ATTRIBUTIONAL STYLE OF ADULT CHILDREN OF ALCOHOLICS

THESIS

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BY

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115 undergraduate students were surveyed to see if attributional style would be different for individuals with alcoholic parents, depressed parents, or neither factor. Subjects were sorted into the three groups based on their responses to a family history questionnaire. Each subject filled out two attributional style questionnaires, the Attributional Style Questionnaire (ASQ) and the Attributional Style Assessment Test (ASAT-II). The three groups did not differ on attributional style for interpersonal, noninterpersonal, or general situations. Within the adult children of alcoholics group, subjects reported that their successes in interpersonal situations were due to their strategy and effort, rather than ability, moreso than for noninterpersonal successes.
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ATTRIBUTIONAL STYLE OF ADULT CHILDREN OF ALCOHOLICS

For years, research on the pathogenesis and treatment of alcoholism focused on the alcoholic individual. More recently, research into the etiology of alcoholism has shown that there is a predisposition for individuals with alcoholic relatives to develop problematic drinking behavior (Black, 1981a; El-Guebaly & Offord, 1977). The focus is now broadening to include the effects of the alcoholic's drinking behavior and associated psychopathology on members of his family.

Alcoholism is currently conceptualized as a family disease (Ackerman, 1983). Children raised in the alcoholic environment come from dysfunctional families. Clinical reports of adult children of alcoholics (ACOAs) suggest that certain patterns of behavior, emotional problems, and interpersonal difficulties characterize this group (Black, 1981a; Seixas & Youcha, 1985; Woititz, 1983, 1985).

Few attributes of ACOAs listed in the literature have been experimentally studied. Since estimates show there are between 28 and 34 million individuals in the United States who were raised or are being raised by at least one alcoholic parent (Black, 1981b), it seems likely that mental
health professionals will be treating individuals from dysfunctional alcoholic families in increasing numbers. Although there are an estimated 20 million children currently living with at least one alcoholic parent, knowledge of the special needs and problems of this group is limited (Scavnicky-Mylant, 1984). Therefore, it seems important to have an understanding of any common characteristics of children of alcoholics.

**Characteristics of Children of Alcoholics**

There is a great deal of current interest in the traits of individuals who grew up with an alcoholic parent. Morehouse and Scola (1986) report that children of alcoholics can be differentiated from children of non-alcoholics in many areas. They tend to have a poor self-concept, difficulty in trusting, a more internal locus of control, and a greater likelihood of fighting with peers.

Ackerman (1983) discusses the feelings of powerlessness and inferiority that children of alcoholics have. He reports that the sense of powerlessness can be pervasive, extending to areas which are not directly affected by the alcoholic's drinking. Ackerman states that a primary goal of therapy with these individuals is teaching them to establish good, positive relationships with others. He views their interpersonal deficit as being a result of their experiences with family relationships, and he believes it is a significant detrimental effect of parental alcoholism.
Cermak (1982) reports that the main issue for ACOAs in a clinical population is control. Members of group therapy who are ACOAs report fears that they have taken too much control during sessions, or conversely that they have been too passive. Cermak (1982) notes that the issue of control is predominant in his experience with this population. Other issues which he has encountered frequently with ACOAs include having difficulty trusting others and oneself; lacking awareness or attention to personal, emotional needs; feeling responsible for situations, and for the feelings of others; and believing that feelings are bad, because they can have a negative affect on others.

Black (1981a) reports that ACOAs are likely to be alcoholics themselves, to marry alcoholics or other high-risk individuals, and to develop chronic patterns of emotional instability. She identifies the major areas of difficulty for ACOAs as intimacy, control, responsibility, identification and expression of feelings, and trust. These areas can be viewed in light of research on the alcoholic family and the alcoholic personality, as well as clinical reports describing children in the alcoholic family system.

Childhood disorders and parental alcoholism. Researchers have investigated the possible relationship between parental alcoholism and dysfunctions in the child. El-Guebaly and Offord (1977) reviewed the literature and discovered that maternal drinking during pregnancy can have
a physiological effect, the Fetal Alcohol Syndrome. Research on school age children of alcoholics indicated that they were likely to be hyperactive or to exhibit passive-aggressive behavior. Adolescents showed a greater tendency toward antisocial behavior. They found that children of alcoholics are more likely to develop problems with drinking. In summary, El-Guebaly and Offord (1977) stated that children of alcoholics are at a greater risk for serious emotional and psychiatric disturbances, including sociopathy, hysterical behavior, and alcoholism.

Anderson and Quast (1983) found references in the literature to a correlation between parental alcoholism and psychopathological factors, including antisocial behavior, excessive dependency, pseudomaturity, interpersonal difficulties, impaired self-concept, suicidal behavior, parent role reversals, and mood changes. They administered the Personality Inventory for Children (PIC) to 50 children, aged six to twelve, of parents in an inpatient alcohol treatment center. They found that their sample showed significant elevations in scores on the Adjustment, Family, and Anxiety factors, with elevations approaching significance on the Depression and Delinquency factors.

Haberman (1966) found that children of alcoholics had a greater incidence of physical and psychological symptoms, and a higher incidence of contact with correctional agencies or mental health facilities, than did children of parents.
with chronic stomach trouble or no apparent pathology. Chafetz, Blane, and Hill (1971) surveyed reports on 100 children of alcoholics and 100 children of non-alcoholics in a child guidance clinic. They found that the children of alcoholics showed a greater likelihood of having difficulties in school and encounters with law enforcement. Jacob and Leonard (1986) found a correlation between parental alcoholism and poor psychosocial functioning, hyperactivity, and behavioral problems in their children.

Deutsch (1982) reports that problems associated with parental alcoholism include depression, somatic complaints, social aggression, emotional detachment and isolation, and suicide. He characterizes the interpersonal relationships of the ACOA as dysfunctional because the effects of inappropriate modeling by the parents, and by poor sibling relationships, result in a lack of appropriate skills and behaviors to be used in relationships outside the family. Lawson, Peterson, and Lawson (1983) report that children in alcoholic homes experience neglect, confusion, and inconsistent discipline, and that they often exhibit difficulties such as acting out aggressively, showing depressive tendencies, being socially isolated, fearing abandonment, lacking self-confidence, fearing the future, and having problems with the spectrum of interpersonal relationships.
The alcoholic personality. Researchers have looked at the possibility that children of alcoholic parents develop an "alcoholic personality" which predisposes them to react to stress by consuming alcohol, rather than by attempting to find an effective way to deal with problems. Weissman and Meyers (1980) looked at disorders correlated with alcoholism in a population of 510 subjects as part of a longitudinal study of a New England community. They concluded that alcoholics have high rates of other psychiatric disorders, particularly depression.

Aronson and Gilbert (1963) developed a questionnaire to assess six traits which they believed were a major part of the alcoholic personality as described in the literature up to that time. They defined that particular personality as acquisitive, displaying inappropriate emotional expression, dependent, manipulative, evading unpleasantness, and experiencing self-dissatisfaction. When they compared 41 teen-age sons of alcoholic fathers to a comparison group composed of three classmates for each subject, they found that all six traits were more predominate in the sons of alcoholics than in the control group. Although no data were given for reliability of the instrument used, and although the validity of the instrument was merely assumed due to the apparent face validity of the individual items, the findings did suggest the possibility that children with alcoholic parents tend to develop more of the traits classically associated with alcoholics than did children without
alcoholic parents.

**The alcoholic family system.** Recently there has been an increase in the amount of popular literature, including guide books, written for therapists and members of alcoholic families which address the issue of parental alcoholism. The authors report certain characteristics of the alcoholic home. Edwards and Zaner (1985) conclude that these characteristics result in a family system which produces stress for the children as a result of inconsistency, unpredictability, and role confusion. Consequently, they state that individuals raised in these home have experienced a serious lack of affection and attention from their parents, and they have problems with denial and trust (Edwards & Zaner, 1985).

Black (1981b) summarizes the alcoholic family in three rules of behavior. These rules tell the child not to talk, not to trust, and not to feel. As a result of this restrictive environment, the child must assume one of a variety of roles in order to survive (Black, 1979; Wegscheider, 1981). Though the behaviors identifying these roles vary widely, they are all perceived to be limiting and maladaptive in interactions outside the home.

Woititz (1983, 1985) offers a list of generalized characteristics of ACOAs, including a tendency to be self-critical, a need to remain serious at the exclusion of enjoying oneself, difficulty with intimate relationships, overreaction to change over which one has no control, and
constantly seeking approval and affirmation. Woititz characterizes the home life of the child of an alcoholic parent as uncertain, volatile, full of deception, frightening, confusing, and extremely inconsistent (Woititz, 1983). The inconsistency comes from unpredictable reactions by the parents to the child's behaviors. Also, since the alcoholic, and often the non-alcoholic spouse, have difficulty expressing affection or giving appropriate attention to the child, the child has little or no control over the provision of these basic needs.

Seixas and Youcha (1985) describe life in the alcoholic home in similar terms, discussing unfulfilled promises and commitments by the alcoholic parent. They report, as does Woititz (1983), that many ACOAs feel responsible for the alcoholic's drinking. In some instances, the child has been told he is to blame, while sometimes he merely comes to this conclusion on his own. A child being raised in an alcoholic home may be confused because his experiences are invalidated by the family's need to maintain a deceptive image. Thus, "... children of alcoholics are not sure of what they see, what they hear, and what they feel. In other words, they don't believe their own perceptions" (Seixas & Youcha, 1985, p. 9).

