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The social-psychological differences between male and female adult children of alcoholics

Marlow, Robelyn S., Ph.D.
The Ohio State University, 1987

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THE SOCIAL-PSYCHOLOGICAL DIFFERENCES
BETWEEN MALE AND FEMALE ADULT
CHILDREN OF ALCOHOLICS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

by

Robelyn S. Marlow, B.S., M.A.

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CHAPTER I
INTRODUCTION

Background of the Problem

It is estimated that there are about 13 million Americans who are considered alcoholic (Kinney & Leaton, 1983). The impact of alcoholism affects more than only the alcoholic. "For every alcohol misuser...5 other persons suffer directly" (cited in Steinglass, 1981, p. 288). If each alcoholic affects the lives of 5 other people, then the nation's 13 million alcoholics have a potential impact on a total of 53 million people—most of whom are family members (Kinney & Leaton, 1983). The effects of alcoholism on the lives of other people are numerous: "In 69% of beatings, 72% of stabbings, and in 64% of homicides, either the attacker or the victim or both had been drinking" (Royce, 1981, pp. 29-30).

Alcoholism is a confusing phenomenon because there is not a specific pattern of behavior or personality type characteristic of the alcoholic (Royce, 1981). The average alcoholic is an employed male or female with a family; only a very small percentage (3 - 5%) are represented by the stereotypical skid row-drinker (Ackerman, 1983; Kinney & Leaton, 1983). About 70% of all
alcoholics are white-collar workers, there are about 45% in professional and managerial positions (Royce, 1981). Alcoholics appear to be above average in intelligence and to be superior in talent and sensitivity (Royce, 1981).

There is much confusion and ambivalence in Americans' attitudes and values regarding alcohol use. Although alcohol has been known and used in most societies throughout the world, there is no universal meaning or function for it. Although there are sociocultural variations in drinking patterns, the consumption of alcoholic beverages by most adults in American society is normative social behavior (Lawson, Peterson, & Lawson, 1983).

Currently, in defining alcoholism, the best definition is one in which duration and quantity of alcohol consumed is unpredictable for the individual. There are physiological, psychological, and sociological theories of alcoholism; however, most scholars agree that all three theoretical perspectives contribute to the problem of alcoholism. Valliant (1983) sums it up by viewing alcoholism as a multi-dimensional process. As a result, alcoholism cannot be viewed solely within a medical model. The development of the "disease concept" of alcoholism relates to a set of symptoms that are the result of a complex series of interactions between etiological agents, psychological factors, and
Because of the recognition of alcoholism as a family problem, by the 1970s, family systems theory became more prominent as a way of assessing alcoholism in the family context (Ewing & Fox, 1968; Steinglass, 1971). Although there is continuing controversy concerning the etiology, treatment, and diagnosis of alcoholism, there is growing evidence that alcoholism has a profound impact on the family members of the alcoholic. Family history of alcohol, or what is typically termed familial alcoholism, is thought to be transmitted both genetically and environmentally (Bohman, Sigvardsson, & Cloninger, 1981; Cotton, 1979; Goodwin, 1979; McKenna & Pickens, 1981; Steinglass, 1979; Vaillant, 1980).

Despite the increasing recognition of alcoholism as a family disease, it generally has not been treated as a family problem and children of alcoholics have remained misdiagnosed and inappropriately treated (Gravitz & Bowden, 1985). Although not all children of alcoholics experience identical emotional and physical effects, they clearly represent a high risk group. The situations in the family environment, such as shifts in parental roles and inconsistencies in support, affection, and security, create an environment in which it is difficult to learn adequate ways of coping with life (Knight, 1980).
A growing body of research reflects the familial nature of chronic alcoholism through genetic, environmental, and family systems theory (Steinglass, 1979). Cotton (1979) in her review of 39 studies, found that rates of alcoholism are substantially higher among relatives of alcoholics than among either relatives of nonalcoholics or in various types of psychiatric populations. She found that regardless of the nature of the comparison group of nonalcoholics studied, a higher rate of parental alcoholism is a specific characteristic in the population of alcoholics.

There has been a recent emphasis on the relationship between adult psychosocial status and the alcoholism of one or both parents; this research notes the likelihood that such children develop behavioral disturbances as well as being at risk for development of alcoholism (Cork, 1969; El-Guebaly & Offord 1977; Fox, 1962). The literature on children of alcoholics suggests that parental alcoholism is related to problems of personality development, identity formation, role performance, and the ability to form relationships (Ablon, 1976; Cork, 1969; Fox, 1962). The severity of problems experienced by children of alcoholics usually depends on the age of the children at the onset of parental alcoholism, personality variables of the child, sex of the alcoholic parent, whether physical and/or sexual abuse occurred, and
socioeconomic status (Gravitz & Bowden, 1985; Knight, 1980; McKenna & Pickins, 1983; Orford, 1979).

In alcoholic homes, children grow up being rescuers, (taking care of and/or responsibility for others) distrustful of others, and unable to express themselves (appropriately) emotionally. All that behavior is learned through what they experience—what they hear—the messages they receive verbally and nonverbally and what they see from their parents and other siblings (Black, 1981; Wegscheider, 1981).

Chafetz, Blane, and Hill (1977) compared 100 alcoholic families to 100 nonalcoholic families and found a higher percentage of marital instability, separation and divorce in the alcoholic families. Hindman (1975) found that children often experience neglect, abuse, and inconsistent discipline which results in isolation, development of adjustment problems and poor peer relationships. Booz-Allen and Hamilton (1974) in a study that assessed the needs and resources for children of alcoholic parents, reported that having an alcoholic parent is such an emotionally disturbing experience for children that, if untreated, the problems will negatively affect the rest of their lives. Children in their sample were deemed to be at higher risk of developing problems if they: (a) belonged to a lower socioeconomic group; (b) witnessed or experienced physical abuse; (c) were younger
than six at the onset of parental alcohol abuse; and (d) lived in a nonsupportive family situation.

The phrase "adult children of alcoholics" (ACOAs) has come to refer to those individuals, commonly in their late 20's, who as a neglected population have largely been seen by therapists, doctors, etc., for a variety of complaints seemingly unrelated to their parents' alcohol use/abuse. Although some of these individuals have come to acknowledge their own alcoholism/drug addiction, they have not taken that step out of their denial to admit to the profound effects growing up in an alcoholic home had on them (Black, 1981). It has been found through clinical observation/studies that these ACOAs are vulnerable to certain emotional, physical, and spiritual problems (Black, 1981; Cork, 1969; Cotton, 1979; Wegscheider, 1981).

Upon reaching adulthood, it has been found that the majority of these individuals has problems related to trust, dependency, control, and identification/ expression of feelings (Black, 1981). Authors vary as to what they see as the most paramount issue confronting an adult child of an alcoholic. Black (1981) in her book It Will Never Happen To Me, based on her clinical observations, identified the adult COAs' inability to ask others for what they need or for any help/support. Gravitz and Bowden (1985), in their book Guide To Recovery, identify
the issue of control as central to other problems such as trust, a black and white perspective, and having difficulty in intimate relationships. Cermak and Brown (1982) also see conflicts involving issues of control as the central focal point for ACOAs. Ackerman (1983) sees their inability to trust as the key issue. And finally, Wegscheider (1981) sees interlocking problems associated with whatever roles the child attained within the family system and therefore maintained into adulthood.

Regardless, all authors who have studied the ACOA, whether through clinical impressions or research methods, find similar (if not the same) key issues for the ACOA to overcome in adulthood if they want to enjoy a satisfying and healthy life.

Gender Differences

Adulthood is largely based upon early childhood experiences, therefore the family is the most influential in terms of the experiences of adult life. The very structure of male and female personality is thought to be largely formed by the structure of traditional roles and relationships in the family (Rubin, 1983). How males and females carry out their social roles within the family and in other social systems is where differences originate on issues of dependency, intimacy, sexuality, and self-esteem. Therefore it is the family environment in which a child develops that has the most direct influence on
behavioral patterns he/she adopts as an adult.

In research of sex of subject differences, the main effects of sex are frequently qualified by situational factors, such as in areas of achievement, affection, and/or family life (Block, 1976). The influence of stereotypes and expectations of others can exert differential influences on males and females (Deaux, 1984). Throughout the literature, the individual dimensions of masculinity and femininity predict behavior in instrumental and expressive domains, respectively, but are found not to be very useful in accounting for the wider range of sex-related behaviors (Deaux, 1977).

However, gender stereotypes are pervasive and there is ample evidence that they exist and that they relate to a variety of judgements and evaluations of males and females (Ashmore & DelBoca, 1979).

The question of which parent is addicted has only been addressed in the literature within the last few years (Gravitz & Bowden, 1985; Sexias & Youcha, 1985). There has been overwhelmingly more data on the husband/father as alcoholic rather than wife/mother, and on the sons of an alcoholic rather than the daughters (El-Guebaly & Offord, 1977). Until recently most of the studies on alcoholism have been focused upon females as the spouse of an alcoholic rather than being alcoholic or growing up in an alcoholic home. Due to the social stigma attached to
female alcoholics, as wives and mothers, there is a tendency for a woman to hide her alcoholism from society at large and her family (Sandmaier, 1980). Miller and Jang (1977) conducted a 20 year longitudinal study of children of alcoholics and found that alcoholic mothers were considered to have more serious negative effects on children since she is usually the primary socializing agent in the family. Their study also demonstrated that sons were more likely to be heavy drinkers than daughters, except when only the mother was alcoholic. Recent evidence suggests that daughters of alcoholic mothers, as compared to sons of alcoholic mothers, suffer the most detrimental effects (Sexias & Youcha, 1985). Kaufman (1984) found that children of alcoholic mothers tended to be rigid, distrustful, and reserved as adults. It has been found that women alcoholics are more likely to have a family history of alcoholism and are twice as likely as male alcoholics to have been brought up by two alcoholic parents (Sexias & Youcha, 1985). On the contrary, McKenna and Pickens (1983) found that children with an alcoholic mother did not differ from children with an alcoholic father. However, essentially there is no agreement in the literature as to whether an alcoholic mother or father is more damaging for children.
Assessment of the Literature

There has been extensive research on the nature of alcoholism within families through generations (Chafetz et al. 1977; Cork, 1969; Cotton, 1979; Kaufman, 1984; McKenna & Pickens, 1981). There are, however, few studies in which the focus is on ACOAs who are alcoholic. There is also contradictory literature on the differential effects of growing up with an alcoholic mother and/or father. In general, there are striking contrasts between drinking patterns of male and female alcoholics (Sandmaier, 1980). In Wilson and Orford's (1978) study on which gender of alcoholic parent is more dysfunctional, they concluded that differences on impact of drinking by mothers and fathers may be a function of sex differences in drinking patterns. The literature on the family and alcoholism tends to ignore these differences and discusses the effects of parental alcoholism as a self-explanatory behavioral entity. McKenna and Pickens (1983) found that there were no differences between those children raised by an alcoholic mother as opposed to an alcoholic father, whereas Kaufman (1984) found that being raised with an alcoholic mother produced more detrimental effects than having been raised by an alcoholic father. In general, the literature suggests that having a mother who is alcoholic may be more detrimental since she has the role of primary care giver (Sandmaier, 1980).
The literature has only recently examined the effects of having one or two alcoholic parents. The percentage of cases in which both parents are alcoholic represents 20% of the alcoholic homes in the United States (Ackerman, 1983). It has been proposed that if an individual has two alcoholic parents, s/he will suffer more emotional and behavioral problems as a child (Ackerman, 1983; Deutsch, 1982; Gravitz & Bowden, 1985). Some research also suggests that if one has two alcoholic parents, one will tend to develop alcoholism much more rapidly (McKenna & Pickens, 1981).

Specific patterns of parent-child relationships tend to be described in the literature as though they are characteristic of all families with an alcoholic parent (Ackerman, 1983; Black, 1981; Cork, 1969; Wegscheider, 1981). However, Cork (1969) in her study on children of alcoholics, found a variety of patterns of parent-child relationships. Some children showed fairly consistent attitudes toward their parents, whereas others were ambivalent about one or both parents. Children in the same family often react quite differently to the same events. There is no explanation to understand how one child may be affected while another is not. The overall perception of the situation by an individual family member may vary within the same family (Ackerman, 1983). It would appear that there are many factors determining the
nature of the parent-child relationship within an alcoholic home. Parental alcoholism alone may not be predictive of the exact nature of the relationship between parents and children or the result of parental alcoholism.

There are some common assumptions held in regard to growing up in an alcoholic home and how it affects the individual as opposed to those children who did not grow up in such a "dysfunctional" family. Through overt or covert participation in a closed family system ruled by denial of the alcohol problem, children learn not to trust, but rather to anticipate their parents' actions in order to maintain control over their environment (Ackerman, 1983; Black, 1981; Cork, 1969). Through the preoccupation with alcohol, an alcoholic home is governed by inconsistent and contradictory behavior (Black, 1981; Cork, 1969; Wegscheider, 1981). Communication among family members is ruled by such internal messages as, "don't talk," "don't trust," and "don't feel" (Black 1981).

**Adult Children of Alcoholics**

A list of 14 generalizations or characteristics of ACOAs has been summarized by Woititz (1983). In order to understand ACOAs, these characteristics have been used extensively in the ACOA literature:

1. Adult children of alcoholics guess at what normal behavior is.
2. Adult COAs become isolated and afraid of people and authority figures.

3. Adult COAs become approval seekers and lose their identity in the process.

4. ACOAs are frightened by angry people and any personal criticism.

5. ACOAs become alcoholics, marry them, or both, or find any other compulsive behavior such as being a workaholic, to fulfill their abandonment needs.

6. ACOAs live life from the viewpoint of victims and are attracted by that weakness in their love, friendship, and career relationships.

7. ACOAs have an overdeveloped sense of responsibility and find it easier to be concerned with others than with themselves; which enables them to not look too closely at their faults or their responsibility to themselves.

8. ACOAs experience guilt feelings when they stand up for themselves instead of giving in to others.

9. ACOAs become addicted to excitement.

10. ACOAs confuse love and pity and tend to "love" people they can pity and "rescue."

11. They have stuffed their feelings from their traumatic childhoods and have lost the ability to feel or express their feelings because it hurts too much.
12. They judge themselves harshly and have low self-esteem.

13. They are dependent personalities who are terrified of abandonment and will do anything to hold on to a relationship in order not to experience the painful abandonment feelings they received from living with sick people who were never there emotionally for them.

14. ACOAs are reactors rather than actors.

The process of recovery for the adult child of an alcoholic involves a revision of the past (Beletsis & Brown, 1981). Based on the validation of experience in a therapeutic setting or in an ACOA meeting, it involves a cognitive restructuring of beliefs which change certain defenses into more appropriative and adaptive ways of coping (Beletsis & Brown, 1981). An appropriate externalization of the cause of one's feelings of unhappiness and hopelessness releases members from guilt and the idealization of total self-control, thus enabling them to grow (Cermak & Brown, 1982).

