of the time?

_____ 10. How important is it to you to listen to his/her very personal disclosures?

_____ 11. How satisfying is your relationship with him/her?

_____ 12. How affectionate do you feel towards him/her?

_____ 13. How important is it to you that he/she understands your feelings?

_____ 14. How much damage is caused by a typical disagreement in your relationship with him/her?

_____ 15. How important is it to you that he/she be encouraging and supportive to you when you are unhappy?

_____ 16. How important is it to you that he/she show you affection?

_____ 17. How important is your relationship with him/her in your life?

APPENDIX F

Waring Intimacy Questionnaire (Modified)

Appendix F

Waring Intimacy Questionnaire (Modified)

Directions: The next set of questions ask you to describe an intimate love/marriage relationship. Think of your most current relationship and write the number from the scale below that most accurately describes the way you feel.

1 = False   2 = True

_____ 1. Differences of opinion never lead to verbal abuse in our relationship.

_____ 2. I am at my best when we are together.

_____ 3. Without my relationship my life would lack meaning.

_____ 4. I ask my partner for the things that really turn me on.

_____ 5. I often feel insecure in social situations.

_____ 6. I wish my partner enjoyed more the activities I enjoy.

_____ 7. I enjoy spending time with the parents of my partner.

_____ 8. If there is one thing that my partner and I are good at, it's talking about our feelings to each other.

_____ 9. I don't think any couple live together with greater harmony than my partner and I.

_____ 10. Our differences of opinion lead to shouting matches.

_____ 11. I always kiss my partner good-bye.

_____ 12. Our relationship satisfaction is more important than career decisions.

_____ 13. Sometimes sex seems more like work than play to me.

_____ 14. Compared to other people that I know, I lack self-esteem.

_____ 15. We seem to work out how to share the chores at our house.

_____ 16. Whenever we visit my partner`s parents, I feel awkward because I have nothing to talk about.

_____ 17. Often I only pretend to listen when my partner talks.

_____ 18. I have some needs that are not being met by my relationship.

_____ 19. Discussing problems with my partner seldom leads to argument.

_____ 20. I feel that there is a distance between my partner and me.

_____ 21. I value our relationship above all else.

_____ 22. I think that the importance of sex is highly over-rated in relationships.

_____ 23. I have a strong sense of who I am.

_____ 24. My partner and I share the same philosophy of life.

_____ 25. My partner's parents' advice is often appreciated and welcome.

_____ 26. I prefer to keep my personal thoughts to myself.

_____ 27. My partner has all of the qualities I have always wanted in a mate.

_____ 28. Old wounds are always reopened when we have differences of opinion.

_____ 29. Despite having this relationship, I often feel lonely.

_____ 30. Even in marriage everyone has to look out for themselves.

_____ 31. Sex with my partner has never been as exciting as in my fantasies.

_____ 32. I really don't think that I am very good at most things.

_____ 33. My partner frequently helps when I am doing an unpleasant chore.

_____ 34. When all the relatives get together, I feel awkward and uncomfortable.

_____ 35. I enjoy sharing my feelings with my partner.

_____ 36. My relationship is not a perfect success.

_____ 37. Yelling and screaming play no part in our attempts to resolve our conflict.

_____ 38. I often tell my partner I love him/her.

_____ 39. When one gets married, it's forever.

_____ 40. Our personal closeness is the major determinant of how satisfactory our sexual relationship is.

_____ 41. I feel that I am the person I would like to be.

_____ 42. My partner and I share the same goals in life.

_____ 43. We are lucky to have relatives to whom we can go for help.

_____ 44. I always try to give my partner my full attention when he/she is talking to me.