The confusion is confounded when the child transfers the blame from the parent to himself. The child will take blame for events which are beyond his control, beginning with the
family's problems, and sometimes generalizing to occurrences such as other people's mistakes, which the child may feel obligated to prevent. Seixas and Youcha (1985) also report that ACOAs doubt their ability to act effectively. They come to perceive themselves as incompetent in many of the areas of daily life, and they come to expect disappointment in their relationships.

The ACOA is repeatedly described in certain ways: she experiences a lack of control over aversive events; she perceives she has a poor ability to bring about positive outcomes; she feels responsible for situations which are beyond her control; and she blames herself for the difficulties she experiences in relationships. In order to understand the effects of the alcoholic home on children raised therein, with respect to their perception of causality, control, and responsibility, it is helpful to review the principal components of theories regarding how attribution affects expectations and emotions.

**Attribution Theory**

Attributional research generally attempts to categorize perceived causes according to different dimensions. Heider (1958) introduced the first of these dimensions, the internal-external factor (which he addressed as personal and impersonal causes). Heider (1958) discussed other factors which affect outcomes, including task difficulty, luck,
ability, effort, and degree of control over the situation. Although he did not offer them as dichotomous dimensions, Heider did report that these factors are perceived as having an effect on outcomes.

Rotter (1966), taking the perspective that reinforcement following a behavior produces an increased expectancy that reinforcement will follow that behavior in the future, notes that, "... depending upon the individual's history of reinforcement, individuals would differ in the degree to which they attributed reinforcement to their own actions" (p. 2). Rotter (1966) compiled evidence that there is a difference in expectancy which is determined by causal ascription to internal or to external factors. Success or failure attributed internally (to skill) produces expectations of similar outcomes. External ascriptions of outcome (such as to chance) produce expectations of different outcomes; that is, that success will occur after a failure, and that failure will occur after success.

Rotter (1966) notes, also, that individuals in situations with 100% reinforcement, and attribution of success to skill, actually take longer to reach extinction than those on a 50% reinforcement schedule. This finding, which contradicts a well-established law in learning theory, is used as evidence by Rotter that the internal-external dimension of causality greatly affects expectancy. Finally, Rotter (1966) reports that individuals who tend to attribute success more
internally tend to be alert to environmental contingencies, to exercise the control they have over the environment, and to be less likely to be influenced by external attempts to alter their opinions.

Weiner (1985) summarizes the development of dimensional analysis of attributions. The three categories which he perceives as most supported by the research are internal-external, degree of stability, and degree of controllability. He notes that other categories have been offered, notably intentionality (Weiner, 1979) and globality (Abramson, Seligman, & Teasdale, 1978). Though it is widely accepted that these contrived dimensions may not include the full range of possible characteristics of causes (Weiner, 1985), still these are the most frequently encountered in research with a first set of individuals freely naming causes, while another group categorizes them.

Attribution studies frequently address changes in expectancy following an attribution for success or failure. Attributions to stable causes (such as skill or task difficulty) tend to produce expectations of similar outcomes, while attributions to unstable causes (such as effort or luck) tend to produce expectations of dissimilar outcomes. McMahan (1973) ran a study with individuals in sixth grade, tenth grade, and college. The results indicate that disconfirmation of an expectancy results in attributions of outcome to effort and luck. Specifically, a low level of expectancy followed by
a positive outcome is likely to yield attribution of the success to increased effort, or chance, and does not produce an increase in future expectancy. Kennelly, Dietz, and Benson (1985) demonstrated that there is a similarity between outcome and the attribution of causality. When rate of success was manipulated and held at a high frequency, attribution for failure, which became infrequent, was to an infrequent (unstable) cause. This suggests that outcomes which consistently occur at a high rate are more likely to be attributed to a stable cause, while outcomes which consistently occur at a low rate are more likely to be attributed to an unstable cause.

Weiner (1974a; 1974b) differentiates between changes in expectancy and affective responses following an outcome. Frieze and Weiner (1971) demonstrated that locus of control is not a factor in expectancy shifts, while perception of stability is. Weiner (1974b) notes that an internal attribution of failure, such as low ability, results in the same decreased expectancy of success as an external attribution of failure, such as task difficulty. He points out, however, that in the former case, affect will tend to be negative, while in the latter there is a lesser chance of negative affect. Weiner (1974a) concludes "... that internal versus external perceptions of causation result in differential affective responses, while stable versus unstable perceptions of causality produce differential expectancy
shifts" (p. 5).

Weiner (1974a) explored the association between the internal-external dimension and the stable-unstable dimension. He notes that an outcome with low consensus and low distinctiveness results in a personal, internal attribution. Specifically, "...personal failure has low distinctiveness and low consensus ("I always fail, but no one else does"), leading to an internal attribution" (p. 19). Thus, the stability of the event, which produces an expectancy of long-term similarity, leads to an internal attribution. Following the previous pattern, the internal attribution for the cycle of failure produces a negative affective response.

Weiner, Russell, and Lerman (1978) found partially confirming evidence of this pattern when they discovered that individuals who tend to give stable and internal attributions for failure are more likely to report affective states of aimlessness, depression, helplessness, hopelessness, and resignation. Anderson, Horowitz, and French (1983) compared depressed college students with nondepressed college students and found that the depressed individuals were more likely to attribute interpersonal failure to internal, stable traits. They were also more likely to attribute success externally. This pattern is predicted by the reformulated theory of learned helplessness (Abramson, Seligman, & Teasdale, 1978; Seligman, Abramson, Semmel, & von Baeyer, 1979), to be discussed later.
Weiner (1986) offers an attributional theory of emotions. He points out that affective responses to outcomes are, to a great extent, determined by the causal ascription. Weiner's (1986) theory of emotion, encapsulated, states that, "Emotions are presumed to have 1) positive or negative qualities of 2) a certain intensity that 3) frequently are preceded by an appraisal of a situation and 4) give rise to a variety of actions" (p. 119).

When discussing the nature of various emotions, Weiner (1986) concludes that attribution of causality influences the perceptual factor of emotion. As an example, he offers a distinction between guilt and shame, both of which are presumed to follow personal failure or rejection. The difference, according to his schemata, is that shame is attributed to an uncontrollable cause, while guilt is attributed to a controllable cause.

Anderson (1983b) studied the differential effects of manipulating attribution of failure in groups categorized by attributional style. He found that producing a strategy/effect attribution in individuals with a tendency to attribute failure to personal traits produced a positive expectancy shift. With an ability/trait manipulated attribution, and with no manipulation of attribution, individuals with personal trait attributions for failure maintained low expectancies following failure. The results led Anderson to conclude that the differences in attributional predisposition were not
necessarily related to a realistic evaluation of ability.

The long-term effect of repeated causal attributions is summed up by Weiner (1986). He states:

Low expectancy of success evokes feelings of hopelessness and still further withdrawal and reluctance to engage in appropriate instrumental activities, such as taking other courses or asking out other people for dates. On the other hand, occasional success, when experienced, will tend to be ascribed to unstable causes (e.g. good luck). In this manner, expectancy of success is minimally, if at all, increased and could even decrease. This pattern of attributions therefore maintains a maladaptive belief system and the behavior fostered by such beliefs.

(pp. 231-232)

**Learned Helplessness**

White (1959) introduced the concept of competence to the field of learning theories. According to White, there is a tendency for organisms to explore, to act on, and to master the environment to the best of their ability. Learned helplessness can be perceived as the result of interference in this natural process.

Maier and Seligman (1976) provide an overview of studies with nonhuman animals which show a disruption in behavior as a result of experiencing non-contingent aversive stimuli. Incorporating this data and data from human studies, Seligman
has worked from a combined experimental and theoretical framework to posit the theory of learned helplessness (as presented in Maier & Seligman, 1976; Maier, Seligman, & Solomon, 1969; Seligman, 1975; Seligman, Maier, & Solomon, 1971). This theory is purported to be the only hypothesis "... integrating the animal and human data" (Abramson, Seligman, & Teasdale, 1978, P. 50) concerning the effects of experiencing uncontrollable aversive events. In summary, the theory states that experiencing non-contingent, or uncontrollable, aversive situations over a period of time results in observable deficits in subsequent behavior in three areas: cognition, motivation, and emotion (Abramson, Seligman, & Teasdale, 1978).

The cognitive aspect of learned helplessness involves the anticipation that future aversive events will be uncontrollable. In addition to this expectation, an organism, human or other, that experiences uncontrollable aversive events will be less likely to perceive contingencies that exist between its behavior and some other event. The motivational aspect refers to the fact that an individual or an organism in a state of learned helplessness, in the face of an aversive stimulus, is less likely to initiate or to persist in a behavior to alter the situation, and is less likely to try alternate behaviors when one behavior fails to alter the situation; than is an individual or organism which is not in a state of learned helplessness. Additionally, organisms in a
state of learned helplessness respond less vigorously and less frequently when placed in a situation where an appetitive reward follows some behavior. The emotional deficit is described as the blunt or flat affect seen in human depressed subjects, which is believed to be partially due to the decrease in motivation.

Abramson, Seligman, and Teasdale (1978) address the weaknesses of the original learned helplessness theory by including an attributional viewpoint. They expound on three areas. They report that, at least for human subjects, individuals can perceive that they themselves have no control over a situation, while someone else may be perceived as being able to control that situation. In addition, they address the ability of the individual to attribute an outcome to an event or cause whose effect is general, influencing many areas, or to an event or cause whose effect is specific, influencing only the current situation. Finally, they state that an event can be attributed to a cause which is persistent across time, or to an ephemeral cause.