Theoretical Framework

In focusing upon both systems theory and Erikson's (1963) stages as theoretical reference points, one may address such questions as to what are the concrete effects on an individual's development as a result of growing up in an alcoholic home. Also, the question of whether there are differences for sons and daughters and differences
according to which (or both) parent was alcoholic can be addressed.

The central tenet of a family systems approach is that alcoholism is an integral component of a family's functioning. A primary goal of the family is to maintain a sense of equilibrium which results in a stable, balanced or unchanging system (Jackson, 1965). Disequilibrium or instability and inconsistency is created by the alcoholism and all family members react to the change in balance within the system.

An individual perspective is taken into consideration when viewing a child's personality development in having been raised in an alcoholic environment. How a child develops emotionally will influence how the child sees and handles the world. Issues of trust, separation and individuation, self-esteem, expression of emotions, and control are all paramount to the development of an individual. Developmentally, depending upon the nature and extent of inconsistency and unpredictability in the home, levels of trust, autonomy, and control are blocked by alcoholic family functioning (Beletsis & Brown, 1981; Black, 1981; Cermak & Brown, 1982). Learning theory would suggest that modeling of the same sex parent is of profound importance to the personality development of the child. It would appear, then, that the same-sex parent would have more of an impact on the child's later
development as an adult. For example, some research has indicated that same-sex alcoholic dyads, such as both mother and daughter being alcoholic, occur more frequently than cross-sexual pairing.

Application of a General Systems Theory to a Family Systems approach involves a set of different parts that are "directly or indirectly related to one another in a network of reciprocal causal effects" (Buckley, 1967, p.41). Therefore, the alcoholism of one family member affects all other family members (Wegscheider, 1981). Each family member adopts defenses and roles in order to maintain a sense of equilibrium (Ablon, 1976; Wegscheider, 1981). These defenses and roles, however, become maladaptive once the child leaves the home and creates social and psychological problems as an adult (Ackerman, 1983; Black, 1981).

Clinebell (1968) found that how much a child is affected was related to the availability/nonavailability of the nonalcoholic parent. Therefore, children are impacted by the alcoholic and nonalcoholic parent as well as by the family system dynamics created as a consequence of alcoholism.

Assumptions

The assumptions of the proposed study are:

1. The alcoholic parent is dysfunctional, which has a primarily negative impact on all other family members.
2. Having an alcoholic parent creates an emotional/psychological disadvantage to the child's development.

3. If the family has never broken the denial of the alcoholism problem, then the ACOA will continue to maintain unhealthy and dysfunctional patterns of living and coping strategies once he/she becomes an adult and leaves home.

4. The negative emotional/psychological effects of growing up in an alcoholic home will be maintained through interactions with others—especially on an intimate level, regardless of whether the ACOA has contact with the alcoholic parent and/or the family system.

5. Alcoholism is a familial disorder which is intergenerationally transmitted. Therefore, if one grows up in an alcoholic environment, the chances are high that one will develop alcoholism or some other form of addictive behavioral pattern.

6. If the ACOA continues to attend some form of therapy or to attend a self-help group, she/he can change and develop healthier coping strategies and a more positive self-image.

Statement of the Problem

The literature is contradictory concerning the nature and extent of problems in behavior and emotions that one has in growing up in an alcoholic home. There is also no conclusive evidence concerning whether there is a
difference in having one or two alcoholic parents and whether gender of alcoholic parent and gender of a child has an effect on the problems experienced by an individual in adulthood. There is virtually no literature on differences between male and female ACOAs and the extent of symptomology experienced as a child or as an adult.

The literature on adult children of alcoholics is heavily based on clinical observations, and the generalizations that have come from those observations have not been systematically evaluated. An examination of overall level of self-esteem, trust in intimacy, need for control, affection, and inclusion in relationships—to gender of subject, gender of alcoholic parent, and number of alcoholic parents—will be addressed. Therefore, the results of this study could have profound implications for the field of alcoholism and in particular for the further evaluation of experiences of those who have grown up in an alcoholic home as well as contribute to the design of interventions with children of alcoholics. The study will contribute to the clarification of the familial nature of alcoholism and the degree to which it affects those close to the alcohol abuser. Finally, this study will help explain the process through which alcoholism is perpetuated.
Research Questions

The study is designed to compare the impact of growing up in an alcoholic home between males and females; and the differential effects on personality development related to self-esteem, trust, control, and sociability. Also, whether having one or two alcoholic parents or gender of alcoholic parent has an impact on the problems experienced by the ACOA as an adult. Perceptions of the family environment will be examined in relationship to significant findings to determine whether such perceptions influence the attitudes and feelings of the participants as adults. These are the fundamental research questions:

1. Are clinical observations regarding gender and gender/differences empirically substantiated in a "large" sample using standardized measures?

2. Are there sex differences among ACOAs in the study in regard to level of self-esteem, trust, need for control, affection, and inclusion?

3. Does a correlation between sex of subject and parental alcoholism contribute to the configuration of effects?

4. Can some of the variables in the study be interpreted by knowledge about the family environment?

Hypotheses

1. There will be no difference between male and female ACOAs on level of self-esteem as measured by the
Tennessee Self-Concept Scale.

2. There will be no difference between male and female ACOAs on levels of trust in intimacy as measured by the Interpersonal Relationship Scale.

3. There will be no difference between male and female ACOAs in their desire/expression for control behaviorally over their environment as measured by the FIRO-B.

4. There will be no difference between male and female ACOAs in their desire/expression for control emotionally as measured by the FIRO-F.

5. There will be no difference between male and female ACOAs in their desire/expression to be included (inclusion) on an interpersonal-behavioral level as measured by the FIRO-B.

6. There will be no difference between male and female ACOAs in their desire/expression to be included (inclusion) on an interpersonal-emotional level as measured by the FIRO-F.

7. There will be no significant difference between male and female ACOAs in their desire/expression for affection on a behavioral level as measured by the FIRO-B.

8. There will be no significant difference between male and female ACOAs in their desire/expression for affection on an emotional level as measured by the FIRO-F.
9. There will be no significant difference between male and female ACOAs in the extent of symptomology associated with being an ACOA as measured by the C.A.S.T.

10. There will be no significant difference between male and female ACOAs on whether they have a problem with alcohol abuse as measured by the demographic questionnaire.

11. There will be no significant difference between male and female ACOAs and whether their choice of intimate partner has a problem with alcohol abuse as measured by the demographic questionnaire.

12. There will be no significant difference between male and female ACOAs and whether their choice of partner is also an ACOA.

13. The hypotheses from 1-9 will not vary as a function of gender of alcoholic parent.

14. The hypotheses from 1-9 will not vary as a function of the number of alcoholic parents.

15. There will be no significant difference in perception of the family environment as measured by the four subscales on the FES and the significant dependent variables with sex of subject, gender of alcoholic parent, and number of alcoholic parents.

Definition of Terms

1. Adult_Children_of_Alcoholics (ACOA). Those adults who suffer distinguishable disruptive patterns of behavior
which originated in their alcoholic home of origin as determined by their score on the Children of Alcoholics Screening Test. (Jones, 1982).

2. **Affection.** The need for deep relationships rather than superficial ones. (Ryan, 1977)

3. **Alcoholic.** A person is an alcoholic if he/she is unable to consistently cope, as a result of drinking, in the areas of family, career, work, health, or the law—and continues to drink (Gravitz & Bowden, 1985).

4. **Alcoholism as a Family Illness.** The systems perspective that a dysfunctional interaction of family members is in reaction to the alcoholic member(s) of the family. It is characterized by five conditions: (a) the centricity of the alcoholic and alcohol-related behavior; (b) denial and shame; (c) inconsistency, insecurity and fear; (d) anger; and (e) guilt and blame (Deutsch, 1982).

5. **Control.** Denial, suppression, and repression of the outward expression and inner awareness of thoughts, feelings, and behaviors (Gravitz & Bowden, 1985).

6. **Family Environment.** The social climate of the family in which the range of relationships and personal growth of the alcoholic family are analyzed by the Family Environment Scale (Moos, 1974b).

7. **Family Roles.** Roles are a form of behavior in which a family member adopts certain attitudes which are related to a sense of position within the family.
8. **Family Rules.** Rules determine the function of the family members and enable the family to maintain a sense of equilibrium (Wegscheider, 1981).

9. **Inclusion.** This refers to one's general social orientation (Ryan, 1977).

10. **Intimacy.** The ability and desire to share oneself honestly and openly—without hiding behind facades based on fear and/or need for control as measured by the Interpersonal Relationship Scale (Guerney, 1977).

11. **Self-Esteem.** An important component to psychological well-being, it is the measure of how much one likes and approves of one's perceived self—wholly and specifically—as measured by the Tennessee Self-Concept Scale (Sanford & Donovan, 1984).

12. **Survivors.** Adult children of alcoholics who experienced a childhood that was chaotic, conflictual, disorganized, inconsistent, and contradictory are called survivors. They grew up with a high need for control, low level of trust, and general unawareness/denial of their emotions.
CHAPTER II
REVIEW OF THE LITERATURE

The purpose of this review of the literature is to (a) provide background on the condition of alcoholism regarding its definition, diagnosis, and etiology; (b) summarize the research investigating alcoholism and the family, in particular the family etiology of alcoholism; (c) provide an appropriate theoretical orientation for the study of the impact of alcoholism on the development of personality of children who grew up in an alcoholic home; (d) present a summary of the major characteristics adopted by those (now) adults who grew up in an alcoholic home; (e) examine sex role differences; and (f) treatment for the adult children of alcoholics.

Alcoholism
Definition and Diagnosis

In the literature there are a variety of terms used to refer to the concept of alcoholism, such as alcohol dependence, problem drinker, alcohol abuser, and alcohol habituation among others. There appears to be no one universal definition of alcoholism throughout the scientific literature. There are multiple patterns of alcohol utilization, use, misuse, and abuse. There are
many practitioners in the field of alcoholism who follow
the disease concept of alcoholism which originated with
Jellinek (1960). The disease concept views alcoholism as
a physiological illness rather than a moral/ethical issue.
It has contributed to some extent to the removal of the
negative stigma associated with alcoholism. The World
Health Organization, as cited in Vaillant (1983), defined
alcoholism as an illness characterized by loss of control
over drinking which results in serious problems in any one
of the following areas: job, school, or financial
affairs; relationships with family and friends; or
physical health. The quantity or frequency of drinking
behavior is not relevant in this definition. As Vaillant
(1983, p. 42) states, "multiple alcohol-related problems
result not from ingesting large amounts of alcohol but
from being unable consistently to control when, where, and
how much alcohol is consumed." However, the American
Psychiatric Association (APA) classified alcoholism as an
addiction in which alcohol intake is great enough to
impair physical, psychological, or social functioning.
The American Medical Association (AMA) proclaims
alcoholism to be an illness characterized by significant
impairment that is directly associated with persistent and
excessive use of alcohol which may involve physiological,
psychological, or social dysfunction (AMA, 1977). Both
the APA and AMA take a medical model approach to the
concept of alcoholism and view the progression of alcoholism as a disease.

Currently, in defining alcoholism the amount of alcohol consumed is deemphasized, the areas of dysfunction are the primary focus. Perhaps the best definition available is the one provided by the National Council on Alcoholism (NCOA, 1976, p. 764) which states that "the person with alcoholism cannot consistently predict on any drinking occasion the duration of the episode or the quantity that will be consumed." Using this definition, alcoholism cannot be viewed solely within a medical model, but rather regarded as both a disease and a behavior disorder.

The point along a continuum of alcohol-related problems at which a diagnosis of alcoholism is made is arbitrary. While it is probably true that loss of control over the consumption of alcohol is not a sufficient criterion for diagnosing alcoholism, it appears that once individuals experience many alcohol-related problems, they perceive themselves and/or others perceive them as no longer in control of their use of alcohol (Vaillant, 1983).

For the purpose of this research, alcoholism will be viewed as a multi-dimensional process in which loss of voluntary control over alcohol consumption becomes a sufficient cause for much of an individual's social,
psychological, and physical problems (Vaillant, 1983). Vaillant's longitudinal study (1983) confirmed that loss of control correlated with the number of alcohol-related problems an individual manifested.

**Familial/Etiology of Alcoholism**

At this time there are multiple theories of the etiology of alcoholism; research on alcoholism is still ambiguous and controversial. Kaufman and Pattison (1982) found that most scientific authorities in the field of alcoholism now concur that there are multiple patterns of dysfunctional alcohol use which occur in multiple types of personalities, with a wide variety of adverse consequences and multiple types of treatment. There are physiological, psychological, and sociological theories of alcoholism and the most current thought is that all these theoretical factors contribute to the problem depending on individual circumstances (Lawson et al. 1983).

In reviewing the relationship between family history and alcohol abuse, Goodwin and others have suggested that "familial" alcoholism may be different from "acquired" alcoholism (Bohman et al. 1981; Cloninger, Bohman, & Sigvardsson, 1981; Goodwin, 1979). Familial alcoholism is thought to have a poorer prognosis and to begin at an earlier age. However, data from Vaillant's study (1980) did not support this view. It was true that alcohol dependence and amount of problems experienced correlated
highly with the number of alcohol-abusing relatives, however, when the relationship between severity of alcohol abuse and heredity were examined in greater detail, the association became less clear cut.

As a group, alcohol abusers with many known alcoholic relatives were two or three times more likely to manifest any given symptoms, but the symptom pattern of alcohol abusers with many alcoholic relatives did not seem very different from that of alcohol abusers with no known alcoholic relatives. (Vaillant, 1983, p. 68)

Hereditary and/or genetic theories have gained popularity recently due to evidence that alcoholism is intergenerationally transmitted (Ackerman, 1983; Black, 1981; Deutsch, 1982; Gravitz & Bowden, 1985; Jacob, 1982). As Murray and Stabeman (1982) state, "without exception every study, irrespective of country, has shown higher rates among relatives of alcoholics than occur in the general population." Cotton (1979) in her review of 39 studies on the familial incidence of alcoholism found that rates of alcoholism are substantially higher in relatives of alcoholics than in relatives of nonalcoholics. She found that regardless of the nature of the population of non-alcoholics studied, a higher rate of parental alcoholism is a specific characteristic in the population of alcoholics.
Although there is little dispute about the familial nature of chronic alcoholism, there is considerable controversy about whether genetic or environmental factors are the primary etiological agents. Steinglass (1979) reviewed both components, namely the genetic studies of twins and adoptees and the nature of the family environment itself. Twin studies have yielded conflicting results in the literature, whereas adoption studies have led to stronger evidence in support of the genetic component. All but one out of five adoption studies have pointed to the fact that although there was no significant relationship between alcohol abuse among adoptees and the foster parents with whom they lived, there was a consistent and significantly increased risk of alcoholism in adoptees if a biological parent had abused alcohol (Goodwin, 1979). However, a review by El-Guebaly and Offord (1977) focusing in part on the literature on the adult psychosocial adjustment of the offspring of alcoholics summarized this "nature vs. nurture" controversy as unresolved.