_____ 45. My relationship could be happier than it is.

_____ 46. When there is a difference of opinion, we tend to negotiate a resolution rather than fight.

_____ 47. We always do something special on our anniversary.

_____ 48. In our relationship we try to live by the principle "all for one and one for all."

_____ 49. Our sexual relationship decreases my frustrations.

_____ 50. I am embarrassed when I am the center of attention.

_____ 51. My partner and I like to do things for self-improvement together.

_____ 52. It is a real effort for me to try and get along with my partner's parents.

_____ 53. I often read the newspaper or watch T.V. when my partner is trying to talk to me.

_____ 54. I have never regretted my relationship, not even for a moment.

_____ 55. I never hit below the belt when we argue.

_____ 56. I will never use my love for my partner as a way to hurt him/her.

_____ 57. I am not prepared to put up with my partner's annoying habits.

_____ 58. My relationship could not possibly be happy without a satisfactory sexual life.

_____ 59. When I compare myself to most other people, I like myself.

_____ 60. My partner and I have worked out the male-female household roles to both our satisfaction.

_____ 61. I feel that my parents interfere in our relationship.

_____ 62. I would lie to my partner if I thought it would keep the peace.

_____ 63. I don't think that anyone could possibly be happier than my partner and I when we are with one another.

_____ 64. When we have differences of opinion, my partner never walks out of the house.

_____ 65. I am often unfriendly towards my partner.

_____ 66. I don't really care whether my partner supports me or not, just as long as he/she lets me lead my own life.

_____ 67. I always seem to be in the mood for sex when my partner is.

_____ 68. I am sometimes afraid that people will see a part of me that I am not aware of.

_____ 69. My partner did not try to make me change after we started going together/got married.

_____ 70. Family reunions are one highlight of our social life.

_____ 71. My personal secrets would hurt my partner.

_____ 72. There are times when I do not feel a great deal of love and affection for my partner.

_____ 73. During our arguments I never try to depreciate my partner's point of view.

_____ 74. Love is being able to say you're sorry.

_____ 75. I would be willing to compromise my beliefs to make our relationship better.

_____ 76. My partner rarely turns away from my sexual advances.

_____ 77. There are many aspects of my personality that I do not like.

_____ 78. I found it difficult to make changes in my lifestyle after we were going together/ married.

_____ 79. Our children interfere with the time we have together.

_____ 80. I can say anything I want to my partner.

_____ 81. There are some things about my partner that I do not like.

_____ 82. Sometimes I think all we ever do is argue.

_____ 83. Buying gifts shows my affection for my partner.

_____ 84. Most of the time at home I feel like I am just killing time.

_____ 85. Our sexual relationship influences our level of closeness.

_____ 86. Other people usually have more to offer in a conversation than I do.

_____ 87. My partner`s sociability adds a positive aspect to our relationship.

_____ 88. Our relationship would be better if our parents didn't meddle in our problems.

_____ 89. I always take time to listen to my partner.

_____ 90. Every new thing I have learned about my partner has pleased me.

APPENDIX G

Family-of-Origin Scale

Appendix G

Family-of-Origin Scale

Directions: The following questions ask you to describe your family of origin. This is the family with which you spent most or all of your childhood years. This scale is designed to help you recall how your family of origin functioned. Since each family is unique, there are no right or wrong choices in this scale. Please respond as honestly as you can as you write the number that corresponds to how well that statement describes your *family of origin as you remember it*.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