The attributional reformulation of the theory of learned helplessness (Abramson, Seligman, & Teasdale, 1978; Seligman, Abramson, Semmel, & von Baeyer, 1979; Seligman, Peterson, Kaslow, Tanenbaum, Alloy, & Abramson, 1984) expands the conceptualization to accommodate these possibilities. The way in which one perceives the cause of an event is hypothesized to be correlated with the presence of low self-esteem, and it
is believed to predict whether the helpless characteristics will generalize and persist across time (Seligman, Abramson, Semmel, & von Baeyer, 1979; Seligman, Peterson, Kaslow, Tanenbaum, Alloy, & Abramson, 1984).

Abramson, Seligman, and Teasdale (1978) divide attribution into three categories: internal vs. external locus of control, globality vs. specificity of the causative factor, and persistence vs. ephemerality of the causative factor. The reformulated hypothesis contends that individuals most likely to exhibit the cognitive, emotional, and motivational deficits of learned helplessness are those who attribute negative events to an internal, global, and chronic factor (such as a personal flaw), while they attribute positive events to an external, specific, and temporary factor (such as chance). This theory is similar to previously cited attributional theories of emotion, in that internal, stable ascriptions for failure result in low expectancy of success and negative affective responses.

Two of the three dimensions of the attributional theory of learned helplessness, internal-external and stability over time, are used by other attribution theorists (Weiner, 1985). Also included is a dimension, globality, which has little empirical support, though it is accepted as plausible (Weiner, 1985). Critics of the theory have addressed the fact that perceived controllability will affect reactions to outcomes, and that a philosophical ability to perceive meaning in the
face of an uncontrollable negative outcome will attenuate the affects of that outcome (Wortman & Dintzer, 1978). The theory, therefore, has weaknesses, but it is one of the most comprehensive combinations of attribution, motivation, and emotion.

Attributional Style and Parental Alcoholism

Wright and Obitz (1984) discovered that 83 alcoholics rated their personal control over future events lower than did a 75-member control group. They also discovered that the alcoholics perceived other people as having more control over life events than they themselves had, while non-alcoholics' perception of their own control over life events was greater than their perception of the control that others had over life events.

It is possible that ACOAs have a similar negative view of their ability to control their environment. From the information previously presented, it seems that ACOAs experience a high frequency of non-contingent aversive stimuli. If the accounts of the individuals in the clinical reports are similar to the events in the lives of most ACOAs, then ACOAs as a population seem more likely than children of non-alcoholic parents to feel a lack of control of their environment.

ACOAs experience the frustration of inconsistency and unpredictability in their parents' behavior and affection.
ACOAs have difficulty getting some of their basic emotional and psychosocial needs met, and they feel responsible for the alcoholic's drinking and for problems in the family.

These situations seem to fit the model of events which lead to learned helplessness and hopelessness, in that the ACOA experiences a lack of control over events which directly affect him. Persistent negative reactions from parents, which are episodes of failure to the individual, come to be viewed as stable. The stability results in an internal ascription. Reports that ACOAs feel responsible for and guilty about the problems in their families suggest that they tend to internalize and to generalize causality to personal traits. The fact that the reports of impaired functioning in ACOAs come from adults who experienced parental alcoholism suggests that the negative attribution of causality persists over a long period of time.

The roles which ACOAs may take on (Black, 1979, 1981a; Seixas and Youcha, 1985; Woititz, 1983, 1985; Wegscheider, 1981) include that of the overly responsible and highly effective person who sacrifices himself for others, and the mascot who is always relieving tension by entertaining others. These roles and aspects of other described roles suggest that a significant number of ACOAs may not exhibit helplessness to the same degree across all settings. One area which these authors and others (e.g., Ackerman, 1983; Deutsch, 1982; Jacob & Leonard, 1986; Lawson, Peterson, &
Lawson, 1983; Morehouse & Scola, 1986) believe to be consistently and pervasively problematic is interpersonal relationships. All offer descriptions of the ACOA's acquisition of social behaviors and intimacy skills which result from dysfunctional, incomplete, and/or nonexistent modeling in the family. ACOAs are described repeatedly as desiring intimacy but fearing it because they feel inferior and unworthy of another person's respect and concern. They reportedly fear that they are incapable of having good relationships because they believe that no one who understands them at an intimate level will want a relationship with them. Thus, while an ACOA may grow up attributing a variety of negative events to an internal, global factor, current literature suggests that a large number of ACOAs employ this negative attributional style specifically with interpersonal relationships. Competence may develop in other areas with age, or may develop for some individuals to a limited degree, but helplessness in interpersonal relationships is viewed as a persistent and pervasive problem for ACOAs.

The purposes to be served by this investigation were threefold: 1) to begin to define operationally the factors which comprise the perception of control in the child of an alcoholic, and the ways in which these factors are affected due to living in a dysfunctional alcoholic family; 2) to confirm and to expand current theory about the effects of
alcoholism on the child of the alcoholic; and 3) to provide data for clinicians and counselors working with this population to help them discern possible areas of need.

This study addressed the relationship which exists between being raised in a family with an alcoholic parent and subsequent perceptions of the causes of events in one's life. Emphasis was placed on perceived ability to engage in and to maintain effective interpersonal relationships. Perception of control was studied by examining the attributional style of subjects. Because the effect of parental alcoholism may be confounded by the fact that alcoholics are likely to have some other form of psychopathology (Weissman & Meyers, 1980), attributional style was also studied in a comparison group of individuals who report parental depression without alcoholism. These two groups were compared to a control group of individuals who reported neither parental alcoholism nor parental psychopathology.

**Hypotheses**

Based on the previous discussion, the following results were expected:

I. The three groups would differ on general attributional style.

II. The three groups would differ on attributional style for interpersonal situations.

III. The three groups would differ on attributional style for noninterpersonal situations.
IV. The attributional style of adult children of alcoholics would differ for interpersonal and noninterpersonal situations.

Method

Subjects

Subjects for this study were solicited from a state university in northern Texas. All were students in undergraduate level courses in psychology. Course instructors offered extra credit points to those who chose to participate. A total of 123 individuals participated. Of that number, two turned in incomplete packets and four turned in completed packets which were thrown out because they did not meet the clear criteria for any of the three designated groups. Two packets were not returned. Thus, the scores of 115 subjects were used in the analysis of the data. Described by gender, 76.5% (n = 88) of the subjects were female and 23.5% (n = 27) were male. Mean age of the females was 23.0. Mean age for males was 23.1. 80.9% (n = 93) of the total sample were Caucasian, 7.0% (n = 8) were Black, 7.0% (n = 8) were Hispanic, and 5.2% (n = 6) were Oriental/Asian.

Instruments

Each subject completed a questionnaire which addressed demographic variables, individual history of alcohol and drug use and abuse, family history of alcohol and drug
abuse, and occurrence of primary affective disorder and general psychopathology in the individual and the individual's family (Appendix A). This questionnaire utilized sections verbatim from a questionnaire used by Shuckit (1980). In addition, there were questions derived from the diagnostic criteria for Alcohol Dependence (303.90) in DSM-III-R (APA, 1987) (Appendix B). To assess attributional style, each subject completed the Attributional Style Questionnaire and the Attributional Style Assessment Test.

The Attributional Style Questionnaire (ASQ; Peterson, Semmel, et al., 1982) is a forty-eight item questionnaire designed to measure the way an individual perceives causality. It presents twelve hypothetical events, six of which have a positive outcome and six of which have a negative outcome.

Following the description of each hypothetical event are four questions. The first question asks for the one major cause for the outcome and is not used in scoring the test; rather, it is used by the subject to answer the following three questions. The three subsequent questions ask the subject to rate the named cause on the internal-external, stable-unstable, and global-specific dimensions using a seven-point scale. The text of the questionnaire is contained in Appendix C.
Scores can be obtained for six factors, Internal Negative, Internal Positive, Stable Negative, Stable Positive, Global Negative, and Global Positive. Factor scores are obtained by deriving the mean of the six ratings given for each factor in each event presented and can range from one to seven. Composite scores are obtained by summing factor scores and can range from three to twenty-one. The Composite Positive (CP) score is the sum of the scores for the positive factors. The Composite Negative (CN) score is the sum of the scores for the negative factors. Since higher scores reflect a greater attribution by the subject to a factor, a higher Composite Positive score and a lower CN score reflect a more competent self view.

Reliability of the Composite Positive score and of the Composite Negative score are reported to be acceptable (alphas of .75 and .72, respectively; Peterson & Seligman, 1984). With respect to the validity of the scale, content analysis of spontaneously offered negative causal explanations produced factors which correlated significantly with the Composite Negative score of the ASQ (r = .38, p < .02; Peterson and Seligman, 1984).

The Attributional Style Assessment Test (ASAT-II; Anderson, Horowitz, & French, 1983) (Appendix D) is a 36-item forced choice questionnaire designed to measure the way an individual perceives the causes of success and failure. Nine interpersonal situations are incorporated
into the test, each being presented with an outcome of success and an outcome of failure, yielding eighteen of the items. The remaining eighteen items involve nine noninterpersonal situations, each expressed with an outcome of success and one of failure. Following the presentation of each situation there are listed three possible explanations for the outcome. The explanations are presented so as to attribute the outcome to strategy, ability, or effort. The subject is asked to choose the one explanation which is most likely to account for the success or failure if the subject were the individual described in the situation.