Goodwin (1976, 1979) observed that the increased rate of alcoholism in the offspring of alcoholics appears to correlate with alcohol abuse in heredity, not environment. His studies on alcoholism and heredity (1982) and McKenna and Pickens study (1981) found two distinguishing characteristics of the familial nature of alcoholism:
(a) there appears to be a positive family history of alcoholism and (b) alcoholism has a progressive nature.

In virtually all retrospective studies of alcoholics and in the two prospective studies (McCord & McCord, 1960; Robins, 1966) an unstable childhood had seemed to predict future alcoholism. Frequently mentioned conditions include broken homes, irresponsible fathers, marital discord, and inconsistent upbringing. However, in the McCord and Robins studies, male subjects were drawn from underprivileged youths known to be at high risk for delinquency. In a study by Vaillant (1980) of more socially privileged male youth, childhood environment did not predict alcoholism. It was Vaillant's conclusion that the association of childhood environmental weaknesses with future risk of alcohol abuse paralleled the relationship of parental alcohol abuse to the subject's future risk of alcohol abuse. Therefore, the increased rate of familial problems in the childhood of the alcoholic men can be explained by parental alcoholism.

In regard to childhood environment, or sociocultural theories, again there are contradictory findings. Sociocultural explanations for the etiology of alcoholism revolve around the socialization process in the form of how values, perceptions, beliefs, and norms are transmitted. The when, why, how, what, where, and how much to drink is viewed as being passed on from parent(s)
to the individual members within the family. Zucker (1976) described five levels of influence in how an adult learns to drink: (a) a family's lifestyle and community involvement; (b) family environment or interaction; (c) individual parental behaviors; (d) peer effects; and (e) the child's personality. Zucker's theory implied a connection between the first three levels and the child's personality by the way in which the child was brought up and how it affected his or her need and behavior systems. According to this theory, attitudes and motivations regarding drinking behavior will be learned through observation of parental behavior. When a child sees alcohol being used as a means of escape, the child will model this behavior and learn problem-producing drinking habits and negative coping mechanisms (White, 1982).

Harburg, Davis, and Caplan (1982) found that offspring generally imitate their perception of same-sex parent's drinking levels more than that of the opposite sex parent. Children of an alcoholic are vulnerable to the poor role modeling of the alcoholic parent and to the unattentiveness and denial-defenses of the nonalcoholic parent (Black, 1981; Cork, 1969; Wegscheider, 1981).

Another trend that has emerged in the literature was a higher rate of alcoholism in the families of women than men alcoholics (Cotton, 1979). Only two studies indicated that men alcoholics were more likely than women alcoholics
to have family histories of alcoholism. This would indicate that women are more vulnerable to the impact of familial alcoholism.

The severity of the problem experienced by children of alcoholics usually depends on (a) the age of the child at the onset of parental alcoholism; (b) personality variables of the child; (c) sex of the alcoholic parent; (d) the quality of the relationship with the non-alcoholic parent; (e) whether physical or sexual abuse occurred; and (f) socioeconomic status (Gravitz & Bowden, 1985; Knight, 1980; McKenna & Pickens, 1983; Orford, 1979).

Contradictory to such a specific description of problems experienced by children of alcoholics, Vaillant (1983) states:

Certainly, parental alcoholism causes emotional pain and psychological disorders in the children of alcoholics; certainly, some children of alcoholics may model themselves on their parents; certainly, the family structure of alcoholics is peculiarly distorted to facilitate alcohol abuse. Nevertheless, there is no evidence that these factors statistically increase the risk of alcohol abuse in children if they are not biologically related to the alcoholic family member. (pp. 64 & 65)

He found two significant childhood precursors of alcoholism: (a) growing up in an alcoholic environment
and (b) having a number of close relatives who are alcoholics. As a result, children from either background became alcoholic in substantially greater numbers than those who experienced other kinds of problems, such as mental illness or parental death, in childhood.

Therefore, not all children of alcoholics experience identical emotional and physical effects. Heredity and environment have an impact on the development of the child and the effects of parental alcoholism may begin very early in the child's life, long before he or she is even aware that there is a problem. Clearly children of alcoholics represent a high risk group for psychological problems. Situations in the family environment such as shift in parental roles; inconsistencies in support, affection and security; and familial denial of the problem create an unhealthy environment in which to learn adequate ways of coping with life (Knight, 1980).

There is evidence to support the view that if a child has adequate emotional support from the nonalcoholic or significant other person in the child's life, the effect of parental alcoholism is minimized (Booz-Allen & Hamilton, 1974; Wilson & Orford, 1978). Perhaps the literature can be criticized for a narrow focus on the negative effects of an alcoholic parent on the development of a child. However, there are very few studies to support the view that there are alcoholic families in
which children are not disrupted by alcoholism. Moos and Billings (1982) focused on the effects of parental sobriety on the children and found no difference between those children and children from nonalcoholic families. This would imply that long-term effects of parental drinking need not be negative. However, most of the literature to date does imply that there are necessarily long-term consequences on emotional development for those children who have grown up in an alcoholic home (Ackerman, 1983; Black, 1981; Gravitz & Bowden, 1985; Sexias & Youcha, 1985; Wegscheider, 1981).

In conclusion, it would seem that the etiology of alcoholism is far too complex to be examined solely from the perspective of one discipline. Perhaps, "its understanding requires the collaborating of scientists from the social, behavioral, and natural sciences" (White, 1982, p. 228). It would appear then that there are different types of alcoholics and different kinds of alcoholisms. Royce (1981, p. 141) stresses "that two or more causes can work together in the same individual and in different proportions in different individuals. It may be that no one cause is sufficient to trigger alcoholism." Perhaps certain physiological factors, either hereditary or environmental, are combined with some psychological or sociocultural factors to produce alcoholism. Because of the extensive disagreements about the etiology and nature
of alcoholism, a number of experts in the field have begun to view alcoholism as a "final common pathway" representing a multidimensional and multidetermined phenomenon (Jacob, Favorini, Meisel, & Anderson 1978). There appears to be no doubt that the family plays a critical role in the degree to which alcoholism affects the various members later in life. Social and behavioral consequences such as work and economic disruptions, diminished social contacts, internal conflict of roles adopted by family members, and finally incest and domestic violence are all a part of the effects of alcoholism within the family. As Steinglass (1982) states,

By and large, we have come to see the family as one of a series of mediating variables that play a significant role in three major areas: first, whether a clinical pathological condition will actually develop; second, the way the condition will express itself (source, course, severity, etc.); and third, the seriousness or effect of the condition once it has emerged. (p. 319)

**Family Systems Approach to Alcoholism**

A systems framework is widely accepted as a theoretical base for understanding the interaction among individuals in an alcoholic family. The main premise of this approach is that alcoholism is an integral component of the family's functioning. The first viable attempt to
apply family systems concepts to problems of alcoholism was a theoretical article by Ewing and Fox (1968). A central feature of Family Systems Theory is the existence of a system of boundaries and maintenance of the boundary system. The effectiveness of such a system is connected to whether the boundaries are open or closed. Within the boundaries the family system consists of interdependent personalities, each member having a particular role function. The behaviors of one individual affect the functioning of the other family members (Ablon, 1976).

Until recently, the alcoholic was the sole focus of attention, whereas the spouse and other family members were almost totally neglected in the study of the etiological consequences of alcoholism. The alcoholic was typically presumed to be the husband; the alcoholic woman was ignored entirely (Royce, 1981). When studies began to be published on family dynamics of alcoholism, in the 1950's, most of the research was done on the wife of the alcoholic who was assumed was a neurotic person who married an alcoholic husband to satisfy an unconscious need to be needed (Ablon, 1976; Jacob et al. 1978). It followed that if the alcoholic husband achieved sobriety, the wife would psychologically and/or physically deteriorate—because she was no longer in control and no longer needed. "Personal maladjustment was seen as the
cause of being married to an alcoholic, not the result" (Royce, 1981, p. 120).

This point of view was challenged by Jackson (1954) who found that the majority of wives of alcoholics were normal personalities at marriage and the neurotic behavior that they exhibited was a reaction to living with the alcoholism. Edwards, Harvey, and Whitehead (1973) also came to the conclusion that no single personality type could be identified and that wives of alcoholics "may exhibit personal dysfunction under specific stresses, and that the dysfunction tends to disappear when the stressors do" (cited in Ablon, 1976, p. 215). This paralleled a shift in alcoholism theory away from psychopathology as the cause of alcoholism and toward a recognition that psychopathology may result from alcoholism (Royce, 1981).

Jackson's (1954) work presented evidence that the concept of a unitary personality type was untenable. Her research placed emphasis on the adaption of the total family to stressors caused by the existence of alcoholism in the household. This orientation was based on a functional and interactional perspective which drew attention to alcoholism as a holistic family problem.

In the 1970's and 1980's, it became clearer that other family members are also seriously affected by the alcoholic. Alcoholism is now commonly referred to as a "family disease" (Hanson & Estes, 1977; Steinglass, 1980),
with all family members subject to constant stressors and fears of various kinds. Family members develop the same behavioral and cognitive disorders as the alcoholic, in which denial is the central problem. The maintenance of the "secret", i.e., alcoholism, is the central focus around which the family is organized (Beletsis & Brown, 1981).

Steinglass (1979, 1982) has done extensive study of alcoholic-family interaction. In his research he notes the importance of understanding the environment in which the family members live and the interactional factors involved. Substantiative evidence has been presented to support the position that alcoholic families organize significant aspects of their interactional life around the process of alcoholism itself. The family systems model as applied to alcoholism is based on a behavioral system in which alcohol consumption and its consequences have become an organizing principle for whatever interactions occur in that system. Wegscheider (1981) used the analogy of a mobile and how it is designed to maintain its equilibrium; regardless of how it's moved, touched, etc., it eventually brings itself back into a state of balance. Although the significance of alcohol may be similar across families, individual perceptions of the family environment may differ (Brown, 1985). Therefore understanding the individual family environment is also extremely important
Alcoholism is both personal and systematic. It affects each family member as an individual and the family system as a whole (Wegscheider, 1981). The overall perception of the situation by an individual family member may vary within the same family.

Each family member requires his or her own individual analysis of the situation. To understand the individual situation, the degree of alcoholism, the type of alcoholic in the family, and the nonalcoholic's individual perceptions must be considered. (Ackerman, 1983, p. 8)

An alcoholic home is a dysfunctional family system. Most alcoholic families appear to be characterized, in varying degrees, by five conditions regardless of income, size, or gender of the alcoholic in the family: "(a) centricity of the alcoholic and alcohol-related behavior; (b) denial and shame; (c) inconsistency, insecurity, and fear; (d) anger and hatred; (e) guilt and blame" (Deutsch, 1982, p. 31). Although these characteristics may not be unique to alcoholic families, they are uniform in most alcoholic homes and are significantly different from the conditions which govern most other households.

The denial in not acknowledging the problem is perpetuated by the rule don't tell anyone (Beletsis &
Brown, 1981; Black, 1981; Wegscheider, 1981). In most alcoholic families there is a major secret that all behaviors revolve around and that is the alcoholism. The centricity becomes the maintenance of that secret and the whole family is organized around it accordingly (Beletsis & Brown, 1981). Under such circumstances, the alcoholic family becomes more isolated and defensive (Beletsis & Brown, 1981). The level of denial varies in families from one of perceiving the alcoholism as nonexistent to denying the seriousness of it. It is rare to find that alcoholism is acknowledged by all members in an alcoholic family to be the central problem (Brown, 1985).

Shame is a reaction to the semi-acknowledgement by the children that their family is different from others and that there is something wrong (Cork, 1969; Deutsch, 1982). Anger and hatred of the alcoholic or for the drinking itself creates an ambivalence which leads to guilt and/or blame. Individual family members assume the responsibility that they can somehow change the situation. Insecurity and fear are created as a result of inconsistent and unpredictable behavior.

When drinking, many alcoholics are physically violent. This produces fear in the other family members. The relationship between alcohol and violence appears to be significant (NIAAA, 1978). Wilson and Orford (1978) found that the presence of violence in the alcoholic home
produced significantly more symptoms of a developmental disorder in both boys and girls, regardless of whether or not the children had been beaten themselves. It would seem that it does not matter whether the violence is directed at the children, the nonalcoholic parent, or the furniture. Nothing reinforces a child's insecurity and fear more than violent behavior (Deutsch, 1982).

Children must participate in their closed family system or risk betraying the family as a whole or individual members within it. They learn not to trust their own perceptions of reality because it would not be congruent with their parents' reality (Brown, 1985). They learn to be unsure of whether a given behavior will elicit approval or condemnation, and such an inconsistency reinforces their denial. The more family members deny the alcoholic's drinking problem and its effects on them, the more intense will be their feelings of fear, anger, and guilt. One of the most common reactions among the children of alcoholics is to anticipate their parents' actions in order to maintain control over their environment (Ackerman, 1983; Black, 1981; Cork, 1969). "In essence, these children constantly monitor their own behavior, frequently at the expense of creating feelings of conflict, resentment, anxiety, and anger within themselves" (Ackerman, 1983, p. 50).
Black stresses the point that parents are not consistently available to their children due to preoccupation with alcohol. This fosters a deep distrust in others by the child. The communication is rigid and closed between family members, and the messages communicated are usually mixed and contradictory, fostering distrust (Black, 1981; Kaufman, 1984). The two most common themes authors use to describe an alcoholic home are inconsistency and unpredictability (Ackerman, 1983; Beletsis & Brown, 1981; Black, 1981; Deutsch, 1982).

When drinking, alcoholics may show mercurial changes—from withdrawn to generous to violent within minutes. When they are not drinking, their lives are still organized around alcohol. (Deutsch, 1982, p. 41)

The lives of the children and the nonalcoholic parent revolve around reacting to the demands, moods, and preoccupation with alcohol or the alcoholic. Thus the child's feelings, needs, and behavior are dictated by the state of the alcoholic at any given time (Beletsis & Brown, 1981).

On the other hand, a functional family system is characterized by promoting a child's sense of psychological well-being through consistent and somewhat predictable behavior, rules, and roles. It is a system which represents component parts which are linked together
in a particular way to accomplish a common purpose. To understand the effects of alcoholism on the family one needs to look at the individual members of the family. The parts (members of a family) are linked together by family rules which determine the functions of each person (roles); the relationships between persons; and the goals, values, expectations, and attitudes of family members (Wegscheider, 1981).