_____ 1. In my family, it was normal to show both positive and negative feelings.

_____ 2. The atmosphere in my family usually was unpleasant.

_____ 3. In my family, we encouraged one another to develop new friendships.

_____ 4. Differences of opinion in my family were discouraged.

_____ 5. People in my family often made excuses for their mistakes.

_____ 6. My parents encouraged family members to listen to one another.

_____ 7. Conflicts in my family never got resolved.

_____ 8. My family taught me that people were basically good.

_____ 9. I found it difficult to understand what other family members said and how they felt.

_____ 10. We talked about our sadness when a relative or family friend died.

_____ 11. My parents openly admitted it when they were wrong.

_____ 12. In my family, I expressed just about any feeling I had.

_____ 13. Resolving conflicts in my family was a very stressful experience.

_____ 14. My family was receptive to the different ways various family members viewed life.

_____ 15. My parents encouraged me to express my views openly.

_____ 16. I often had to guess at what other family members thought or how they felt.

_____ 17. My attitudes and my feelings frequently were ignored or criticized in my family.

_____ 18. My family members rarely expressed responsibility for their actions.

_____ 19. In my family, I felt free to express my own opinions.

_____ 20. We never talked about our grief when a relative or family friend died.

_____ 21. Sometimes in my family, I did not have to say anything, but I felt understood.

_____ 22. The atmosphere in my family was cold and negative.

_____ 23. The members of my family were not very receptive to one another's views.

_____ 24. I found it easy to understand what other family members said and how they felt.

_____ 25. If a family friend moved away, we never discussed our feelings of sadness.

_____ 26. In my family, I learned to be suspicious of others.

_____ 27. In my family, I felt that I could talk things out and settle conflicts.

_____ 28. I found it difficult to express my own opinions in my family.

_____ 29. Mealtimes in my home usually were friendly and pleasant.

_____ 30. In my family, no one cared about the feelings of other family members.

_____ 31. We usually were able to work out conflicts in my family.

_____ 32. In my family, certain feelings were not allowed to be expressed.

_____ 33. My family believed that people usually took advantage of you.

_____ 34. I found it easy in my family to express what I thought and how I felt.

_____ 35. My family members usually were sensitive to one another's feelings.

_____ 36. When someone important to us moved away, our family discussed our feelings of loss.

_____ 37. My parents discouraged us from expressing views different from theirs.

_____ 38. In my family, people took responsibility for what they did.

_____ 39. My family had an unwritten rule: Don't express your feelings.

_____ 40. I remember my family as being warm and supportive.

APPENDIX H

Consent Form

Appendix H

Consent Form

You are invited to participate in a research project on your adult relationships with a close friend and an intimate love partner. You have been identified as a possible participant because you are an adult over the age of 21 and have probably experienced various relationships. Therefore, your participation in this study will help provide an opportunity to think about yourself and your relationships in some new and interesting ways, perhaps discovering more about your own perceptions, feelings, and experiences.

The results of this study will help in understanding how various factors from current and childhood experiences relate to adult relationships. Specifically, the study may provide insight into relationships of adults who grew up with parents who drink compared to people whose parents did not drink. Each person's experiences and perceptions are unique, and I appreciate your sharing yours.

This study is important because research like this has not been done before. Participation is both voluntary and confidential, with individual answers being used for statistical purposes only. Everyone's individual answers will be grouped with those of others. No information about

you will be disclosed to anyone, and your anonymity will be preserved even after the study.

The accompanying packet contains six brief questionnaires about your current relationships, your family of origin, and personal and parental drinking patterns. It will take approximately 1 hour to complete all of the questions. Each section varies in length and type of question asked. If possible, try to complete all of the questions in one sitting and at a time when you are unlikely to be disturbed. When you have completed all six questionnaires, please return them along with this consent form in the enclosed, self-addressed envelope. Should you begin the study and change your mind about participating, you may withdraw at any time.

If you have any questions or desire to know the results of the project, please feel free to contact me at (phone number provided).

Thank you for your help,

Karen Settle, Doctoral Candidate

North Texas State University

I HEREBY GIVE CONSENT to Karen Settle to perform or supervise the following investigational procedure: gathering information regarding friendships, love relationships, family of origin, and information about self.

I have seen a clear explanation and understand the nature and procedures of the study and understand the possibility of discomforts which may arise. I have seen a clear explanation and understand the benefits to be expected. I understand that the procedure to be performed is investigational and that I may withdraw my consent at any time. With my understanding of this, having received this information and satisfactory answers to the questions I have asked, I voluntarily consent to the procedure described above.

Date:______________ ____________________________

Signature of Participant

If you wish to receive a copy of the results, please check the line and write in your address.