The Kuder-Richardson (K-R 20; Shrout & Fleiss, 1979) reliability coefficients were calculated from the analyses of ability attributions, which were determined by the number of behavioral (effort, strategy) attributions since each group was mutually exclusive. The average reliability across the four types of situations was .54. With reference to the validity of the measure, ability attributions of interpersonal failures correlated significantly with scores on the UCLA Loneliness Scale (r = .424, p < .001; Anderson, Horowitz, & French, 1983). Ability attributions for interpersonal failures correlated significantly with scores on the Beck Depression Inventory (r = .372, p < .001; Anderson, Horowitz, & French, 1983), as did attributions for noninterpersonal failures (r = .272, p < .005; Anderson, Horowitz, & French, 1983).
Procedure

The ASQ, ASAT, and the questionnaire addressing family history of substance abuse and psychopathology were put together in page size envelopes, thus making individual test packets. The attributional style questionnaires were presented first, before the family history questionnaire. It was believed that this would prevent deliberation of alcohol and drug use and abuse patterns in the subject's family from affecting responses on the other two questionnaires. The order of the two attributional style questionnaires was alternated to control for carryover effects.

Potential subjects were first given an informed consent form (Appendix E) explaining what they would be asked to do. That form also introduced the study by reporting that two of the questionnaires would ask for information on how one viewed events which occurred, while the third asked for some personal and family history. Each packet had a designated number appearing on the outside of the envelope, and each of the three questionnaires was marked with the same identifying number. Names did not appear on any of the research instruments to ensure anonymity. Extra credit vouchers were given to individuals who turned in a completed packet.

Groups

Subject groups were formed according to responses on the family history questionnaire. If a subject reported
that one or both parents met three or more of the DSM-III-R (APA, 1987) diagnostic criteria for alcohol dependence, and this was validated by the subject reporting that the parent was alcoholic or that the parent met Shuckit's criteria for a drinking problem, she was put in the adult children of alcoholics group. If the subject reported that one or both parents had experienced symptoms of depression which interfered in his or her daily functioning, without reporting parental alcoholism, that subject was placed in the adult children of depressives group. Subjects who reported neither parental alcoholism nor parental depression were placed in the control group. Subjects who reported both parental alcoholism and parental depression were placed in the adult children of alcoholics group, since depression often accompanies alcohol dependence or the co-dependence of an alcoholic's spouse. Subjects who reported that one or both parents met three or more of the DSM-III-R diagnostic criteria for alcohol dependence, without validating by labeling the parent as alcoholic or indicating associated problems, were left out of the final data analysis because they did not meet the criteria for any group.

The scores of 115 subjects were used for data analysis. Twenty-three subjects met the criteria for the adult children of alcoholics group, 31 met the criteria for the adult children of depressives group, and 61 met neither criteria and, thus, were placed in the control group. The children of alcoholics group was 87.0% female (n = 20) and
13.0% male (n = 3). 82.6% (n = 19) were Caucasian, 8.7% (n = 2) were Black, 4.3% (n = 1) were Hispanic, and 4.3% (n = 1) were Oriental/Asian. Mean age of the group was 23.2 (n = 23). The children of depressives group was 71.0% (n = 22) female and 29.0% (n = 9) male. 83.9% (n = 26) were Caucasian, 6.5% (n = 2) were Black, 3.2% (n = 1) were Hispanic, and 6.5% (n = 2) were Oriental/Asian. Mean age of the group was 23.2 (n = 31). The control group was 75.4% (n = 46) female and 24.6% (n = 15) male. 78.7% (n = 48) were Caucasian, 6.6% (n = 4) were Black, 9.8% (n = 6) were Hispanic, and 4.9% (n = 3) were Oriental/Asian. Mean age of the group was 22.8 (n=61).

Results

Hypothesis I

The first hypothesis predicted that the three groups would differ on general attributional style. General attributional style was defined by scores on the ASQ. Four scores, internal ascription for positive outcomes (IP), internal ascription for negative outcomes (IN), composite (internal, global, and stable) ascriptions for positive outcomes (CP), and composite ascriptions for negative outcomes (CN) were considered to be indicative of attributional style. Tables 1 through 4 contain the mean and standard deviation of the IP, IN, CP, and CN scores for each group, respectively.
Table 1
Mean and Standard Deviation of IP by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic Parents</td>
<td>23</td>
<td>5.29</td>
<td>0.74</td>
</tr>
<tr>
<td>Depressive Parents</td>
<td>31</td>
<td>5.29</td>
<td>0.74</td>
</tr>
<tr>
<td>Controls</td>
<td>61</td>
<td>5.32</td>
<td>0.78</td>
</tr>
</tbody>
</table>

Table 2
Mean and Standard Deviation of IN by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic Parents</td>
<td>23</td>
<td>4.30</td>
<td>0.69</td>
</tr>
<tr>
<td>Depressive Parents</td>
<td>31</td>
<td>4.26</td>
<td>0.75</td>
</tr>
<tr>
<td>Controls</td>
<td>61</td>
<td>4.04</td>
<td>0.87</td>
</tr>
</tbody>
</table>
Table 3

Mean and Standard Deviation of CP by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic Parents</td>
<td>23</td>
<td>16.01</td>
<td>2.01</td>
</tr>
<tr>
<td>Depressive Parents</td>
<td>31</td>
<td>15.62</td>
<td>1.96</td>
</tr>
<tr>
<td>Controls</td>
<td>61</td>
<td>15.97</td>
<td>1.96</td>
</tr>
</tbody>
</table>

Table 4

Mean and Standard Deviation of CN by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic Parents</td>
<td>23</td>
<td>12.39</td>
<td>2.15</td>
</tr>
<tr>
<td>Depressive Parents</td>
<td>31</td>
<td>12.36</td>
<td>1.66</td>
</tr>
<tr>
<td>Controls</td>
<td>61</td>
<td>11.82</td>
<td>1.75</td>
</tr>
</tbody>
</table>
To test the hypothesis, a one-way ANOVA was calculated to compare each of the four scores across all three groups. Statistical analysis of the data failed to confirm the hypothesis. Appendix F contains summaries of the analyses.

Hypothesis II

The second hypothesis predicted that the three groups would differ on attributional style for interpersonal situations. Attributional style for interpersonal situations was defined operationally as a subject's scores on the interpersonal situations portion of the ASAT-II. A subject's score reflected the number of times out of nine possible that she attributed her success or failure to her own ability, rather than to strategy or effort. Scores for Interpersonal Success (IS) situations were compared across groups, as were scores for Interpersonal Failure (IF). The mean and standard deviation of IS and IF scores across groups are listed in Tables 5 and 6, respectively.

A one-way ANOVA of IS scores by group was performed, as well as a one-way ANOVA of IF scores by group, to test the hypothesis. Differences between the groups were not found to be significant and, therefore, the hypothesis was not supported. Summaries of the analyses appears in Appendix F.
Table 5

Mean and Standard Deviation of IS by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic Parents</td>
<td>23</td>
<td>1.48</td>
<td>1.50</td>
</tr>
<tr>
<td>Depressive Parents</td>
<td>31</td>
<td>1.52</td>
<td>1.77</td>
</tr>
<tr>
<td>Controls</td>
<td>61</td>
<td>1.84</td>
<td>1.60</td>
</tr>
</tbody>
</table>

Table 6

Mean and Standard Deviation of IF by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic Parents</td>
<td>23</td>
<td>1.57</td>
<td>1.34</td>
</tr>
<tr>
<td>Depressive Parents</td>
<td>31</td>
<td>1.58</td>
<td>1.15</td>
</tr>
<tr>
<td>Controls</td>
<td>61</td>
<td>1.57</td>
<td>1.20</td>
</tr>
</tbody>
</table>
Hypothesis III

The third hypothesis predicted that the three groups would differ on noninterpersonal attributional style. Noninterpersonal attributional style was defined operationally as a subject's scores on the ASAT for noninterpersonal events. Scores were compared for Noninterpersonal Success (NS) and Noninterpersonal Failure (NF). A subject's score reflected the number of successes or failures, out of a possible total of nine, that she attributed to her own ability or lack of ability. Tables 7 and 8 contain the mean and standard deviation of NS and NF, respectively, for each group.

One-way ANOVAs of NS by group and NF by group failed to support the hypothesis. Summaries of the analyses appear in Appendix F.

Table 7

**Mean and Standard Deviation of NS by Group**

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic Parents</td>
<td>23</td>
<td>2.57</td>
<td>1.47</td>
</tr>
<tr>
<td>Depressive Parents</td>
<td>31</td>
<td>2.45</td>
<td>1.52</td>
</tr>
<tr>
<td>Controls</td>
<td>61</td>
<td>2.34</td>
<td>1.66</td>
</tr>
</tbody>
</table>
Table 8

Mean and Standard Deviation of NF by Group

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic Parents</td>
<td>23</td>
<td>2.17</td>
<td>1.83</td>
</tr>
<tr>
<td>Depressive Parents</td>
<td>31</td>
<td>2.10</td>
<td>1.51</td>
</tr>
<tr>
<td>Controls</td>
<td>61</td>
<td>2.44</td>
<td>1.58</td>
</tr>
</tbody>
</table>

Hypothesis IV

The fourth hypothesis predicted that adult children of alcoholics would differ on attributional style for interpersonal versus noninterpersonal situations. To test the hypothesis, the scores of adult children of alcoholics on the ASAT-II were analyzed. Scores for Interpersonal Success (IS) were compared to scores for Noninterpersonal Success (NS), and scores for Interpersonal Failure (IF) were compared to scores for Noninterpersonal Failure (NF). Table 9 compares the mean and standard deviation of ACOAs attributing success to ability, as opposed to good strategy or sufficient effort, for interpersonal and noninterpersonal situations. Table 10 compares the mean and standard deviation of ACOAs attributing failure to lack of ability, as opposed to poor strategy or
insufficient effort, for both interpersonal and noninterpersonal situations.