Despite the increasing recognition of alcoholism as a family disease, children of alcoholics remain misdiagnosed and inappropriately treated (Ackerman, 1983; Black, 1981; Cork, 1969; Gravitz & Bowden, 1985). Because of the centricity of the alcoholic, the children's problems are rarely addressed or recognized, and the alcoholism is never discussed (Black, 1981; Deutsch, 1982; Wegscheider, 1981). Although attention given to children of alcoholics has increased understanding of the powerful impact parental alcoholism has on them, the increased vulnerability to alcoholism among these children has not been appropriately studied.

Children of Alcoholics

One of the first studies on children of alcoholics was done by Cork (1969). In her book, *The Forgotten Children*, she reported on the commonality of experiences of 115 children from alcoholic families. In these families Cork found little sensitivity to the needs of the
children. She found that children became so absorbed in family problems that they were unable to develop a sense of responsibility or an ability to solve problems. These children were confronting adult problems and had not expressed their feelings about it with others.

In reporting what factors negatively affected the lives of children of alcoholics, Clinebell (1968) focused on the nonavailability of the nonalcoholic parent. Since the needs of the non-alcoholic parent are not being met, he/she can't meet the needs of the children. As the individual progresses in his/her alcoholism, it is normal for the spouse to become increasingly preoccupied with the behavior of the alcoholic. For the children, this results in neither parent being responsive and available on a consistent, predictable basis (Black, 1981). Therefore, children are impacted by the alcoholic and nonalcoholic parent, as well as the abnormal family dynamics created as a consequence of alcoholism. These dynamics and all family members are governed by rules and roles within the family system.

Wegscheider (1981) proposes that rules perform four broad functions for the family system:

(a) to establish attitudes, values and goals for the family; (b) to determine who will hold the power and authority, how they will be used, and how members are expected to respond to them; (c) to anticipate how
the family will deal with change—in itself as a unit, in its members, and in the outside world; (d) to dictate how members may communicate with one another and what they may communicate about. (p. 47)

Healthy rules are made for the benefit of the whole family not just one person and are flexible, stable, and contain open communications. Rules are more explicit in functional families and do not change from day to day (Gravitz & Bowden, 1985). "While one of the clearest indicators of a smoothly working family is consistency, the words which best describe living in an alcoholic family are inconsistency and unpredictability" (Black, 1981, p. 13). Therefore, in an alcoholic home, rules appear to be based on a structure of fear, guilt, and denial (Black, 1981; Gravitz & Bowden, 1985; Wegscheider, 1981).

Examples of rules Wegscheider (1981) encountered in her clinical work with alcoholic families were: (a) the dependent's use of alcohol is the most important thing in the family's life; (b) a pervasive denial that alcohol is the problem; (c) no one is to discuss the issue inside or outside of the family; and (d) no one may say what he/she is really feeling. Black (1981) simplified the concept of denial in the alcoholic family by compacting the dysfunctional rules—"don't talk, don't trust, and don't feel." A family in which communication is based on denial
and fear represents a closed and rigid system (Black, 1981; Wegscheider, 1981). In a closed system, the family remains insular which increases the denial and secrecy of family members (Broderick & Smith, 1979). Hanson and Estes (1977) in looking at dynamics of alcoholic families found little willingness to communicate on a level of constructive exchange of feelings. Efforts are made to control the other person's behavior through downgrading, avoidance, and/or blaming. Kaufman (1984) defined such a family as a "neurotic enmeshed family system" where the drinking behavior interrupts normal family tasks, causes conflict, and creates a shift in roles.

Whether a child grows into a mature adult depends largely on how well each family member plays his/her special role in the family. Each role gives a unique identity to each member of the family, and how well one person plays his/her role affects how well other family members play their roles. The general emotional climate is an important factor in the role development of family members.

Children growing up in alcoholic homes seldom learn the combinations of roles which mold healthy personalities. Instead, they become locked into roles based on their perception of what they need to do to 'survive' and to bring some stability to their lives. (Black, 1981, p. 14)
Through her clinical work with alcoholic families, Black (1981) defines the role behavior of children of alcoholics in basically two categories (a) the scapegoat, acting out child; and (b) the super-responsible, placator. It is this last category that Black (1981) believes the majority of children of alcoholics fall into:

I contend most children in alcoholic families are not seen by school counselors, are not addressed in juvenile justice systems, are not treated for asthma or hyperactivity. While there is a substantial number of problematic children from alcoholic homes, the majority of these children simply do not draw enough attention to themselves to even be identified as being in need of special attention. They are a neglected population. If they are busy and look good, they will be ignored. (p. 16)

Pilat and Jones (1984) administered the Children of Alcoholics Screening Test (C.A.S.T.) to tenth, eleventh, and twelfth grade children from different achievement tracks and found that 27% (47 students) were identified as having an alcoholic parent. Of this 27%, none were identified as having school problems, but rather the majority of these children were working at the appropriate grade level or above. Perhaps this lends credence to the theory that these children are "survivors" and do exercise control over their environment.
Family members work hard at their individual roles in order to save the family system at the expense of their own emotional and physical health. Wegscheider (1981) also identified role behaviors specific to an alcoholic family system. She proposed "that family members eventually become addicted to their roles, seeing them as essential to survival and carrying them out with the same compulsion, delusion, and denial as the dependent plays his role of drinker" (Wegscheider, 1981, p. 88).

Although there are rewards for these role behaviors (responsible ones are successful; adjusters are adaptable), there are also negative consequences for playing these roles. These roles do not change when they leave the alcoholic family or when the alcoholic achieves sobriety without a positive change in the family system (Black, 1981; Cork, 1969; Lawson et al. 1983; Wegscheider, 1981). The emphasis on don't talk, don't trust, and don't feel (Black, 1981) leads to a predominance of defensive coping strategies.

In their study, Booz-Allen and Hamilton (1974) as cited in Lawson et al. (1983) identified four coping mechanisms that parallel the role behaviors adapted by children growing up in an alcoholic home:

1. Flight. These children avoid the alcoholic by not being home, hiding in their rooms, emotionally
withdrawing, blocking memory, going to college, getting a job, or getting married.

2. Fight. These children are aggressive and act out; they are the ones which are seen as behavior problems.

3. Perfect child. These children are "good" and never do anything wrong.

4. Super coper. They are super responsible and are more adult than children.

These coping mechanisms are the key to surviving in an alcoholic home. The children (and co-alcoholic) learn to adapt their behavior in order to minimize the effects of alcoholism (Ackerman, 1983).

It appears obvious that those children growing up in an alcoholic home have a difficult time obtaining a sense of self; they obtain no sense of value from parents who are forever absorbed in their own affairs (Black, 1981). "Children see parental behavior as a reflection of their own worth" (Ackerman, 1983, p. 50). Children of alcoholics may tend to feel that because there is something wrong in their family, then there is something wrong with them.

Development

Environment has a profound influence on emotional and personality development. "Development is seen to reflect either biological or environmental influences which result
in changes in the structure, thought, or behavior of a person" (Craig, 1976) as cited in Ackerman (1983).

How a child develops emotionally will influence how the child sees and handles the world. Although children of alcoholics do experience healthy dynamics, such as love and laughter, within their homes; feelings of fear, guilt, anger, and anxiety predominate. Security, an essential component of self-worth, is usually absent in an alcoholic family. Absence of security in children of alcoholics can often produce undesirable and/or destructive defense mechanisms, which are then carried over into adulthood (Ackerman, 1983; Black, 1981). Examples of such defense mechanisms are projection, intellectualization, and denial of emotions and/or problems.

Many developmental theorists divide life experiences into stages, whereupon each stage consists of basic tasks which must be overcome—a resolution of conflicts and crises—in order to achieve adequate levels of development.

For many children of alcoholics the crises confronted in successive stages are compounded by unsolved problems left over from previous stages, plus the continuing stresses caused by living with an alcoholic parent. (Ackerman, 1983, p. 67) Such a compounding effect can have detrimental consequences for personality development.
Erickson (1963) and Mahler, Pine, and Bergman (1975) have outlined detailed theoretical frameworks from which to view psychosocial development. The development of trust is a vital element of a healthy personality. The development of an adequate relationship with the mother is necessary for a healthy attitude toward self and others in interpersonal relationships. Trust is a process and does not seem to be necessarily dependent on demonstrations of love but rather the quality of the maternal relationship (Erickson, 1963).

It is true that a woman is almost always the primary caregiver of infants and, because a woman has been a primary person in the life of a child, it is with her that first identification is made (Rubin, 1983). As infancy passes, the period of separation and individuation begins. The fear that separation means abandonment in which the state of anxiety prevails is a result of a male or female child's fear that outside the mother's presence either the mother or the child will cease to exist (Winnicott, 1960). In an alcoholic home in which a mother may not be responsive to the child's needs, this fear manifests itself in adulthood as a fear of abandonment, thus creating a block for trust and intimacy.

In a family where the mother is an alcoholic, the mother/infant relationship will be impaired. The mother's primary emotional involvement may be with alcohol and the
child's needs will be secondary; also the consistency of the mother's behavior toward the child may be nonexistent due to her preoccupation with herself (Beletsis & Brown, 1981).

In terms of roles and the identity process between mother and daughter, the separation struggle in which the child establishes the boundaries of self is more complicated for girls than boys. "Because they are the same gender, it's more difficult for a girl to separate, harder for her or her mother to know where one ends and the other begins" (Rubin, 1983). However, in establishing gender identity, the difference between mother and son makes it more difficult and complicated for boys.

If the father is the alcoholic, the mother's preoccupation is still with the alcoholic and/or the problems associated with it. Such inadequate and inconsistent caretaking results in the psychological abandonment of the child.

Trust

To trust another entails investing confidence and faith in that person. The loss of responsiveness to the child's needs creates a basic sense of mistrust (Erickson, 1963). Therefore, there is the tendency in children of alcoholics to deny or adapt needs to themselves and/or others around them. The failure to develop confidence
(trust) creates a tendency for the child to withdraw in an attempt to control the environment and over control of self (Erickson, 1963).

Trust is an ongoing process and in order for children to trust, they must feel some sense of security. They need to be able to psychologically, emotionally, and physically depend on their parents (Black, 1981). In alcoholic homes parents are either drunk, physically absent, or mentally and emotionally preoccupied with alcohol or the alcoholic. Consequently, children cannot rely on their parents to provide that sense of security.

Contradictory messages or distorted images of the truth also reinforce mistrust in children of alcoholics. No child can trust or be expected to trust on any significant level unless those around him/her are also open and honest about their own feelings (Black, 1981). Because of an alcoholic's level of denial, self-honesty is hard to come by.

Children of alcoholics do not seem to have the sense of security in order to take risks. In order to trust another, some level of trust is involved when words and behavior do not coincide: It is the parent's behavior which allows a child to believe.

Because of broken promises and not being able to rely on consistency of positive interactions, children are often confused by them, and many times don't trust
the motivation behind them. (Black, 1981, p. 44)

Problems arise in children of alcoholics because their environmental circumstances make it nearly impossible for them to feel safe and secure, or to rely on or trust others. The failure to develop basic trust is the predecessor of more severe problems with interpersonal relationships such as inability to tolerate intimacy and confusion over locus of control (Beletsis & Brown, 1981; Gravitz & Bowden, 1985).

**Individuation/Separation**

The second stage of development according to Erikson is autonomy vs. shame and doubt which is virtually impossible to attain for children of alcoholics. Since the child is already sensitive to the parents' needs, to unpredictable responses, and possible inconsistent physical treatment, the child may not be able to develop sufficient autonomy (Beletsis & Brown, 1981).

It is this period when the fundamental sense of responsibility for others develops. The child who has unsuccessfully differentiated has not developed the ego boundaries necessary to discriminate the source of feelings, who is responsible for whom, nor to risk testing out and defining limits and boundaries (Beletsis & Brown, 1981, p. 193). Mahler et al. (1975) refers to this ego differentiation as the separation and individuation stage. An integrated
sense of self facilitates stable commitment to objects and also increases the ability to tolerate difference and separateness from those one loves and admires (Wood, 1984). As Meissner (1984) points out, there is a sense of continuity and sameness that characterizes a well-integrated personality. Such stability and individuation appear absent in many ACOAs who characteristically are often erratic and extreme in their interpersonal commitments.

Children of alcoholics are unable to differentiate the real responsibilities from the perceived responsibilities in terms of control or affecting the parents' drinking. They seem to believe that they can do something to help or control the parent although the reality is one of failure and helplessness. For these children, the failure to develop autonomy and to begin the process of separation and individuation creates a family system which remains both increasingly dysfunctional and unresolvable (Beletsis & Brown, 1981). In poorly individuated persons, there is an inherent difficulty in maintaining their own emotional functioning. As in an alcoholic family, when a family member is in crisis there is also a tendency for other family members to suffer some element of crisis.
Self-Esteem

A sense of connectedness to others, balanced by a sense of separateness from them, is an essential ingredient to self-esteem (Sanford & Donovan, 1984). If a child's sense of self is subsumed within the alcoholic's identity, or based on the problem of alcohol in the family, he/she cannot distinguish the ways in which he/she is unique and apart from others.

In an alcoholic family, when a child reaches school age the confidence/trust in self and the transition to initiative and mastery may already be distorted by feelings of anxiety and fear. The child's needs and behavior may be increasingly dictated by the state of the alcoholic or the nonalcoholic's involvement (Beletsis & Brown, 1981). The defensive coping strategy of control becomes more and more important as the child attempts to manage and control his/her environment.

Peer relationships may be difficult to maintain because of fear and shame of their family environment. It prevents children of alcoholics from bringing friends to the house which reinforces the social isolation of these children (Cork, 1969). Important social skills and sense of ease is absent in peer relations because of these children's preoccupation with the survival of the family secret (Beletsis & Brown, 1981; Black, 1981).
The major emphasis in this stage is on the overall family's use of denial. This emphasis on denial as a major defense in the family has a powerful effect on the child. His/her perceptions are often contradicted by the parents' words and what they see. It becomes increasingly difficult for these children to develop initiative and mastery when they do not trust in themselves or others.

Children raised in alcoholic homes will do whatever they possibly can to bring stability and consistency into their lives (Black, 1981). In confronting the family denial they learn to focus on the environment or on other people, or learn to detach themselves from the family. Therefore, they learn to discount and repress their perceptions and feelings; some may even invest energy into not feeling at all (Black, 1981; Wegscheider, 1981). "The very mechanisms which allow for survival—denial, withdrawal, lack of trust and secrecy—cut the child off from learning and demonstrating their mastery" (Beletsis & Brown, 1981, p. 194).

A persona is erected by a child in a troubled environment to protect his/her inner self from being submerged within the failure of an alcoholic system of parental care and adaptation (Wood, 1984). Good care is lost to the preoccupation with alcohol, and the needs of the child are lost in the pursuit and use of alcohol by
both the alcoholic and the spouse of the alcoholic. Such an adoption of a false sense of self by the child of an alcoholic creates an unawareness of many aspects of his/her inner experience, as well as the ability to establish a detachment from it (Wood, 1984).