___ Yes, I would like a copy of the results.

Address: ____

APPENDIX I

Tables

Table 1

Education and Income

	Comp-NT % (n)	Comp-T % (n)	ACA-T % (n)	ACA-NT % (n)
Education[a]				
H. S. or less	10.4 (8)	2.1 (1)	11.9 (7)	5.7 (3)
Some college	10.4 (8)	27.1 (13)	30.5 (18)	18.9 (10)
College degree	40.3 (31)	47.9 (23)	37.3 (22)	58.5 (31)
Grad. degree	39.0 (30)	22.9 (11)	20.3 (12)	17.0 (9)
Income[b]				
Less than $10,000	1.3 (1)	4.2 (2)	6.8 (4)	5.8 (3)
10-20,000	6.6 (5)	16.7 (8)	11.9 (7)	3.8 (2)
20,000-35,000	21.1 (16)	10.4 (5)	35.6 (21)	23.1 (12)
35,000-50,000	17.1 (13)	16.7 (8)	25.4 (15)	21.2 (11)
50,000-75,000	26.3 (20)	35.4 (17)	11.9 (7)	26.9 (14)
More than $75,000	27.6 (21)	16.7 (8)	8.5 (5)	19.2 (10)

[a] Chi-square (9) = 22.72, $p < .01$

[b] Chi-square (15) = 30.15, $p < .01$

Table 2

Parents' Marital Status

	Comp-NT		Comp-T		ACA-T		ACA-NT	
	%	(n)	%	(n)	%	(n)	%	(n)
Married	97.4	(75)	91.3	(42)	74.6	(44)	64.2	(34)
Separated	0.0		2.2	(1)	1.7	(1)	11.3	(6)
Not remarried	0.0		2.2	(1)	3.4	(2)	3.8	(2)
Remarried	2.6	(2)	4.3	(2)	20.4	(12)	20.7	(11)

Table 3

Interpersonal Relationships

	Comp-NT % (n)	Comp-T % (n)	ACA-T % (n)	ACA-NT % (n)
Marital status[a]				
Single	27.6 (21)	22.9 (11)	22.0 (13)	28.3 (15)
Married	69.7 (53)	58.3 (28)	42.4 (25)	58.5 (31)
Sep/div	2.6 (2)	18.8 (9)	35.6 (21)	13.2 (7)
Love relationship[b]				
Dating	11.8 (8)	20.9 (9)	30.8 (16)	29.2 (14)
Cohabit or married	88.2 (60)	79.1 (34)	69.2 (36)	70.8 (34)
Sex of friend				
Same	68.4 (52)	72.9 (35)	71.2 (42)	78.8 (41)
Opposite	31.6 (24)	27.1 (13)	28.8 (17)	21.2 (11)
Sex of loved one				
Same	7.8 (6)	16.7 (8)	3.4 (2)	9.4 (5)
Opposite	92.2 (71)	83.3 (40)	96.6 (57)	90.6 (48)

[a] chi-square (6) = 27.35, $p < .001$

[b] chi-square (3) = 7.87, $p < .05$

Table 4

Friendship Intimacy (MSIS)

	Comp-NT		Comp-T		ACA-T		ACA-NT		F^a
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	(3,230)
Total	116.19	27.16	120.81	18.04	122.95	21.85	119.78	26.42	
Frequency	37.19	10.56	37.85	7.85	41.10	8.76	38.22	10.11	2.01
Intensity	79.00	17.51	82.96	11.36	81.84	13.92	81.57	17.23	0.76

[a] p = n.s., Univariate Analysis by group

Table 5

Love Intimacy (WIQ)