A correlated groups t-test of success scores, comparing attributions for interpersonal and noninterpersonal situations, showed a significant difference between the way adult children of alcoholics attributed interpersonal versus noninterpersonal success ($t = 3.062, df = 22, p < .01$). A correlated groups t-test of failure scores, comparing attributions for interpersonal and noninterpersonal situations, was not significant ($t = 1.774, df = 22, p > .05$). Appendix G summarizes the data from these analyses.

Table 9
Mean and Standard Deviation of IS and NS for ACOAs

<table>
<thead>
<tr>
<th>Type of Success</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal</td>
<td>23</td>
<td>1.48</td>
<td>1.50</td>
</tr>
<tr>
<td>Noninterpersonal</td>
<td>23</td>
<td>2.57</td>
<td>1.47</td>
</tr>
</tbody>
</table>
Table 10

Mean and Standard Deviation of IF and NF for ACOAs

<table>
<thead>
<tr>
<th>Type of Failure</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal</td>
<td>23</td>
<td>1.57</td>
<td>1.34</td>
</tr>
<tr>
<td>Noninterpersonal</td>
<td>23</td>
<td>2.17</td>
<td>1.83</td>
</tr>
</tbody>
</table>

Discussion

The data supported only one of the hypotheses. That is to say, adult children of alcoholics were shown to differ on attributional style for interpersonal versus noninterpersonal success. The hypotheses predicting that adult children of alcoholics, adult children of depressives, and adult controls would differ on general, interpersonal, and noninterpersonal attributional styles were not confirmed. First, the possible explanations for nonconfirmation of the first three hypotheses will be addressed. Second, the meaning of the significant difference between attributions for interpersonal and noninterpersonal success by adult children of alcoholics will be explored. Finally, the results of this study will be discussed in terms of their impact on future research.

Attributional style as defined by the two instruments used in this study did not seem to be related to the family of
origin as defined by parental alcoholism or depression. There are several possible explanations for this lack of significant difference. Primarily, the three groups may not differ at all on attributional style. Perhaps an individual's life experiences which lead to the development of an attributional style encompass more than parental behavior. Perhaps it is very specific occurrences which affect the development of an attributional style, and not just general patterns of occurrences. For example, two or three vivid instances of success or failure may influence later attributional style far more than general tendencies to succeed or fail under certain conditions. Finally, one may be predisposed to develop a specific attributional style, and that predisposition may enhance or alter the contribution of life experiences to attributional style development.

A true difference in attributional style may exist between individuals in the defined groups. A more psychometrically sound instrument to measure and to define attributional style might produce significant differences between the groups. The ASQ (Peterson, Semmel, et al., 1982) and ASAT-II (Andedrson, Horowitz & French, 1983) have acceptable reliability, but they may not be sufficiently sensitive to detect true differences between these groups, should they exist. An instrument which used more emotionally charged situations may be more likely to produce significant results. Interpersonal situations which involved closer
relationships and stronger themes of love, acceptance, and rejection might produce more significant differences, since the difficulties described in ACOAs' relationships are defined by these issues (Ackerman, 1983; Black, 1979; Deutsch, 1982; & Woititz, 1983, 1985). Noninterpersonal situations which focused more on esteem and attainment might be influenced by feelings of self-worth, another area which was described previously as an area of difficulty for ACOAs (Ackerman, 1983).

The patterns of behaviors, perceptions, and expectations which are used to define this population clinically may not be related to attributional style, or attributional style may only be one factor which affects them. More psychologically dynamic components such as personal identity, one's value and belief systems, and one's philosophical outlook may counteract or interact with the previously described patterns of causal ascription to produce the mood states, expectations, and judgments of the self characteristic of ACOAs.

One hypothesis produced a significant result when tested. Within the adult children of alcoholics group, individuals were more likely to attribute interpersonal success to strategy or effort, and were more likely to attribute noninterpersonal success to ability. Though the t-test comparing interpersonal and noninterpersonal failure attributions was not significant, the difference was in the same direction as the difference for successes. Adult
children of alcoholics tended to attribute interpersonal failure to poor strategy and lack of effort more often than they attributed noninterpersonal failure to the same. They tended to attribute noninterpersonal failure more frequently to a lack of ability. The difference between attributions for the two types of failure did approach significance (t = 1.774, df = 22, critical t for p < .05 = 2.074, critical t for p < .10 = 1.717).

The attributional style of adult children of alcoholics may best be understood if one looks at the more frequent, rather than the less frequent, explanation. Fewer ability attributions can be viewed as a greater number of strategy or effort attributions. ACOAs were significantly more likely to explain interpersonal success in terms of strategy and effort when compared to noninterpersonal success. They tended to attribute interpersonal failure to poor strategy or insufficient effort more frequently than they attributed noninterpersonal failure to those factors, to a degree which approached statistical significance. Taken together, these data suggest that ACOAs do not feel incapable of succeeding in interpersonal situations. Rather, they seem to feel that their own success or failure in interpersonal situations is more dependent on the amount of preparation and involvement they manifest.

This pattern of assuming that one's investment in a task is more important for interpersonal than for noninterpersonal
situations may help to explain a reported pattern of ACOAs from the clinical literature. ACOAs reportedly blame themselves for the failure of relationships to an excessive and, perhaps, unrealistic degree. They remain loyal to individuals when it is detrimental to do so, and they remain in relationships which they describe as unfulfilling and painful (Black, 1981b; & Woititz, 1983, 1985). Data from this survey suggest that ACOAs believe that their strategy and effort are important determinants of the success or failure of a relationship. This may help to explain why ACOAs tend to assume the responsibility for relationships. The attributional style described can be extrapolated to say that ACOAs may believe a better strategy or greater effort can increase the likelihood of interpersonal success, while they devalue the importance of other factors which contribute to their success. Focusing on one's strategy and effort is as likely to cause an internal attribution as is focusing on one's ability. Strategy and effort attributions are unstable. Thus, ACOAs may tend to believe that greater effort and a better strategy will increase the likelihood that they will succeed in the next situation following a failure, and that they will fail if they do not maintain the same level of effort and planning in the next situation following a success. If this pattern of overvaluing one's control through planning in an interpersonal situation is persistent with ACOAs, then clinicians working with this population may be able to help
identify the pattern for individuals and offer them a more balanced and realistic explanation for the success or failure of relationships.

This study did not produce data which differentiated adult children of alcoholics from adult children of depressives or controls in terms of attributional style. The effects of being raised in an alcoholic family are the focus of much current debate, and they are the topics of books and lectures by mental health professionals (Black, 1979, 1981b; Woititz, 1983). Therapists are incorporating techniques for dealing with the needs of the ACOA into treatment, and treatment programs and therapeutic groups are being formed around the premise that ACOAs form a clinical population with common features and needs (Cermak, 1982). Because of this, future research needs to address the topic of characteristics and patterns of behavior which separate ACOAs from other individuals. It seems prudent to verify theories and confirm beliefs about groups of individuals, especially when those ideas are being incorporated into treatment plans. Further studies with ACOAs which look at common experiences in childhood and adulthood, commonly reported emotions and thoughts in reactions to situations, or patterns of behavior in interactions with other people may help to define these individuals more clearly as a clinical population.
Appendix A

Family History Questionnaire on Alcoholism and Psychopathology
Family History Questionnaire on Alcoholism and Psychopathology

This questionnaire takes only about 10 to 15 minutes to complete. All information will be used for research only and will be kept strictly confidential. If you are not sure of the answer to a question, please answer as best you can. Please try to answer every item. If you need more space to clarify a response, please use the back of the last page.

FIRST, WE HAVE SOME GENERAL QUESTIONS:

1. What is today's date? _____/_____/______
2. What is your birthdate? _____/_____/______
   So that makes you _______ years old.
3. What sex are you? _____ Male  _____ Female
4. What is your ethnic background? (ex. Black, Hispanic, Oriental, Caucasian, etc.)
   __________________________
5. How many years of regular schooling have you completed?
   __________________________ years (For example: 12th grade = 12 years; 3rd year college = 15 years)

For the following questions, please give ONLY the relationship of the individuals to you. Do not use any names

6. Whose opinions about yourself were you most likely to listen to as you were growing up?
7. Whose opinions about yourself are you most likely to listen to now?
8. Who was your role model for handling difficult situations; that is, who would you say you are most like in the way you handle difficult situations?
9. Who was your role model for handling failure; that is, who would you say you are most like in the way you handle failure?
10. Who was your role model for handling success; that is, who would you say you are most like in the way you handle success?

THE FOLLOWING QUESTIONS ARE ABOUT YOUR FAMILY BACKGROUND:

11. Until your eighteenth birthday, how many years were you raised by your:

   Real (biologic) father _____ years; Another father, such as a foster father, stepfather, adoptive father, or relative _____ years

   Real (biologic) mother _____ years Another mother, such as a foster mother, stepmother, adoptive mother, or relative _____ years
12. If you were not raised by your real mother and father, were you legally adopted?

   ____ No    ____ Yes
   ____ Does not apply, I was raised by my real mother and father

13. How many years of schooling did your father (or the man you lived with longest) complete?

   ____________________ years

14. How many years of schooling did your mother (or the woman you lived with longest) complete?

   ____________________ years

When answering the following questions about family members, please use the following criteria for the Father and Mother categories:

**Father**—The male who served as primary parental influence in your opinion. If uncertain, consider a) who influenced the atmosphere of the family you were raised in, and b) who was more influential in your earlier years of life (birth to early school age) as important factors deserving extra weight.

**Mother**—The female who served as primary parental influence in your opinion. If uncertain, consider a) who influenced the atmosphere of the family you were raised in, and b) who was more influential in your earlier years of life (birth to early school age) as important factors deserving extra weight.