Control

In order to have a sense of self-esteem, children need to learn that they have control over their own behavior. In an alcoholic home, a child is more likely to maintain an assumed role, an identity pressed on him/her by circumstances beyond his/her control (Brown & Beletsis, 1981).

A child growing up in a troubled family has great reason to be insecure because her/his survival is dependent upon parents who are distracted or completely overwhelmed by problems. Since her/his parents are so consumed by problems, they are not available to meet the child's needs, thus resulting in a fear of abandonment and a feeling of responsibility to take care of others in order to feel worth keeping around. This denial of self as a unique and worthwhile person creates a sense of vulnerability that, in late adolescence and into adulthood, is kept hidden behind a facade of strength and being in control (Beletsis & Brown, 1981; Sanford & Donovan, 1984). The accumulation of lack of trust in others, loss of confidence in self, lack of a sense of
mastery and initiative, and a high need for control in ones life, creates an inadequate developmental make-up for a child growing up in an alcoholic home. Therefore, these children maintain the experience of denying feelings and needs, which does not permit reaching out for support or help and makes relationships with others difficult.

The efforts by family members to maintain a sense of equilibrium is an orientation from which a family systems operates. Through the use of denial, control, and other various rules and roles adopted by the family members, a dysfunctional equilibrium is maintained in an alcoholic system. An individual developmental perspective operates also within the family system. Hanson and Estes (1977) stated that since the alcoholic parent is not functioning in his/her role adequately, nonalcoholic members shift role performance to compensate in an effort to keep the family functioning. However, due to the nonalcoholic's preoccupation with the alcoholic, more often than not the child's needs are thwarted. Individuals within the family system suffer on some level developmentally, whether it is trust, self-esteem, control, and/or expression of emotions (Ackerman, 1983; Beletsis & Brown, 1981; Black, 1981; Gravitz & Bowden, 1985). Taking both a systems perspective and an individual perspective provides a framework in which to understand how intimacy and trust in interpersonal relationships are so difficult for those who
have been raised in an alcoholic home.

Adult Children of Alcoholics

Various authors (Beletsis & Brown, 1981; Black, 1981; Gravitz & Bowden, 1985; Jacob, 1982; Wood, 1984) have found that the offspring of alcoholics experience a recognizable pattern of interpersonal and introspective difficulties during their adult years. Their development has been hindered by the inconsistency of behavioral expectations and limits, physical and emotional care, and communication and interaction (Cork, 1969; Deutsch, 1982; Fox, 1962; Sexias & Youcha, 1985).

Recent estimates indicate that there are between 28 and 34 million children of alcoholics, over half of whom are now adults (Black, 1981). Of these approximately 17 million ACOAs, over half are at risk of becoming alcoholic themselves or developing other addictive behavior; they are at risk of marrying an alcoholic; and they are at risk of developing predictable problematic patterns of behavior (Black, 1981; Cotton, 1979; Gravitz & Bowden, 1985). The term ACOA became readily used by professionals in the late 1970's when research began to reveal that children growing up in alcoholic families are particularly vulnerable to certain emotional/ psychological, and physical problems (Black, 1981; Booz-Allen & Hamilton, 1974; Cork, 1969; Cotton, 1979; Gravitz & Bowden, 1985). In fact, the National Association for Adult Children of Alcoholics
NAACOA is an organization which considers adult children of alcoholics as having an adjustment disorder in reaction to familial alcoholism. It is a professional and advocacy network established in order to meet the educational and treatment needs of professional and lay ACOAs nationwide.

ACOAs are described as "survivors" in that they made it through childhoods in which their lives were threatened emotionally and physically. They enter adulthood coping with life by what/how they experienced childhood (Gravitz & Bowden, 1985). They take their childhood rules, roles, and coping strategies with them into adulthood; however, they discover that what worked in their dysfunctional family environment does not work as well in adult life.

The rules of childhood (Black, 1981)—"don't talk, don't trust, don't feel"—often become rigid laws of adulthood. They seldom share their inner feelings and do not allow others to truly know who they are (Black, 1981; Woititz, 1983). When they do allow themselves to identify an emotion, they have a strong tendency to make absolute decisions related to a particular feeling, such as moving or leaving a spouse. There appears to be a deep nonunderstanding of their feelings which intensifies the fear of them. As Black (1981) states:

Years ago, as small children they began rolling their feelings up in a bundle like a small piece of snow rolling down a hill and these feelings have now
become a snowball. By the time the snowball reaches the bottom of the hill - by the time the children have grown up - the feelings have simply been stored up, bad feelings upon bad feelings. No wonder adult children are scared. Now, when they do get in touch with all their feelings, down to the very core, they are overwhelmed. (p. 108)

They have learned to deny, block out, repress, isolate, and dissociate input from their feelings, thoughts, and senses (Gravitz & Bowden, 1985). As a result, they at times unwittingly convince themselves in their facades to others that they are well-adjusted and do not need anyone's help or support. ACOAs are often misdiagnosed because their coping styles tend to be approval-seeking and socially acceptable, and they themselves are unaware of what is the source of their pain (Woititz, 1983).

More recently, the literature has reflected a concern with what happens to the child in an alcoholic family, when, as is frequently true, she/he remains untreated into adulthood. Authors such as Woititz (1983), Perrin (1983), and Cermak and Brown (1982), have compiled a list of behavioral and emotional characteristics which seem to appear on a consistent and regular basis in ACOAs. The characteristics described by all these authors are the result of their clinical work with ACOAs and represent a
severe developmental disruption of their capacity for love and work (Wood, 1984). The important issues which have been identified in ACOAs are very low self-esteem; an excessive preoccupation with acquiring and maintaining control of people, places, and things; an inability to express their emotions and to ask for what they need; a profound sense of distrust in self and others; the tendency to come from an "all or nothing" perspective or a "black and white" philosophy; an addiction to excitement; an inability to have fun or relax; a constant need for approval and affirmation; and an inability to attain and/or maintain intimate relationships.

Gravitz and Bowden (1985) from their clinical work with ACOAs in group therapy see these core issues/characteristics becoming the most noticeable in the area of intimate relationships. They stress that intimate relationships require trust, give and take, surrender of control, spontaneity, and an ability to see oneself and others as human, changeable, and fallible, all of which are difficult for children of alcoholics (Gravitz & Bowden, 1985).

The child's fear of abandonment, which connects to Erickson's ego loss, creates the excessive need by the ACOAs for control over their environments. Unfortunately, the fear of being "out of control" does not lead to much risk taking behavior which in turn directs them toward
isolation rather than intimacy (Beletsis & Brown, 1981; Gravitz & Bowden, 1985). The coping strategies used to reckon with their fears and control outward and inward expressions of thoughts, feelings, and behaviors are denial, suppression, and repression (Gravitz & Bowden, 1985).

Another prominent issue which pervades all areas of ACOAs' lives is the "all-or-none" functioning which is the tendency to think, feel, and behave in an all-or-none way (Gravitz & Bowden, 1985). The all-or-none approach can result in adult children's difficulties establishing adequate boundaries between themselves and others. In their relationships with their parents, many children of alcoholics confused love with need or caretaking and as adults "they frequently confuse other feelings, including intimacy with smothering, spontaneity with irrationality, and relaxation with depression" (Gravitz & Bowden, 1985, p. 50). Such a confusion of feeling-states contributes to their difficulties with personal boundaries and relationships. As Meissner (1984) points out, successful individuation is linked to one's capacity to maintain attachment to another despite the inevitable disappointments, conflicts, and disillusionments that arise in any interpersonal relationship. ACOAs will either persist in relationships regardless of whether they are healthy ones or not, sometimes to the detriment of
both parties, or abandon a relationship in a moment of intense feeling. The all-or-none functioning creates a world bordering on the extremes. As their experience must coincide with their black and white view of the world, they are not able to adequately utilize information from the environment (Gravitz & Bowden, 1985; Wood, 1984).

Control and an all-or-none functioning are crucial to understanding the repetitive and self-defeating patterns of behavior which typically characterize ACOAs. Cermak and Brown (1982) found control to be so pervasive that it affects other issues, such as trust, feelings, and appropriate taking of responsibility. The all-or-none functioning seems to influence the issue of control. Control is either present or absent and for ACOAs "control is guarded like a house of cards - if one piece is moved, the whole structure might collapse" (Gravitz & Bowden, 1985, p. 66). This rigidity in thinking, feeling, and behaving limits ACOAs interactions with others.

In summary, adult COAs are found to exhibit behavioral and emotional characteristics such as low self-esteem, self-criticism, inability to identify and express their emotions, inability to vocalize their needs, distrust in self and others, constant need for approval, excessive need for control over self and environment, a dichotomous view of the world, and having difficulty in attaining and/or maintaining intimacy in interpersonal
relationships (Beletsis & Brown, 1981; Black, 1981; Cermak & Brown, 1982; Gravitz & Bowden, 1985; Sexias & Youcha, 1985; Woititz, 1983). If ACOAs do seek professional help, it is usually in the area of intimate relationships where they see patterns of conflicting feelings or behaviors which do not work (Gravitz & Bowden, 1985).

**Gender Differences**

There is no agreement in the literature as to whether an alcoholic mother or father is more damaging for children. There is, however, overwhelmingly more data on the husband/father as alcoholic rather than wife/mother as alcoholic, and the sons of an alcoholic as opposed to the daughters (El-Guebaly & Offord, 1977). In their examination of the literature, they pointed out that there have been no consistent differences found between children with maternal and paternal alcoholism, however there is some evidence that boys with alcoholic fathers showed more disturbances than did boys with alcoholic mothers.

Wilson and Orford (1978) conducted a study of 11 families with one parent in treatment to determine which gender is more dysfunctional to a child's development. The evidence was inconclusive, and they concluded that differences in impact of drinking by mothers and fathers may be a function of sex differences in drinking patterns. McKenna and Pickens (1983) found that children with only an alcoholic mother did not differ from children with an
alcoholic father. However, Kaufman (1984) indicated that alcoholic fathers tend to abuse their children sexually and violently, while alcoholic mothers are more prone to abuse their children through neglect. Although this may be true, one would be hard pressed to state which would have more harmful effects on the child.

Recent evidence suggests that daughters of alcoholic mothers suffer the most detrimental effects of any parent/sex of child combination (Sexias & Youcha, 1985). "Women alcoholics are more likely to have a family history of alcoholism, and they are more than twice as likely as male alcoholics to have been brought up by two alcoholic parents" (Sexias & Youcha, 1985, p. 136). Kaufman (1984) pointed out that children of alcoholic mothers tended to be cold, rigid, distrustful, and reserved as adults. In the traditional view of mother as primary caretaker, it follows that having an alcoholic mother would be more detrimental to a child's development (Fox, 1962).

There is not much literature on the psychological effects of having two parents who are alcoholic. However, the assumption is that if there are two alcoholic parents, there will be additional emotional and behavioral problems and a greater likelihood of developing alcoholism (Ackerman, 1983; Deutsch, 1982; Gravitz & Bowden, 1985). McKenna & Pickens (1981) found that children of two alcoholic parents reported significantly more behavioral
problems than did other children in the study. The percentage of cases where both spouses are alcoholics represents approximately 20% of the alcoholic homes in the U.S., however, because females tend to hide their drinking from others, this percentage could be higher (Ackerman, 1983; Sandmaier, 1980).

**Intervention**

There is little research focusing on treatment for the offspring of alcoholics and virtually nothing on adults from alcoholic homes (El-Guebaly & Offord, 1977). Of the effects discussed, such as inability to trust, excessive need for control, low self-esteem, and extensive defensive coping strategies, several studies suggest that these effects tend to exert their strongest influence during adolescence and early adulthood (Beletsis & Brown, 1981; Black, 1981; Cermak & Brown, 1982).

It is about this time, when a young person reaches the mid-twenties that the effects of growing up in an alcoholic home begin to become apparent. These now adult children of alcoholics begin to experience a loneliness which doesn't make sense to them. They become aware of feelings which separate them from others, and find themselves depressed. They have problems related to intimacy; they find themselves having difficulty maintaining a close relationship, or find that something seems to be missing in their relationships (Black, 1981).
As adults, the majority of children of alcoholics continue to experience problems related to trust, dependency, control, and identification and expression of feelings (Beletsis & Brown, 1981; Black, 1981; Gravitz & Bowden, 1985). Most of the literature on adult children of alcoholics centers around group therapy or individual therapy.

"The decision to enter therapy or join a group represents the first break in the denial system of the individual" (Beletsis & Brown, 1981, p. 197). They enter hoping to resolve the conflicts of control, trust, responsibility, and identification and expression of feelings (Cermak & Brown, 1982). Such conflicts result from the coping styles of the alcoholic and the effect of alcoholism on the family, and group and individual therapy are seen as a beneficial therapeutic modality. Therapy is a way of getting to know why one behaves the way one does and learning new ways of coping and being the person one wants to be (Sexias & Youcha, 1985). An advantage of individual therapy is the special relationship that builds up between therapist and client. The intensity of individual treatment may mean one moves more quickly to making comprehensive assessments of oneself (Sexias & Youcha, 1985).

Group therapy, on the other hand, enables individuals to recognize that they must talk about their experiences
in their alcoholic families and learn through the process to validate their perceptions, which for so long have been denied, repressed, and distorted (Beletsis & Brown, 1981; Cermak & Brown, 1982; Sexias & Youcha, 1985).

Cermak and Brown (1982), in their study on group therapy with ACOAs, found conflicts involving issues of control to be pervasive and often were the context within which other issues of trust, acknowledgement of personal needs, responsibility, and feelings were dealt with. The issues of trust, control, separation, and dependency are all confronted within a group therapy context. For example, group members may fear that they tend to be too controlling or that silence indicates criticism or disinterest (Beletsis & Brown, 1981; Cermak & Brown, 1982).

State of the Art on Research on ACOAs

The impact of alcoholism on marital and family functioning represents a challenge to theorists, researchers, and clinicians alike. Much of the literature is characterized by inadequacies in methodological and experimental design.

There have been few well-controlled studies on the psychosocial status of children of alcoholics. Most of the literature on the personality characteristics and the family relationships of such children has been based on individual interviews, case histories,
reports of children or parents, or results of psychological tests. (Jacob et al. 1978, p. 1236)

There appears to be a limited number of ideas about interpersonal relationships in general and psychopathology and alcoholism in particular which has restricted the range of theoretical concepts and experimental strategies used to analyze the relationships between alcoholism and family interaction.