	Comp-NT		Comp-T		ACA-T		ACA-NT		F^a
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	(3,230)
Total	54.81	4.55	54.35	5.91	47.72	7.27	52.45	6.36	
Conflict Resolution	17.34	2.51	16.65	2.66	15.35	3.02	16.49	2.68	5.89*
Affection	17.64	2.07	17.17	2.11	15.84	2.19	17.17	2.33	8.03*
Cohesion	17.35	2.08	16.67	2.22	15.00	2.23	16.57	2.32	13.58*
Sexuality	15.84	2.69	16.08	2.14	15.32	2.13	16.09	2.90	1.29
Identity	17.25	2.17	17.19	2.52	14.39	2.66	16.32	2.61	17.26*
Compatibility	17.45	2.33	16.63	2.37	14.96	3.03	16.70	2.87	10.06*
Autonomy	17.35	2.45	16.27	3.08	14.39	3.65	16.29	3.18	10.27*
Expressiveness	17.26	2.61	17.48	2.35	15.56	3.00	17.28	2.20	6.91*
Social Desirability	14.16	3.24	12.56	2.75	11.49	2.28	13.51	3.21	10.00*

* $p < .001$

a Univariate Analysis by group

Table 6

Family of Origin Health (FOS)

	Comp-NT		Comp-T		ACA-T		ACA-NT		
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	F^a
Total	148.22	23.78	130.65	36.34	79.08	24.71	117.57	34.56	
Clarity of Expression	14.39	2.58	12.83	3.82	8.05	3.06	11.36	3.59	42.79*
Responsibility	14.52	2.55	12.74	3.37	7.74	3.02	10.91	3.74	51.82*
Respect	14.21	3.26	12.42	4.29	7.05	2.86	11.15	4.31	42.84*
Openness	14.34	2.86	12.59	3.79	7.75	2.89	11.30	3.78	45.63*
Separation	14.25	3.39	13.52	3.82	8.76	3.49	12.88	3.98	28.27*
Range of Feelings	14.21	3.40	12.66	4.40	6.68	3.04	11.77	4.04	46.37*
Mood and Tone	16.87	2.92	15.66	3.71	8.29	3.66	12.75	4.43	66.14*
Conflict Resolution	14.42	2.56	12.25	4.10	6.78	2.66	10.15	3.76	64.00*
Empathy	15.26	2.69	13.75	3.91	8.22	3.36	12.43	4.04	47.40*
Trust	15.77	2.87	14.15	3.88	10.05	3.48	13.09	3.83	29.84*
Autonomy	71.70	12.12	63.06	17.83	39.20	12.06	57.36	16.88	57.36*
Intimacy	76.52	12.28	67.58	19.26	39.88	13.50	60.21	18.34	63.76*

[a] df for 10 dimensions = 3, 219; df for Autonomy and Intimacy = 1, 223, Univariate Analysis by group

* $p < .001$

Table 7

Depression and Suicide

	Comp-NT % (n)	Comp-T % (n)	ACA-T % (n)	ACA-NT % (n)
Depression[a]	28.6 (22)	68.8 (33)	98.3 (58)	51.9 (27)
Planned Suicide[b]	10.4 (8)	27.1 (13)	55.9 (33)	17.3 (9)
Attempted Suicide[c]	0.0	8.3 (4)	15.3 (9)	5.8 (3)

[a] chi-square (3) = 70.28, $p < .001$

[b] chi-square (3) = 38.59, $p < .001$

[c] chi-square (3) = 12.57, $p < .01$

Table 8

Physical and Sexual Abuse

	Comp-NT		Comp-T		ACA-T		ACA-NT	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Abused by								
Partner[a]	13.52	2.72	14.47	3.34	17.37	9.38	14.25	5.98
Mother[b]	14.65	3.27	14.98	5.31	20.95	12.69	15.65	9.15
Father[c]	14.13	3.65	14.43	3.28	20.55	11.68	18.71	8.18
Sexual[d]	1.00	.00	1.23	.99	1.83	1.68	1.04	.19

[a] $F(3, 225) = 5.98$, $p < .001$

[b] $F(3, 225) = 9.47$, $p < .001$

[c] $F(3, 225) = 9.50$, $p < .001$

[d] $F(3, 225) = 9.89$, $p < .001$

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