15. Were you ever depressed, sad, blue, despondent, hopeless, "down in the dumps," irritable, fearful, worried, or discouraged constantly for two weeks or longer? Don't count times when you were drinking heavily or using drugs excessively. Be certain that you were depressed all day every day for two weeks or longer.

   ____ No    ____ Yes
   Did this period of depression seriously interfere with, or cause a major disruption in your life?

   ____ No    ____ Yes
   If yes, how did it interfere? (For example: I lost a job or had to drop out from school because I was so depressed.)

16. Have you ever experienced an emotional or mental disorder which required treatment by a physician or a mental health worker, such as a psychologist, counselor, or social worker?

   ____ Yes    ____ No

   If yes, please give a brief description of the condition for which treatment was sought, including name of the condition or diagnosis if known:

17. Was your mother ever depressed, sad, blue, despondent, hopeless, "down in the dumps," irritable, fearful, worried, or discouraged constantly for two weeks or longer? Don't count
times if she was drinking heavily or using drugs excessively. Be certain that she was depressed all day every day for two weeks or longer.

No Yes

Did this period of depression seriously interfere with, or cause a major disruption in her life?

No Yes

If yes, how did it interfere?

18. Has your mother ever experienced an emotional or mental disorder which required treatment by a physician or a mental health worker, such as a psychologist, counselor, or social worker?

Yes No

If yes, please give a brief description of the condition for which treatment was sought, including name of the condition or diagnosis if known:

19. Was your father ever depressed, sad, blue, despondent, hopeless, "down in the dumps," irritable, fearful, worried, or discouraged constantly for two weeks or longer? Don't count times if he was drinking heavily or using drugs excessively. Be certain that he was depressed all day every day for two weeks or longer.

No Yes

If yes, how did it interfere?

20. Has your father ever experienced an emotional or mental disorder which required treatment by a physician or a mental health worker, such as a psychologist, counselor, or social worker?

Yes No

If yes, please give a brief description of the condition for which treatment was sought, including name of the condition or diagnosis if known:

21. Was any other member of your family ever depressed, sad, blue, despondent, hopeless, "down in the dumps," irritable, fearful, worried, or discouraged constantly for two weeks or longer? Don't count times if s/he was drinking heavily or using drugs excessively. Be certain that s/he was depressed all day every day for two weeks or longer.

No Yes

Did this period of depression seriously interfere with, or cause a major disruption in his/her life?

No Yes

If yes, how did it interfere?

22. Have any of your other relatives ever experienced an emotional or mental disorder which required treatment by a physician or a mental health worker, such as a psychologist,
Appendix A

A counselor, or social worker?
____ Yes ______ No

If yes, please give relationship of the individual and a brief description of the condition for which treatment was sought, including name of the condition or diagnosis if known:

IT IS VERY IMPORTANT THAT WE UNDERSTAND YOUR HISTORY OF ALCOHOL USE.
PLEASE ANSWER THE FOLLOWING QUESTIONS AS ACCURATELY AS YOU CAN.

23. Over the last 6 months, on the average, how many days a month did you have a drink?
____ days a month

24. Over the last 6 months, on a day when you were drinking, how many drinks did you usually have in 24 hours?
One drink is:
- a 12 oz. can of beer
- a 4 oz. glass of wine
- a single shot
- a single mixed drink
____ drinks per 24 hours

25. What is your preferred alcoholic beverage? (Indicate one only)
____ Beer
____ Whiskey
____ Wine
____ Scotch
____ Vodka
____ Other (please describe)
____ None: I do not drink alcohol

NOW WE HAVE SOME QUESTIONS ABOUT DRINKING PROBLEMS

The following is a list of problems that people might have because of their own drinking:

1) Marital separation or divorce because of their drinking.
2) Laid off from work or fired because of their drinking.
3) Two or more drunk driving arrests because of their drinking.
4) Two or more arrests for public intoxication, drunk and disorderly conduct because of their drinking.
5) Doctor said alcohol itself had harmed their health.
6) Repeatedly unable to care for the house or family because of their alcohol use.

26. Have you or any of your close relatives ever had any of these problems?
Yourself ______ No ______ Yes; Number of each applicable problem:
Appendix A

Father  No   Yes; Number of each applicable problem:

Mother  No    Yes; Number of each applicable problem:

Any brother  No    Yes; Number of each applicable problem:

Any sister  No    Yes; Number of each applicable problem:

27. Please use this quick checklist of problems associated with drinking to indicate behaviors of your parents. Use the previous criteria given for the categories of Mother and Father. Indicate if either of your parents:

(1) Ever lost control of drinking; that is to say, has consumed alcohol in obviously larger quantities or for an obviously longer period of time than s/he intended when s/he began drinking
   No    Yes, Mother    Yes, Father    I don't know

(2) Has a) tried to cut down his/her drinking; or b) expressed a desire to decrease his/her consumption of alcoholic beverages
   No    Yes, Mother    Yes, Father    I don't know

(3) Spends a great deal of time at liquor stores or in bars buying alcohol (including beer or wine), continually has a drink in his/her hands during some part of the day or week, or spends a great deal of time "sleeping it off"
   No    Yes, Mother    Yes, Father    I don't know

(4) Fails to fulfill commitments to job or family because s/he is intoxicated; sleeps in, misses work, or misses social events and/or other commitments because s/he is hung over; or attempts to fulfill commitments but fails because s/he is intoxicated
   No    Yes, Mother    Yes, Father    I don't know

(5) Has withdrawn from or entirely given up recreational activities, social events, and/or job opportunities because of alcohol
   No    Yes, Mother    Yes, Father    I don't know

(6) Consumes alcohol at a level that has caused arguments in the family, problems for him/her on the job, or physical discomfort
   No    Yes, Mother    Yes, Father    I don't know
Appendix A

If yes, did s/he continue to drink in spite of those difficulties? __________

(7) Requires more alcohol to reach a set level of intoxication, or is able to consume greater amounts of alcohol without becoming intoxicated

No __ Yes, Mother __ Yes, Father __ I don't know

(8) Has suffered from Delirium (the "DT's") after stopping alcohol consumption; that is, has been known to be shaking or sweaty, has had great difficulty paying attention, has been disoriented, or has experienced hallucinations of any kind during the period after drinking

No __ Yes, Mother __ Yes, Father __ I don't know

(9) Has been known to take a drink to decrease the physical affects of withdrawal from alcohol, or to drink at a low but steady rate to avoid withdrawal symptoms

No __ Yes, Mother __ Yes, Father __ I don't know

28. If you or any of your close relatives ever had any problems other than those already asked about because of drinking or drug abuse, please list them below:

29. Do you consider yourself or a close relative to be or to have been an alcoholic or drug abuser?

No __ Yes, Self alcoholic __ Yes, Self drug abuser

No __ Yes, Mother alcoholic __ Yes, Mother drug abuser

No __ Yes, Father alcoholic __ Yes, Father drug abuser

No __ Yes, Brother/s alcoholic

Yes, Brother/s drug abuser

No __ Yes, Sister/s alcoholic

Yes, Sister/s drug abuser

Please explain why you consider yourself or this/these relative/s to be an alcoholic or drug abuser:

You are finished with the questionnaire. If you have any questions or comments about anything we have asked you, please list them in the space below.

COMMENTS:

If you have anything that you feel should be added to what you have already told us about yourself, please list it in the space below.

*****THANK YOU VERY MUCH FOR YOUR COOPERATION*****
Appendix B

DSM-III-R Criteria for Psychoactive Substance Dependence
DSM-III-R Criteria For Psychoactive Substance Dependence
(pp. 167-168)

A. At least three of the following:

(1) substance often taken in larger amounts or over a longer period than the person intended

(2) persistent desire or one or more unsuccessful efforts to cut down or control substance use

(3) a great deal of time spent in activities necessary to get the substance (e.g., theft), taking the substance (e.g., chain smoking), or recovering from its effects

(4) frequent intoxication or withdrawal symptoms when expected to fulfill major role obligations at work, school, or home (e.g., does not go to work because hung over, goes to school or work "high," intoxicated while taking care of his or her children), or when substance use is physically hazardous (e.g., drives when intoxicated)

(5) important social, occupational, or recreational activities given up or reduced because of substance use

(6) continued substance use despite knowledge of having a persistent or recurrent social, psychological, or
physical problem that is caused or exacerbated by the use of the substance (e.g., keeps using heroin despite family arguments about it, cocaine-induced depression, or having an ulcer made worse by drinking)

(7) marked tolerance: need for markedly increased amounts of the substance (i.e., at least a 50% increase) in order to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount

Note: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP):

(8) characteristic withdrawal symptoms (see specific withdrawal syndromes under Psychoactive Substance-induced Organic Mental Disorders)

(9) substance often taken to relieve or avoid withdrawal symptoms

B. Some symptoms of the disturbance have persisted for at least one month, or have occurred repeatedly over a longer period of time.
Appendix C

Text of the Attributional Style Questionnaire (ASQ)
Text of the Attributional Style Questionnaire

ATTRIBUTIONAL STYLE QUESTIONNAIRE

DIRECTIONS

1) Read each situation and vividly imagine it happening to you
2) Decide what you believe would be the major cause of the situation if it happened to you
3) Write this cause in the blank provided
4) Answer three questions about the cause, filling in one bubble per question
5) Go on to the next situation
6) Write on the answer sheet only. Please do not write on this questionnaire

SITUATIONS

YOU MEET A FRIEND WHO COMPLIMENTS YOU ON YOUR APPEARANCE.
1) Write down the one major cause.
2) Is the cause of your friend's compliment due to something about you or something about other people or circumstances?
3) In the future when you are with your friend, will this cause again be present?
4) Is the cause something that just affects interacting with friends or does it also influence other areas of your life?