Early identification and treatment of children of alcoholics is a step toward preventing alcoholism and other related life problems as those children become adults. At present there is a scarcity of data and existing studies are often small scale and unsystematic. However, no replication of results is possible unless there are clear definitions of alcoholism and drinking problems, as well as other variables (El-Guebaly & Offord, 1977). An example of the weakness of the research on alcoholism is less focus on daughters as opposed to sons since, as future wives/mothers their impact is as important as that of their male counterparts. At this time, small sample sizes, lack of attention to gender differences of Adult Children of Alcoholics and parental alcoholism, and infrequent use of standardized measures to assess adult functioning are but a few of the problems in recognition, research, and prevention in the area of being raised in an alcoholic home.
Summary

Given its limitations, the existing literature suggests that there are certain characteristics of ACOAs. Human development is so complex and difficult to understand that it would be hazardous to say that all adult children suffer from these classic symptoms of low self-esteem, an inability to trust, a denial or suppression of emotions, fear of intimacy, an exaggerated sense of responsibility, and an extreme need for control to the same degree. It would be quite simplistic to assume that because a person is part of a group, he or she necessarily takes on all the characteristics of that group. "As for Adult Children of Alcoholics, their responses to their home situations vary, just as their personalities do" (Sexias & Youcha, 1985, p. 50).

The way in which an individual reacts to any given situation depends on that individual's personality, the family system in which he/she was raised, and a whole host of other variables. In an alcoholic system, whether one has one or two alcoholic parents is an important consideration. Also, the quality of the relationship between the child and both parents is a significant factor in analyzing an alcoholic family system.
CHAPTER III
METHODOLOGY

Introduction

The purpose of this study was to identify gender differences in Adult Children of Alcoholics (ACOAs) as a function of selected psychological factors. Specifically, the independent variables were sex of subject, gender of alcoholic parent, and number of alcoholic parents. The dependent variables were self-esteem; trust in intimacy; desire/expression for control, inclusion, and affection; and degree of symptomology of family environment. Three fourths of the subjects were selected from participants in an ACOA meeting (ACOA is an affiliate with Al-Anon), a self-help group for those who were raised in an alcoholic environment; and the other one fourth of the subjects were selected from participants in Alcoholics Anonymous meetings.

Six kinds of information were obtained from the subjects: (a) descriptive/demographic background information; (b) self-report measures of self-esteem; (c) trust in intimate relationships; (d) desire/expression for control, inclusion, and affection; (e) degree of
symptomology of family environment; and (f) perceptions of the family environment.

**Subjects**

A purposive sample was obtained from two sources: a self-help group for ACOAs (Al-Anon) and a self-help group for alcoholics (AA). All subjects volunteered to participate in the study and over one fourth of those who participated were interested in obtaining the results of the study. Seventy two subjects met the criteria for the study. There were 43% (n = 31) males and 57% (n = 41) females. Of the whole sample, 71.8% (n = 51) had one parent who was alcoholic and 29.2% (n = 21) had two alcoholic parents.

In order to be eligible to participate in this research project, subjects met the following criteria: They (a) were attending either an ACOA or AA self-help group, (b) identified their family of origin as alcoholic, thus having at least one alcoholic parent, and (c) were between the ages of 25-45. A descriptive profile of the subjects is presented in Chapter V.

**Data Collection**

Data for this study were collected over a 4 month period, October, 1986 through January, 1987. Subjects completed seven paper and pencil questionnaires: (a) a descriptive/demographic background questionnaire; (b) the Tennessee Self-Concept Scale (TSC); (c) The Interpersonal
Relationship Scale (IRS); (d) the Fundamental Interpersonal Relations Orientation–Behavior (FIRO-B); (e) the Fundamental Interpersonal Relations Orientation–Feelings (FIRO-F); (f) the Children of Alcoholics Screening Test (C.A.S.T.); and (g) the Family Environment Scale (Form R). Seventy two subjects completed the questionnaire, 41 women and 31 men. Out of 100 people approached, 2 subjects (2%) did not meet the criteria as their family of origin was identified as dysfunctional rather than alcoholic. Eight (8%) subjects met the criteria, but either returned the material unfinished or were not within the age range designated for the study. Eighteen (18%) subjects who volunteered to complete the questionnaire failed to return them.

Contact with the two self-help groups was made through the researcher's personal affiliation with individuals who attend these groups. The AA/ACOA meetings were selected randomly throughout a large midwestern metropolitan area. Ten different meetings were attended in a period of one month in the Fall of 1986. No subject was approached until after the meeting had ended. Subjects had the option of completing the questionnaires at the end of the meeting, or taking the self-addressed envelope home and returning them via mail. Those who chose to take them home were instructed to complete all materials at one time, thereby ensuring consistency with those who
completed the materials at the end of the meeting. Approximately 15-25 subjects completed the questionnaires at the end of the meeting; the majority of the subjects chose to take the questionnaires home and return them through the mail. All of the subjects who completed the questionnaires were Caucasian.

Thus, of 100 people contacted who met the criteria for sample selection, 72 subjects provided complete and usable data. This project was approved by the Human Subjects Review Committee (Appendix A). Each subject gave his/her approval to participate in the study (Appendix B) and was given an oral instruction on how to complete the questionnaire (Appendix C).

Instrumentation

The independent variables, sex of the subject, gender of the alcoholic parent, whether one or both parents were/are alcoholic, and other background information were assessed through the fixed-choice and open-ended questionnaire items (Appendix D). In addition, whether the subject considered her/himself to have an alcohol problem, length of time in recovery program, whether his/her partner is an ACOA or has an alcohol problem, subject's perception of parent marital happiness, whether the parents engaged in abusive behavior, and whether the subject had been abused as a child were assessed through the descriptive questionnaire. The dependent variable,
self-esteem, was assessed by the Tennessee Self-Concept Scale (Fitts, 1964). Trust in intimacy was assessed by the Interpersonal Relationship Scale (Guerney, 1977). The other dependent variables—need for control, inclusion, and affection—were assessed by the FIRO-B and FIRO-F respectively (Schutz, 1967). Differences in perceptions of family life between the two groups were measured by the Moos (1974b) Family Environment Scale, Form R. Finally, the number of symptoms experienced as a child was determined by the C.A.S.T. (Jones, 1981).

The Tennessee Self-Concept Scale

Fitt's (1964) Tennessee Self-Concept Scale is a self-report scale which measures one's self-concept across several domains. It was developed from a clinical perspective and provides both an overall self-esteem score and a complex self-concept profile.

The 100 items fall into five general categories: physical self, moral-ethical self, personal self, family self, and social self. In turn, each of these areas is divided into statements of self-identity, self-acceptance, and behavior. There are five response categories for each question ranging from completely true to completely false. There is a total positive score which comprises the overall self-esteem measure and there are various subscores across the five areas along with a
variability score reflecting differences in self-esteem across areas.

Test-retest reliability of the total positive score over a two week period was .92 with the various subscores ranging from .70 to .90. Convergent validity of the scale was correlated -.61 with the Butler-Haigh Q-Sort (Buros, 1970). There is no correlation with social desirability, although a lie scale makes it possible to invalidate certain responses.

The Children of Alcoholics Screening Test (C.A.S.T.)

The C.A.S.T. (Jones, 1981) consists of 30 items measuring adolescent and adult children's attitudes, feelings, behavior, and experiences pertaining to their parents' use of alcohol. The test items were derived from an adult population who was receiving treatment for alcoholism and their perceptions of their family environment (Spiegler, 1983). There are 30 "yes-no" items. The "yes" answers summed yield a C.A.S.T. score. A score of 0 indicates no reported experiences of alcohol misuse, a score of 6 or more implies at least one parent is alcoholic, and a score of 20 and greater represents multiple severe experiences with alcohol abuse.

The test items were judged to have face validity by an unspecified number of alcohol counselors and adult children of alcoholics. The author (Jones, 1981) found that children of alcoholics differ significantly from the
control group for all 30 items. No children of alcoholics scored less than 5 whereas three quarters of the controls obtained scores of 5 or less. The reliability and validity information was obtained from two small studies, one of 215 children and adolescents, and the other involving 81 adults. The author obtained split-half reliability coefficients of .98. However, the fact that the reliability and validity were based on two small studies suggests caution in interpreting the C.A.S.T. as a highly reliable and valid screening and research tool. Also, there are no data in the manual regarding sex and ethnic differences, and there are no distinctions made for different age groups.

The Interpersonal Relationship Scale (IRS)

The Interpersonal Relationship Scale (Guerney, 1977) measures trust and intimacy in interpersonal relationships. Respondents are asked to rate each item on a 5-point Likert scale ranging from strongly agree to strongly disagree. The higher the score, the greater the level of trust and intimacy.

Rappaport (1976) found a test-retest Pearson Product Moment correlation (r) of .92. Schein (cited in Guerney, 1977) found significant correlations (r) between the IRS and a number of measures of communication and the quality of interpersonal relationships.
The Fundamental Interpersonal Relations Orientation-Scales (FIRO-B; FIRO-F)

The Fundamental Interpersonal Relations Orientation-Behavior (Schutz, 1967) is a 54 item questionnaire designed to measure three fundamental dimensions of interpersonal relationships: inclusion, control, and affection.

Inclusion assesses the degree to which a person associates with others. Control measures the extent to which a person assumes responsibility, makes decisions, or dominates people. The affection score reflects the degree to which a person becomes emotionally involved with others. (Ryan, 1977, p. 5)

This measure leads to six scores: expressed inclusion behavior (e/i), wanted inclusion behavior (w/i), expressed control behavior (e/c), wanted control behavior (w/c), expressed affection behavior (e/a), and wanted affection behavior (w/a). For each of the six dimensions a nine-item scale was constructed.

The scales were developed from responses of 150 subjects of college age. They were then cross-validated to ensure that the scales maintained the required characteristics of acceptable Guttman scales. For the cross-validation study a population of 1500 subjects was used. The scale score ranges from 0-9.
The coefficient of internal consistency mean of .76 is a satisfactory coefficient of stability. The intercorrelation between FIRO-B scales obtained from a sample of 108 subjects was .70. Concurrent validity has been documented on studies of political attitudes, occupational choice, and conformity behavior. All studies have documented means of .90 and higher.

The Fundamental Interpersonal Relations Orientation-Feeling (Schultz, 1960) is a measure of an individual's orientation toward expressed and wanted feelings in the area of inclusion, control, and affection; these feelings are respectively, importance, competence, and lovability. Reliability and validity have not been established.

**Family Environment Scale (FES)**

The Family Environment Scale (FES) is one of nine social climate scales which describes or compares the social environments of families (Moos & Moos, 1981). Each scale/instrument consists of a series of true/false statements on which there are 80 to 100 items scored on 7 to 10 dimensions (Moos, 1974a).

The Family Environment Scale (FES) is comprised of 10 subscales which measure the social environment of all types of families. The FES has three forms but only Form R, which measures people's perceptions of their nuclear family environment, was used in the study. The 10 FES subscales determine three sets of dimensions: the
Relationship dimension, the Personal Growth dimension, and the System Maintenance dimension (Moos & Moos, 1981). The subscales of cohesion, expressiveness, and conflict assess the degree of commitment, help, and support family members provide for one another; the extent to which family members are encouraged to act openly and to express their feelings directly; and the amount of openly expressed anger, aggression, and conflict among family members. (Moos & Moos, 1981, p.1)

Moos and Moos (1981) used the Form R subscales to report data on normative families and distressed families. One subsample of the distressed family was a subsample of an alcohol abusing family. Families with an alcoholic member were found to be lower on the Cohesion, Organization, Expressiveness, Independence, Intellectual-Cultural Orientation, and Active-Recreational Orientation subscales. Families with an alcoholic parent were higher on the conflict and control scale (Filstead, 1979). There are 90 items on the regular Form R.

The 10 subscales have internal consistencies of .61 to .86. Test-retest reliabilities varied from .68 for independence to .86 for cohesion. These test-retest reliabilities and internal consistencies are presented in Table 1. Holahan and Moos (1982) state that the construct validity had been established by over 50 studies that have used the FES.
Table 1

**Form_R_Subscale_Internal_Consistencies_and Test-Retest_Reliabilities**

<table>
<thead>
<tr>
<th>Dimensions and subscales</th>
<th>Internal consistency (N = 1067)</th>
<th>2-Month test-retest reliability (N = 47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship</td>
<td></td>
<td></td>
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<tr>
<td>Cohesion</td>
<td>.78</td>
<td>.86</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>.69</td>
<td>.73</td>
</tr>
<tr>
<td>Conflict</td>
<td>.75</td>
<td>.85</td>
</tr>
<tr>
<td>Personal growth dimensions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independence</td>
<td>.61</td>
<td>.68</td>
</tr>
<tr>
<td>Achieving orientation</td>
<td>.64</td>
<td>.74</td>
</tr>
<tr>
<td>Intellectual-cultural orientation</td>
<td></td>
<td>.82</td>
</tr>
<tr>
<td>Active-recreational orientation</td>
<td>.67</td>
<td>.77</td>
</tr>
<tr>
<td>Moral-religious emphasis</td>
<td>.79</td>
<td>.80</td>
</tr>
<tr>
<td>System maintenance dimensions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>.76</td>
<td>.76</td>
</tr>
<tr>
<td>Control</td>
<td>.67</td>
<td>.77</td>
</tr>
</tbody>
</table>

Source: Moos and Moos, 1981, p. 6

*Note.* Subscale used in study.
Treatment of the Data

Data analysis methods used to address the research hypothesis included measures of central tendency and frequency, two-sample t-tests, chi-square tests, Pearson r correlations, and one- and two-way analysis of variance.

In order to create a descriptive analysis of the sample, frequency counts, means, and standard deviations were computed. Two-sample t-tests and chi-square tests were computed to determine differences between male and female ACOAs at a significance level of .05.

Analysis of variance was used to determine group differences in dependent variables as well as differences as a function of sex of subject, gender of alcoholic parent, and number of alcoholic parents using a significance level of .01. ANOVA was regarded as a legitimate method of analysis for examination of group mean differences.

Correlation coefficients (r) were obtained in order to determine the relationship among the dependent variables within sex and parent alcohol status categories. Correlation coefficients were also used to describe the relationship between the significant results and the results on the Family Environment Scale and its four subscales of cohesion, conflict, expressiveness, and control.
Limitations

1. One of the limitations of the study related to the selection of subjects. The selection of subjects who have already identified themselves as an adult child of an alcoholic is less than ideal. Prior identification may result in a more positive degree of similarity between subjects in the area of gender differences. There may already be an inherent bias operating once an individual identifies him/herself to a certain group. Those individuals who are aware of their problems are already one step ahead of those who have no such awareness. In particular, if males and females hold the same identification and are engaged in behavior to change their situation, whatever differences would have originally been apparent may become less so.

2. Voluntary participation in the study may introduce a bias. The fact that the researcher was a member of the mental health/substance abuse field may have attracted a certain type of study participant and given the subjects confidence that their situation was understood.

3. In using an identified "problem" population, one may infer that they would be likely to falsify their responses in order to appear in a positive way. It is difficult to generalize to a "healthy" adult population based on a so-called maladjusted population. Although the sample may be generalized to other adult children of
alcoholics, it is doubtful that those individuals who grew up in alcoholic homes but are unaware of doing so would respond in a similar way.