YOU HAVE BEEN LOOKING FOR A JOB UNSUCCESSFULLY FOR SOME TIME.
5) Write down the one major cause.
6) Is the cause of your unsuccessful job search due to something about you or something about other people or circumstances?
7) In the future when looking for a job, will this cause again be present?
8) Is the cause something that just influences looking for a job or does it also influence other areas of your life?

YOU BECOME VERY RICH.
9) Write down the one major cause.
10) Is the cause of your becoming rich due to something about you or something about other people or circumstances?
11) In your financial future, will this cause again be present?
12) Is the cause something that just affects obtaining money or does it also influence other areas of your life?

(©1984 Martin E.P. Seligman. Used by permission of the author)
A FRIEND COMES TO YOU WITH A PROBLEM AND YOU DON'T TRY TO HELP THEM.
13) Write down the one major cause.
14) Is the cause of your not helping your friend due to something about you or something about other people or circumstances?
15) In the future when a friend comes to you with a problem, will this cause again be present?
16) Is the cause something that just affects what happens when a friend comes to you with a problem or does it also influence other areas of your life?

YOU GIVE AN IMPORTANT TALK IN FRONT OF A GROUP AND THE AUDIENCE-reacts negatively.
17) Write down the one major cause.
18) Is the cause of the audience reacting negatively due to something about you or something about other people or circumstances?
19) In the future when giving talks, will this cause again be present?
20) Is the cause something that just affects giving talks or does it also influence other areas of your life?

YOU DO A PROJECT WHICH IS HIGHLY PRAISED
21) Write down the one major cause.
22) Is the cause of being praised due to something about you or something about other people or circumstances?
23) In the future when doing a project, will this cause again be present?
24) Is the cause something that just affects doing projects or does it also influence other areas of your life?

YOU MEET A FRIEND WHO ACTS HOSTILELY TOWARDS YOU
25) Write down the one major cause.
26) Is the cause of your friend acting hostile due to something about you or something about other people or circumstances?
27) In the future when interacting with friends, will this cause again be present?
28) Is the cause something that just influences interacting with friends or does it also influence other areas of your life?

YOU CAN'T GET ALL THE WORK DONE THAT OTHERS EXPECT OF YOU.
29) Write down the one major cause.
30) Is the cause of your not getting the work done due to something about you or something about other people or circumstances?
31) In the future when doing the work that others expect, will this cause again be present?
32) Is the cause something that just affects doing work that others expect of you or does it also influence other areas of
Appendix C

your life?

YOUR SPOUSE (BOYFRIEND/GIRLFRIEND) HAS BEEN TREATING YOU MORE LOVINGLY.
33) Write down the one major cause.
34) Is the cause of your spouse (boyfriend/girlfriend) treating you more lovingly due to something about you or something about other people or circumstances?
35) In your future interactions with your spouse (boyfriend/girlfriend), will this cause again be present?
36) Is the cause something that just affects how your spouse (boyfriend/girlfriend) treats you or does it also influence other areas of your life?

YOU APPLY FOR A POSITION THAT YOU WANT VERY BADLY (e.g., IMPORTANT JOB, GRADUATE SCHOOL ADMISSION, etc.) AND YOU GET IT.
37) Write down the one major cause.
38) Is the cause of your getting the position due to something about you or something about other people or circumstances?
39) In the future when applying for a position, will this cause again be present?
40) Is the cause something that just influences applying for a position or does it also influence other areas of your life?

YOU GO OUT ON A DATE AND IT GOES BADLY
41) Write down the one major cause.
42) Is the cause of the date going badly due to something about you or something about other people or circumstances?
43) In the future when dating, will this cause again be present?
44) Is the cause something that just influences dating or does it also influence other areas of your life?

YOU GET A RAISE
45) Write down the one major cause.
46) Is the cause of your getting a raise due to something about you or something about other people or circumstances?
47) In the future on your job, will this cause again be present?
48) Is the cause something that just affects getting a raise or does it also influence other areas of your life?
Appendix D

Attributional Style Assessment Test, Second Edition

(ASAT-II)
Attributional Style Assessment Test

Rating the Reasons for Success and Failure

This questionnaire presents some common situations with different possible explanations for the outcome (success or failure) of each situation. Imagine yourself in each situation, and consider each possible reason for the situation or explanation that would most likely account for the outcome if it happened to you. There is no right or wrong answer, of course, so do not spend a lot of time making up your judgments. Simply choose the reason that would best explain the outcome if it actually happened to you.

1. A child that you have been tutoring in reading has failed to improve as much as expected. Which reason best accounts for the child's failure to improve?
   A. I did not use the best teaching technique for that child.
   B. I did not work hard enough with the child.
   C. I am not very good at teaching reading skills.

2. You have just failed at coordinating an outing for a group of people you like very much. Which reason best accounts for this outcome?
   A. I am not very good at arranging social events.
   B. I did not stress enough the importance of everyone pitching in.
   C. I did not try hard enough to coordinate everyone involved.

3. You have lost a competitive match in your favorite sport. Which reason best accounts for this loss?
   A. I used the wrong strategy for this opponent.
   B. I am not as good at this sport as my opponent.
   C. I did not put enough effort into the match to win.

4. Things have been working out well between you and your roommate. Which reason best accounts for this outcome?
   A. I work very hard at getting along with my roommate.
   B. I am good at getting along with roommates.
   C. I take a casual approach to minor problems in living arrangements.

5. Your short story has been accepted for publication by a national magazine. Which reason best accounts for this success?
   A. I am a good writer of short stories.
   B. I used the appropriate style of writing for the magazine.
   C. I worked very hard in writing the story.
6. You have just attended a party for new students and did not make any new friends. Which reason best accounts for this failure?
   A. I did not try hard enough to meet new people.
   B. I am not good at meeting new people at parties.
   C. I used the wrong approach in trying to meet new people.

7. In a memory experiment, where your task was to memorize pairs of words, you did not memorize enough of the pairs to be included in a follow-up study. Which reason best accounts for this failure?
   A. I am not good at memorization tasks.
   B. I did not try very hard to memorize the word pairs.
   C. I used the wrong memorization technique for this kind of memory task.

8. You went out on a blind date and enjoyed yourself. Which reason best accounts for this?
   A. I tried to relax and enjoy myself.
   B. I am good at relaxing and enjoying myself in this kind of a situation.
   C. I kept the conversation going and found myself relaxing and enjoying myself.

9. In an attempt to save money for a large, special purchase, you have set a carefully planned budget. Month after month you find you have gone over your budget. Which reason best accounts for this overspending?
   A. I just cannot stay within tight spending limits.
   B. I did not use the right techniques to prevent wasteful spending.
   C. I did not try hard enough to stay within my budget.

10. Over vacation you have gained a few pounds, and set a goal of losing them by mid-quarter. At the mid-quarter the extra weight is still with you. Which reason best accounts for this situation?
    A. I did not try hard enough to lose the weight.
    B. I did not use the right weight reduction method.
    C. I am just not good at controlling my weight.

11. You have succeeded in selling your best photographs to a national magazine. Which reason best accounts for this success?
    A. I am good at presenting my work to sell.
    B. I put a lot of effort into selling my pictures.
    C. I used the right selling approach.

12. You find yourself enjoying some social activity most every Saturday night. Which reason best accounts for
this situation?
A. I always contact my friends early in the week to arrange an activity.
B. I put a lot of effort into arranging social activities.
C. I am good at planning social activities.

13. You have just won a game of Scrabble (the word game). Which reason best accounts for this success?
A. I used the right strategy in trying to win.
B. I am good at word games like Scrabble.
C. I put a lot of effort into trying to win.

14. You were recently unsuccessful at trying to cheer up your roommate who was having a personal problem. Which reason best accounts for your failure at cheering your roommate up?
A. I used the wrong approach to cheer him/her up.
B. I am not good at cheering up others.
C. I did not really try very hard to cheer him/her up.

15. You have just succeeded at completing the crossword puzzle in the daily newspaper. Which reason best accounts for this success?
A. I put a lot of effort into completing the puzzle.
B. I am good at crossword puzzles.
C. I used the right approach to solving the puzzle.

16. You have just succeeded at resolving an argument with a close friend. Which of the following reasons best accounts for this success?
A. I used a conciliatory approach and it worked.
B. I put a lot of effort into resolving this argument.
C. I am good at resolving such arguments.

17. You have just received a high score on the midterm test in a class. Which reason best accounts for this success?
A. I worked very hard in the class.
B. I used the best study technique for the test.
C. I am very good in that particular subject area.

18. While working as a volunteer caller for the American Lung Association you succeeded at persuading a lot of people to donate money. Which reason best accounts for this success?
A. I am a persuasive person.
B. I put a lot of effort into persuading people to donate.
C. I used the right persuasion technique.

19. You have failed to complete the crossword in the daily newspaper. Which reason best accounts for this failure?
A. I did not try very hard to complete the puzzle.
B. I am not very good at crossword puzzles.
C. I did not use the right approach to solving the crossword puzzle.

20. You have just succeeded at coordinating an outing for a group of people you like very much. Which of the following reasons best accounts for this outcome?
A. I am good at arranging social events.
B. I stressed the importance of everyone pitching in.
C. I put a lot of effort into coordinating everyone involved.

21. You have changed dorms because things had not worked out well between you and your roommate. Which of the following reasons best accounts for this outcome?
A. I did not try very hard to get along with my roommate.
B. I just could not get along with my roommate.
C. I took too serious an approach to minor problems in our living arrangements.

22. You have just failed the midterm test in a class. Which reason best accounts for this failure?
A. I did not work hard enough in the class.
B. I did not use the best study techniques for the test.
C. I do not have much ability in the particular subject area.