4. Another possible limitation of the study is in the nature of the instruments. Using retrospective measures creates a large range for error in how people remember specific details, events, or situations. This is of particular concern for the C.A.S.T. and Moos' FES. Both instruments ask the subject to recall past feelings and/or behaviors which may become distorted through time. In terms of self-report inventories in general, additional verification is needed to assess whether the person is truly as she/he describes.

5. The manner in which the instruments were given leaves room for error. Since the subjects were permitted to take the questionnaires home, it was not possible to know the conditions under which they completed the information. The mail-in technique also leaves uncontrolled variability in the amount of time each subject required to complete the forms. There was no identification made between those who completed the questionnaires after the meeting and those who took the questionnaires home and returned them by mail.

6. Responses on the C.A.S.T. and FES were limited to two choices and may have resulted in a forced response. Responses to the FES statements could have been distorted
by what the subjects believed was a socially desirable response. The instruments for the FES directed the subjects to answer according to "your family." The researcher became aware that a certain amount of confusion developed in terms of whether the subject was to use his/her present family or family of origin.

7. The date of onset of parental alcoholism was not identified; therefore there is no way to determine how long the individual lived with active alcoholism within his/her family of origin.
CHAPTER IV
RESULTS

This study was designed and conducted to (a) provide a systematic analysis of the personality characteristics between male and female ACOAs; (b) measure significant differences on personality variables based on gender of alcoholic parent; (c) measure significant differences on personality variables of ACOAs based on whether they had one or two alcoholic parents; (d) compare male and female ACOAs on the variables of self-esteem, trust, control, inclusion, and affection; (e) determine if there is a correlation between having two alcoholic parents and degree of symptomology experienced by the ACOAs by the C.A.S.T.; and (f) determine if there is a correlation between male and female ACOAs in terms of family environment based on the significant findings.

This chapter presents a descriptive analysis of the sample, findings related to the hypotheses, the results from the ANOVAs and correlational analyses. Data analyses were computed using the Statistical Analysis System (SAS Institute, Inc., 1982).
Respondents

Description of the Sample

The sample included 72 people who identified themselves as an ACOA. The descriptive information is summarized in Tables 2 and 3. The subjects met the following criteria for participation in the study: Both male and female groups (a) had identified themselves as having an alcoholic parent; (b) were either in therapy or attending ACOA, AA, or Al-Anon; and (c) were between the ages of 25 and 45.

Table 2

Means and Standard Deviations for Selected Descriptive Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group A</th>
<th>Group B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
</tr>
<tr>
<td>Age of respondents</td>
<td>34.5</td>
<td>33.9</td>
</tr>
<tr>
<td></td>
<td>6.6a</td>
<td>7.4b</td>
</tr>
<tr>
<td>Length of time in</td>
<td>3.06</td>
<td>2.74</td>
</tr>
<tr>
<td>recovery</td>
<td>1.48c</td>
<td>1.31d</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. an = 31. bn = 41. cn = 30. dn = 39

The following categories of descriptive data will be presented for the participants of this study: (a) age of
participant, (b) gender and number of alcoholic parent, (c) length of time in recovery program, (d) whether the subject was at the time involved in an intimate relationship, (e) whether the subject identified her/himself as having a problem with alcohol; (f) whether the subject's partner was an ACOA; (g) whether the subject's partner identified her/himself as having a problem with alcohol; (h) attained level of education; (i) annual individual income; (j) how the subject rated his/her parents' marriage; (k) whether the subject was abused (psychologically, physically, or sexually); and (l) whether the parents engaged in abusive behavior. Means and standard deviations for age of participants and length of time in recovery program are in Table 2. Frequency distributions are presented for the variables where means and standard deviations were not appropriate (See Table 3).

**Age and Distribution of Sex of Participants**

In Group A there were 31 males, and in Group B there were 41 females. As shown in Table 2, the mean age for males (Group A) was 34.5 years, ranging from 25 to 45 years of age. The standard deviation was 6.6. The mean age for females (Group B) was 33.9 years with a range from 25 to 45 years. The standard deviation was 7.4. The age range was based on criteria made for the study.
Table 3

**Frequency Distribution of Selected Descriptive Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group A</th>
<th></th>
<th></th>
<th>Group B</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Males</strong></td>
<td><strong>Females</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>n = 31</strong></td>
<td><strong>n = 41</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>n</strong></td>
<td><strong>%</strong></td>
<td><strong>n</strong></td>
<td><strong>%</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
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<td>43.1</td>
<td>41</td>
<td>57</td>
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<tr>
<td>Gender and number of alcoholic parents</td>
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<td></td>
<td></td>
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<td></td>
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<td>Mother</td>
<td>6</td>
<td>19.4</td>
<td>8</td>
<td>19.5</td>
<td></td>
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<tr>
<td>Father</td>
<td>17</td>
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<td>48.8</td>
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<td>25.8</td>
<td>13</td>
<td>31.7</td>
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<td>Currently involved in intimate relationship</td>
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<td>45.2</td>
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<td>Subject has alcohol problem</td>
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<tr>
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<td>80.6</td>
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<td>18</td>
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<td>Subject's partner ACOA</td>
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<td>Yes</td>
<td>11</td>
<td>78.6</td>
<td>17</td>
<td>54.8</td>
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<td>21.4</td>
<td>14</td>
<td>45.2</td>
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<tr>
<td>Partner has alcohol problem</td>
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<td></td>
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<tr>
<td>Yes</td>
<td>9</td>
<td>64.3</td>
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<td>17</td>
<td>54.8</td>
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<td>Group B Females</td>
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<td>Annual individual income</td>
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<td>Group B</td>
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<tr>
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<tr>
<td></td>
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<td>Parents' marital happiness</td>
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<tr>
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<td>3.23</td>
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<td>4.88</td>
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<td>Happy</td>
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<td>12.90</td>
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<td>Mixed</td>
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<td>19.35</td>
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<td>38.71</td>
<td>19</td>
<td>46.34</td>
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<td>24</td>
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<tr>
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<td>21</td>
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<td>7</td>
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<td>Type of child abuse</td>
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<td>48.7</td>
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</tr>
<tr>
<td>Sexual</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3 (continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group A Males</th>
<th>Group B Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Type of child abuse (cont)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All of above</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physical &amp; emotional/psychological</td>
<td>10</td>
<td>32.3</td>
</tr>
<tr>
<td>Emotional/psychological &amp; sexual</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Gender/Number of Alcoholic Parent.

As shown in Table 3, Group A (males) who had a father who was identified as alcoholic was 54.8% (n = 17) and Group B (females) who had an alcoholic father was 48.8% (n = 20). Males who had a mother identified as alcoholic was 19.4% (n = 6) and females who had an alcoholic mother was 19.5% (n = 8). Those in Group A who had both parents who were alcoholic totaled 25.8% (n = 8) and those in Group B who had both parents who were alcoholic was 31.7% (n = 13).
Participants in both groups had about the same amount of time in a recovery program—a mean of greater than 6 months and less than 2 years for males and a mean of 6 months to 1 1/2 years for females (Table 2). The number of years of time in a recovery program ranged from less than 3 months to 5 1/4 to 10 years for both groups.

As shown in Table 3, 75.6% of the females (n = 31) were currently involved in an intimate relationship whereas only 45.2% (n = 14) of the males were currently involved at the time of the study. This represented a significant difference ($\chi^2 = 6.983, df = 1, p < .01$).

Of the males, 80.6% (n = 25) and 53.6% (n = 22) of the females responded that they identified themselves as having an alcohol problem. While 45% (n = 18) of the females did not perceive themselves as having an alcohol abuse problem, only 19.4% (n = 6) of the males did not perceive themselves as having an alcohol abuse problem. This constituted a significant difference at the $p < .05$ level with a phi coefficient at .27 (see Table 3).

As shown in Table 3, 62.2% (n = 45) of the participants responded with yes to the question pertaining to whether the subject's partner was also an ACOA. In
Group A (males), out of 45.2% (n = 14) who were currently involved, 78.6% (n = 11) had partners who were ACOAs. Out of 75.6% (n = 31) of the females who were currently involved, 54.8% (n = 17) had partners who were ACOAs.

Partner_Having_an_Alcohol_Abuse_Problem.

As shown in Table 3, in Group A (males) 64.3% (n = 9) stated that their partner did have a problem with alcohol whereas in Group B (females) 45.2% (n = 14) of the females responded affirmatively to the question regarding partner's alcohol abuse.

Attained_Level_of_Education

Six levels of education were coded for the sample. Twenty nine percent (n = 21) of the participants in both groups had some amount of college; 22.58% (n = 7) of the males and 17.07% (n = 7) of the females had graduated from college. Sixteen percent (n = 5) of the males and 32% (n = 13) of the females had graduate and/or professional training (see Table 3).

Annual_Individual_Income

The largest percentage of the males' annual income occurred in the 12,000 to 16,000 range (19.4%, n = 6) and the 25,000-30,000 (16%, n = 5) group. The largest percentage for women (23%, n = 9) occurred in the 16,500 to 20,000 range. 29% (n = 20) of both groups had an annual income less than 12,000 and 33% (n = 23) of both groups had an annual income above 25,000 (see Table 3).
Parents' Marital Happiness

Forty three percent (n = 31) of all participants rated their parents' marriage as "unhappy". The next highest category for both groups was "very unhappy" which consisted of 25% (n = 18) of the responses. Only 18% (8 females and 5 males) rated their parents' marriage as either "very happy" or "happy" (see Table 3).

Subject Abused as a Child

As shown in Table 3, 76.4% of both groups (males and females) responded affirmatively to whether they had suffered either psychological, physical, and/or sexual abuse while growing up. Eighty three percent (n = 34) of the female participants stated "yes", whereas 68% (n = 21) of the males responded positively. Forty one percent of the participants stated the abuse was emotional/psychological and 24% stated it was both physical and psychological/emotional (see Table 3).

Parental Abuse

Seventy eight percent (n = 56) of the participants stated that their parents had engaged in abusive behavior with each other. 43.5% (n = 30) of both groups stated their parents engaged in physical and psychological abusive behavior (see Table 3).

In summary, the respondents in this study consisted of 72 persons who had at least one alcoholic parent. All the respondents resided in Central Ohio. Of the sample,
43.1% were males (Group A, n = 31) and 56.9% were females (Group B, n = 41). A majority of the respondents were in their middle thirties and had attained at least 14 years of education. A larger proportion of females than males had attained graduate and or/professional training. Annual individual income was proportionately ranged for both groups above the national median.

More females than males were currently intimately involved at the time of the study. Length of time in a recovery program for both groups consisted of an average of 1 year and a majority of respondents identified themselves as having an alcohol problem. Thirty four percent of the participants stated that their partner had an alcohol problem. A greater number of females had partners who were ACOAs than males.

In both groups (males and females), 51.4% had a father who was an alcoholic, whereas 19.4% had a mother who was alcoholic. A larger percentage of females (31.7%) had both parents who were alcoholic than did males (25.8%). A large proportion of subjects (75.6%) rated their parents' marriage as unhappy and stated that their parents had engaged in abusive behavior and that they as children has been abused.

**Results of Analyses**

The results of the inferential statistical analysis used in this study are presented in this section. First,
the means and standard deviations of the major variables by group, i.e. males and females, one or two alcoholic parents, and gender of alcoholic parent are presented. Findings related to the analysis of variance (ANOVA) and findings related to the correlational analyses are presented for the major variables with reference to the hypotheses. Finally, four subscales of the Moos are given as further analysis of the significant effects found with the major variables.

The Means and Standard Deviations of the Major Variables

The means and standard deviations of the major variables will be presented by group (males and females) and number(one or two)/gender of alcoholic parent. Each group is subsequently subdivided into three groups. Therefore, Group A (males) consists of males with father, mother, or both parents who are alcoholic; likewise Group B (females) consists of females with father, mother, or both parents who are identified as alcoholic (see Table 4).

The possible range of scores for the Tennessee Self Concept was 150 to 450. The reported means for overall level of self-esteem score in Group A, males with alcoholic fathers (n = 17), was 324.24, which was higher than the mean (306.15) for Group B, females with alcoholic fathers (n = 20). However, the reverse was true for both groups with alcoholic mothers. The mean for Group A
### Table 4

Means and Standard Deviations for Major Variables and Number of Alcoholic Parents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group A</th>
<th></th>
<th>Group B</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=31</td>
<td></td>
<td>n=42</td>
<td></td>
</tr>
<tr>
<td></td>
<td>One alcoholic</td>
<td>Two alcoholic</td>
<td>One alcoholic</td>
<td>Two alcoholic</td>
</tr>
<tr>
<td></td>
<td>parent (n=23)</td>
<td>parents (n=8)</td>
<td>parent (n=20)</td>
<td>parents (n=13)</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------</td>
<td>-------</td>
<td>------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>312.13 34.57</td>
<td>307.25 19.24</td>
<td>311.21 40.52</td>
<td>311.61 30.17</td>
</tr>
<tr>
<td>Trust in</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>intimacy</td>
<td>170.04 41.20</td>
<td>182.50 34.08</td>
<td>188.57 41.5</td>
<td>182.69 42.84</td>
</tr>
<tr>
<td>PIRO-CE</td>
<td>2.86 2.97</td>
<td>4.37 2.97</td>
<td>2.85 2.57</td>
<td>3.97 2.59</td>
</tr>
<tr>
<td>PIRO-CW</td>
<td>3.43 2.98</td>
<td>5.12 2.35</td>
<td>4.07 2.01</td>
<td>4.30 2.09</td>
</tr>
<tr>
<td>PIROB-IE</td>
<td>2.86 2.47</td>
<td>2.08 1.51</td>
<td>3.78 2.09</td>
<td>4.15 2.99</td>
</tr>
<tr>
<td>PIROB-IW</td>
<td>2.56 3.20</td>
<td>4.12 3.94</td>
<td>3.93 3.31</td>
<td>4.07 3.94</td>
</tr>
<tr>
<td>PIROB-AE</td>
<td>3.08 2.82</td>
<td>1.12 0.99</td>
<td>2.68 2.33</td>
<td>3.92 2.39</td>
</tr>
<tr>
<td>PIROD-AW</td>
<td>4.73 2.04</td>
<td>4.75 3.18</td>
<td>4.75 1.73</td>
<td>5.38 2.86</td>
</tr>
<tr>
<td>PIROF-CE</td>
<td>2.38 1.66</td>
<td>1.12 1.35</td>
<td>1.92 1.30</td>
<td>2.92 2.10</td>
</tr>
<tr>
<td>PIROF-CW</td>
<td>5.21 1.73</td>
<td>4.00 2.13</td>
<td>5.35 2.75</td>
<td>5.53 2.59</td>
</tr>
<tr>
<td>PIROF-IE</td>
<td>4.21 2.33</td>
<td>2.00 2.32</td>
<td>3.60 2.24</td>
<td>4.76 2.27</td>
</tr>
<tr>
<td>PIROF-IW</td>
<td>5.04 2.30</td>
<td>4.75 2.37</td>
<td>5.64 2.32</td>
<td>5.69 2.95</td>
</tr>
<tr>
<td>PIROF-AE</td>
<td>2.82 2.30</td>
<td>1.75 1.66</td>
<td>2.92 2.34</td>
<td>3.76 2.31</td>
</tr>
<tr>
<td>PIROF-AW</td>
<td>4.82 2.44</td>
<td>4.75 1.48</td>
<td>5.40 2.43</td>
<td>5.30 3.22</td>
</tr>
<tr>
<td>CASTyes</td>
<td>18.95 5.89</td>
<td>20.75 7.42</td>
<td>19.53 6.71</td>
<td>24.15 3.80</td>
</tr>
</tbody>
</table>

**Note:** Significant results.
(312.33) was lower than the mean for Group B with alcoholic mothers (323.87). Therefore, an inverse relationship exists for males and females with either an alcoholic mother or father. The mean in overall level of self-esteem having two alcoholic parents is higher for females (n = 13, \( \bar{X} = 311.61 \)) than for males (n = 8, \( \bar{X} = 307.25 \)). This finding suggests that women with two alcoholic parents have a higher rate of self-esteem than do males with two alcoholic parents (see Table 4).