23. A child that you have been tutoring in reading has improved more than expected. Which of these reasons best accounts for the child's reading improvement?
A. I used the best teaching technique for that child.
B. I worked very hard with the child.
C. I am good at teaching reading skills.

24. In a memory experiment, where your task was to memorize pairs of words, you memorized enough of the pairs to be included in the follow-up study. Which reason best accounts for this success?
A. I am good at memorization tasks.
B. I put a lot of effort into memorizing the word pairs.
C. I used the right memorization technique for this kind of memory task.

25. You have just failed to resolve an argument with a close friend. Which of the following reasons best accounts for this failure?
A. I was too argumentative and not conciliatory enough.
B. I did not try very hard to resolve the argument.
C. I am not good at resolving such arguments.

26. You were recently successful at cheering up your roommate who was having a personal problem. Which of
these reasons best accounts for this success?
A. I used the right approach to cheer him/her up.
B. I am good at cheering up others.
C. I tried very hard to cheer him/her up.

27. You have failed to sell your best photographs to a national magazine. Which reason best accounts for this failure?
A. I am not very good at presenting my work to sell.
B. I did not try hard enough to sell my pictures.
C. I did not use the right selling approach.

28. You went out on a blind date and you were unable to relax and enjoy yourself. Which reason best accounts for your feeling of discomfort?
A. I did not really try to relax and enjoy myself.
B. I cannot relax and enjoy myself in this kind of situation.
C. I talked too much and did not give myself a chance to relax and enjoy myself.

29. Your short story has been rejected for publication by a national magazine. Which reason best accounts for this failure?
A. I am not a good enough writer of short stories.
B. I did not use the best style of writing for the magazine.
C. I did not work hard enough on the story.

30. You have just attended a party for new students and made some new friends. Which reason best accounts for this success?
A. I put a lot of effort into meeting new people.
B. I am good at meeting new people at parties.
C. I used the right approach in trying to meet and make new friends.

31. In an attempt to save money for a large, special purchase, you have set up a carefully planned budget. Month after month you find that you have stayed well within your budget. Which reason best accounts for this success?
A. I am good at staying within the set limits.
B. I used the right technique to prevent wasteful spending.
C. I put a lot of effort into staying within my budget.

32. While working as a volunteer caller for the American Lung Association, you failed to persuade very many people to donate money. Which reason best accounts for this lack of persuasiveness?
A. I am not a very persuasive person.
B. I did not try hard enough to persuade people to donate.
C. I used the wrong persuasion technique.

33. You have just lost a game of Scrabble (the word game). Which reason best accounts for this loss?
A. I did not use the right strategy in trying to win.
B. I am not very good at word games like Scrabble.
C. I did not try very hard to win.

34. You have just won a competitive match in your favorite sport. Which reason best accounts for this success?
A. I used the right strategy for this opponent.
B. I am better at this sport than my opponent.
C. I put a lot of effort into the match to win.

35. Over vacation you have gained a few pounds, and set a goal of losing them by mid-quarter. At mid-quarter the extra weight is all gone. Which reason best accounts for this success?
A. I tried very hard to lose the weight.
B. I used the right weight reduction method.
C. I am good at controlling my weight.

36. You find yourself alone on a Saturday night and regret that you had not arranged to do something with a friend. Which reason best accounts for this situation?
A. I did not contact my friends soon enough to arrange an activity.
B. I did not try very hard to make any arrangements.
C. I am not good at planning social activities.
Appendix E

Informed Consent Form
INFORMED CONSENT FORM

My research involves attributional style, or how people perceive the reasons for different events. I am trying to see if there is a connection between an individual's past experiences and the way he or she explains the reason for current events.

Individuals who volunteer to participate in my research will be handed a numbered packet which contains three questionnaires. The number will be the only means of identifying participants. Your name will not appear on the questionnaires you fill out, and there will not be a record of the names of the different subject numbers. Therefore, all information received will be confidential.

The packet will contain two questionnaires which describe events and ask you to give and/or explain the most likely cause for what has happened. The third packet will ask about personal background and family history. Included in that questionnaire will be questions about ethnicity, age, gender, your family of origin, your family's history of involvement with the mental health profession, stressful events in your family members' lives, and the degree of alcohol and/or drug use by you and your family members.

If you choose to participate, sign this letter, which gives your consent to participate as a subject in research. Exchange this informed consent for a packet. You may change your mind and decide not to participate at any time until your completed packet is turned in and put with other completed packets. At that time, it will be impossible for the examiner to verify that a specific packet is yours, so removing research data at that point could be considered tampering. You will receive the research credit for your participation when you turn in a completed packet.

Sincerely,

Steve Coxsey
UNT Graduate Student
Department of Psychology

I, ________________________________, hereby give consent to Steve Coxsey to use information from questionnaires I fill out for his research. I understand that all information I give will be strictly confidential. I understand that my participation will take approximately 1 hour. I am participating voluntarily, and I understand that I have the right to
withdraw my participation at any time before I turn in the packet. I respect that the questionnaires are research tools and, therefore, I will not reproduce or distribute them. I understand my participation may be beneficial in advancing theories and practices of counseling for individuals who have a certain view of why events happen to them.
Appendix F

Tables 11, 12, 13, 14, 15, 16, 17, 18

ANOVA Summary Tables
Table 11

ANOVA: ASO Internal Positive Factor By Group

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SS = Sum of Squares  
df = Degrees of Freedom  
MS = Mean Square  
p = Probability of Error
Table 12

ANOVA: ASO Internal Negative Factor by Group

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SS = Sum of Squares  df = Degrees of Freedom
MS = Mean Square     p = Probability of Error
### Table 13

ANOVA: ASO Composite Positive Score By Group

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SS = Sum of Squares  
MS = Mean Square  
df = Degrees of Freedom  
p = Probability of Error
Table 14

ANOVA: ASO Composite Negative Score By Group

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SS = Sum of Squares  
df = Degrees of Freedom  
MS = Mean Square  
p = Probability of Error
Table 15

ANOVA: ASAT-II Interpersonal Success Score By Group

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SS = Sum of Squares  
df = Degrees of Freedom  
MS = Mean Square  
p = Probability of Error
Table 16

ANOVA: ASAT-II Interpersonal Failure By Group

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<td>1.483</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>166.122</td>
<td>114</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SS = Sum of Squares        df = Degrees of Freedom
MS = Mean Square           p = Probability of Error
Table 17

ANOVA: ASAT-II Noninterpersonal Success By Group

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>0.865</td>
<td>2</td>
<td>0.433</td>
<td>0.171</td>
<td>0.843</td>
</tr>
<tr>
<td>Within</td>
<td>283.100</td>
<td>112</td>
<td>2.528</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>283.965</td>
<td>114</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SS = Sum of Squares    df = Degrees of Freedom
MS = Mean Square       p = Probability of Error
Table 18
ANOVA: ASAT-II Noninterpersonal Failure By Group

<table>
<thead>
<tr>
<th>Source</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>2.885</td>
<td>2</td>
<td>1.442</td>
<td>0.555</td>
<td>0.576</td>
</tr>
<tr>
<td>Within</td>
<td>291.063</td>
<td>112</td>
<td>2.599</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>293.948</td>
<td>114</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SS = Sum of Squares  df = Degrees of Freedom
MS = Mean Square     p = Probability of Error
Appendix G

Tables 19 and 20

Summaries of Correlated Groups t-tests for

Adult Children of Alcoholics Group
Table 19

**Correlated Groups t-test: Interpersonal vs. Noninterpersonal Successes of Adult Children of Alcoholics**

<table>
<thead>
<tr>
<th>n</th>
<th>df</th>
<th>Adj SSis</th>
<th>Adj SSns</th>
<th>Pooled SD</th>
<th>t</th>
<th>Crit t</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>22</td>
<td>15.964</td>
<td>15.974</td>
<td>0.355</td>
<td>3.062</td>
<td>2.074</td>
</tr>
</tbody>
</table>

$df =$ Degrees of Freedom

Adj SSis = Adjusted Scores Sum of Squares for Interpersonal Success

Adj SSns = Adjusted Scores Sum of Squares for Noninterpersonal Success

Adj Pooled SD = Standard Deviation Based on Pooled Sum of Squares from Adjusted Scores

$t =$ Difference Between the Means in Terms of Pooled Standard Deviation

Crit $t =$ Value Above Which $t$ Is Significant With $p<.05$
Table 20

Correlated Groups \( t \)-test: Interpersonal vs. Noninterpersonal Failures of Adult Children of Alcoholics

<table>
<thead>
<tr>
<th>n</th>
<th>df</th>
<th>Adj SSif</th>
<th>Adj SSnf</th>
<th>pooled SD</th>
<th>t</th>
<th>Crit ( t )</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>22</td>
<td>14.903</td>
<td>14.915</td>
<td>0.343</td>
<td>1.774</td>
<td>2.074</td>
</tr>
</tbody>
</table>

\( df = \) Degrees of Freedom

\( Adj \ SSif = \) Adjusted Scores Sum of Squares for Interpersonal Failure

\( Adj \ SSnf = \) Adjusted Scores Sum of Squares for Noninterpersonal Failure

\( Adj \ Pooled \ SD = \) Standard Deviation Based on Pooled Sum of Squares from Adjusted Scores

\( t = \) Difference Between the Means in Terms of Pooled Standard Deviation

\( Crit \ t = \) Value Above Which \( t \) Is Significant With \( p < .05 \)
References


Seligman, M. E. P., Abramson, L. Y., Semmel, A. & von


and attribution theory (pp. 105-113). Morristown, New Jersey: General Learning Press.