The possible range of scores for the Interpersonal Relationship Scale (IRS) was 1 to 260. Overall, the means for the IRS, in both groups and in all subgroups, were similar (see Table 4). Although the means for females with alcoholic fathers appears much higher than males with alcoholic fathers, the unequal sample size renders such a result nonsignificant. Score variability was also similar across gender and number of alcoholic parents in both groups (Table 5).

The possible range for the FIROs was 1 to 6. Overall, the means and standard deviations for all participants for the FIROB on desire and expression of control, inclusion and affection with one vs. two alcoholic parents were similar (see Table 4). The only exception on the FIROB and the two groups was on affection-expression (FIROB-AE) in which there was a significant difference in means between the two groups in
Table 5

Means and Standard Deviations for Major Variables by Sex of Subject and Gender of Alcoholic Parent

(N=72)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Group A: males</th>
<th>Group B: females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=31</td>
<td>n=41</td>
</tr>
<tr>
<td></td>
<td>Mother (n=6)</td>
<td>Father (n=17)</td>
</tr>
<tr>
<td></td>
<td>Mother (n=8)</td>
<td>Father (n=20)</td>
</tr>
<tr>
<td>Means</td>
<td>Means</td>
<td>SD</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>312.13</td>
<td>43.40</td>
</tr>
<tr>
<td>Trust and intimacy</td>
<td>172.83</td>
<td>41.22</td>
</tr>
<tr>
<td>FIROB-CE</td>
<td>3.00</td>
<td>3.22</td>
</tr>
<tr>
<td>FIROB-CW</td>
<td>2.50</td>
<td>3.02</td>
</tr>
<tr>
<td></td>
<td>Means</td>
<td>SD</td>
</tr>
<tr>
<td>----------------</td>
<td>-------</td>
<td>-----</td>
</tr>
<tr>
<td>FIROB-IE</td>
<td>2.66</td>
<td>3.07</td>
</tr>
<tr>
<td>FIROB-IW</td>
<td>2.16</td>
<td>3.06</td>
</tr>
<tr>
<td>FIROB-AE</td>
<td>2.33</td>
<td>2.07</td>
</tr>
<tr>
<td>FIROB-AW</td>
<td>5.16</td>
<td>3.12</td>
</tr>
<tr>
<td>FIROF-CE</td>
<td>1.66</td>
<td>1.03</td>
</tr>
<tr>
<td>FIROF-CW</td>
<td>5.83</td>
<td>2.14</td>
</tr>
<tr>
<td>FIROF-IE</td>
<td>3.33</td>
<td>2.25</td>
</tr>
<tr>
<td>FIROF-IW</td>
<td>5.33</td>
<td>2.88</td>
</tr>
<tr>
<td>FIROF-AE</td>
<td>3.33</td>
<td>2.16</td>
</tr>
<tr>
<td>FIROF-AW</td>
<td>4.82</td>
<td>2.44</td>
</tr>
<tr>
<td>CASTyes</td>
<td>18.33</td>
<td>4.23</td>
</tr>
</tbody>
</table>
relationship to having one or two alcoholic parents. The mean for males with one alcoholic parent was 3.00, ($SD = 2.02$); and 1.12, ($SD = 0.99$) for two alcoholic parents. The mean for females with one alcoholic parent was 2.60, ($SD = 2.33$); and 3.92, ($SD = 2.39$) for two alcoholic parents. It is significant that males have a higher mean when they have one alcoholic parent and females have a higher mean when they have two alcoholic parents (see Table 4). Overall, the means for the FIROF on desire and expression for both groups with one or two alcoholic parents were also similar except on the FIROF-IE and the FIROF-CE (see Table 4). Again, the same pattern occurs in that the responses of the women with two alcoholic parents are higher than the men with two alcoholic parents.

The range of scores on the C.A.S.T. was 1 to 33. The mean score for the C.A.S.T. was also significant across groups in that both males and females scored significantly higher in having two alcoholic parents as opposed to one (see Table 4).

The range of scores on the Moos FES is 1 to 9. The reported means and standard deviations on the four subscales for the overall population with one or two alcoholic parents are in Table 6.
### Table 6

**Perceptions of Family Environment by Sex of Subject and Number of Alcoholic Parents**

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Gender of subject</th>
<th></th>
<th></th>
<th></th>
<th>Gender of subject</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>Female</td>
<td>One (n=51)</td>
<td>Two (n=21)</td>
<td></td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>X</td>
<td>S.D.</td>
<td>X</td>
<td>S.D.</td>
<td>X</td>
<td>S.D.</td>
<td>X</td>
</tr>
<tr>
<td>1) Cohesion</td>
<td></td>
<td>4.13</td>
<td>2.74</td>
<td>3.51</td>
<td>2.69</td>
<td>4.08</td>
<td>2.72</td>
<td>3.05</td>
</tr>
<tr>
<td>2) Conflict</td>
<td></td>
<td>4.19</td>
<td>2.77</td>
<td>5.15</td>
<td>2.78</td>
<td>4.59</td>
<td>2.76</td>
<td>5.10</td>
</tr>
<tr>
<td>3) Expression</td>
<td></td>
<td>3.45</td>
<td>2.38</td>
<td>2.71</td>
<td>2.09</td>
<td>3.02</td>
<td>2.29</td>
<td>3.05</td>
</tr>
<tr>
<td>4) Control</td>
<td></td>
<td>4.65</td>
<td>2.54</td>
<td>5.85</td>
<td>2.54</td>
<td>5.33</td>
<td>2.50</td>
<td>5.33</td>
</tr>
</tbody>
</table>
Data Analysis

As indicated in Table 5, the two groups were similar in terms of sex of subject differences. However, as a function of having one or two alcoholic parents there were significant differences on four of the variables. The multivariate analysis proved inappropriate because the data did not meet the assumption that the correlation between any two dependent variables is the same in all groups. Since the multivariate analysis proved inappropriate, a 2-way ANOVA using sex of subject, gender and number of alcoholic parent(s) was carried out to test group differences on the dependent variables. Only two independent variables were used at the same time, i.e., sex of subject and number of alcoholic parents, because of the small sample sizes involved.

Findings Related to the Hypotheses

The hypotheses in this study were tested to determine whether there were any significant differences between males and females who had one or two alcoholic parents and/or gender of alcoholic parent. Findings related to the hypotheses are presented in this section.

Hypothesis 1. There will be no difference between males and females on their level of self-esteem as measured by the Tennessee Self-Concept Scale.

Male and female groups were compared using a one-way ANOVA with sex of subject as the independent variable.
Results indicate that there is no difference between the groups on their overall level of self-esteem ($SS = 680.08$, $F = 0.55$, $p > F = .46$). Main effect for sex of subject was not significant. On the basis of this analysis, the null hypothesis on differences in self-esteem based on sex of subject was accepted.

Hypothesis 2. There will be no difference between males and females on level of trust in intimacy as measured by the Interpersonal Relationship Scale.

A one-way ANOVA was applied with sex of subject as the independent variable. Main effect for sex of subject was not significant ($SS = 3879.52$, $F = 2.24$, $p > F = .14$). On the basis of this analysis, the null hypothesis that there will be no difference between sex of subject and trust in intimacy was accepted.

Hypothesis 3. There will be no difference between males and females in their desire/expression for control behaviorally over their environment as measured by the FIROB (FIROB-CE & FIROB-CW).

A one-way ANOVA was used with sex of subject as the independent variable. Main effect for sex of subject on the FIROB-CE was not significant ($SS = 1.93$, $F = 0.25$, $p > F = .61$). Main effect for group on the FIROB-CW was also not significant ($SS = 1.33$, $F = 0.17$, $p > F = .68$). On the basis of this analysis, the null hypothesis that there will be no difference between males and females on their
Hypothesis 4. There will be no difference between males and females in their desire/expression for control emotionally as measured by the FIROB (FIROB-CE and FIROB-CW).

A one-way ANOVA was applied with sex of subject as the independent variable. Main effect for sex of subject on the FIROB-CE was not significant (SS = 1.05, F = 0.41, p>F = 0.52). Main effect for sex of subject on FIROB-CW was also not significant (SS = 4.61, F = 0.83, p>F = 0.36). On the basis of this analysis, the hypothesis that there will be no difference between males and females in their desire/expression for control emotionally was accepted.

Hypothesis 5. There will be no difference between males and females in their desire/expression for inclusion on a behavioral level as measured by the FIROB (FIROB-IE and FIROB-IW).

A one-way analysis of variance was used with sex of subject as the independent variable. Main effect for sex of subject on the FIROB-IE was not significant, however it approached significance (Table 7) and will be discussed in Chapter 5 (SS = 27.90, F = 5.03, p>F = 0.02). Main effect for sex of subject on FIROB-IW was not significant (SS = 2.79, F = 0.23, p>F = 0.63). On the basis of this analysis, the null hypothesis that there will be no
### Table 7

**Analysis of Variance: Comparison for Sex of Subject and Number of Alcoholic Parents**

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>Adjusted SS</th>
<th>df</th>
<th>F</th>
<th>&gt;F</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIROB-AE</td>
<td>36.16</td>
<td>1</td>
<td>7.87</td>
<td>0.0066</td>
</tr>
<tr>
<td>FIROF-IE</td>
<td>40.75</td>
<td>1</td>
<td>7.76</td>
<td>0.0069</td>
</tr>
<tr>
<td>FIROF-CE</td>
<td>16.74</td>
<td>1</td>
<td>6.60</td>
<td>0.0124</td>
</tr>
</tbody>
</table>

Analysis of variance with number of alcoholic parents

| CASTyes            | 190.92      | 1  | 5.11| 0.0271|

Analysis of variance by sex of subject with two alcoholic parents

| MOOS COH          | 37.45       | 1  | 7.15| 0.01  |
| MOOS CON          | 32.87       | 1  | 4.50| 0.047 |

Note. Approached significance at $\alpha = 0.05$.

---

difference between males and females in their desire/ expression for inclusion behaviorally was accepted.

Hypothesis 6. There will be no difference between males and females in their desire/expression for inclusion on an emotional level as measured by the FIROF (FIROF-IE AND FIROF-IWL).
A one-way ANOVA was used with sex of subject as the independent variable. Main effect for sex of subject on the FIROF-IE was not significant (SS = 1.92, $F = 0.37$, $p>F = .54$). Main effect for sex of subject on FIROF-IW was also not significant (SS = 8.42, $F = 1.41$, $p>F = .24$). On the basis of this analysis, the null hypothesis that there will be no difference between males and females in their desire/expression for inclusion on an emotional level was accepted.

Hypothesis 7. There will be no difference between males and females in their desire/expression for affection on a behavioral level as measured by the FIROB (FIROB-AE and FIROB-AW).

A one-way ANOVA was applied with sex of subject as the independent variable. Main effect on FIROB-AE for sex of subject was not significant (SS = 4.56, $F = 0.99$, $p>F = .32$). Main effect for group on FIROB-AW was also not significant (SS = 0.77, $F = 0.18$, $p>F = .67$). On the basis of this analysis, the null hypothesis that there will be no difference between males and females in their desire/expression for affection on a behavioral level was accepted.

Hypothesis 8. There will be no significant difference between males and females in their desire/expression for affection on an emotional level as measured by the FIROF (FIROF-AE and FIROF-AW).
A one-way ANOVA was used with sex of subject as the independent variable. Main effect for sex of subject on the FIROF-AE was not significant (SS = 7.38, \( F = 1.44 \), \( p > F = .23 \)). Main effect for group on the FIROF-AW was also not significant (SS = 5.64, \( F = 0.89 \), \( p > F = .34 \)). On the basis of this analysis, the hypothesis that there will be no difference between males and females desire/expression for affection on an emotional level was accepted. 

Hypothesis 9. \textit{There will be no significant difference between males and females in the extent of symptomology associated with being an ACOA as measured by the C.A.S.T.}

A two-way ANOVA was applied with sex of subject as the independent variable. Main effect for sex of subject was not significant (SS = 44.10, \( F = 1.18 \), \( p > F = .28 \)). On the basis of this analysis, the null hypothesis that there will be no significant difference between males and females in the extent of symptomology associated with being an ACOA was accepted.

Hypothesis 10. \textit{There will be no significant difference between males and females on whether they have a problem with alcohol abuse as measured by the demographic question.}

Male and female groups were compared using a Chi-square analysis. Of the 71 subjects assessed by the questionnaire on whether the subject had an alcohol abuse
problem, 43.66% were males and 56.34% were females. Of the 31 males, 80.6% indicated they had an alcohol abuse problem. Of the 40 females, 55% indicated they had an alcohol abuse problem. These proportions were significantly different for males and females ($\bar{X} = 5.13$, $df = 1$, $p < .02$). On the basis of this analysis, the null hypothesis that there will be no significant difference between males and females on whether they have an alcohol abuse problem was rejected. It appears that males are more likely than females to say they have an alcohol problem. Only 19.4% of the males did not admit to having a problem with alcohol, while 45% of the females stated they did not have a problem with alcohol (see Table 3).

Hypothesis 11. There will be no significant difference between males and females and whether their choice of intimate partner has a problem with alcohol as measured by a forced choice question.

Groups were compared using a Chi-Square analysis. Of the 45 subjects assessed on the questionnaire on whether their partner has an alcohol abuse problem, 31.1% were males and 69% were females. Of the 14 males, 64.3% ($n = 9$) indicated that their partner has an alcohol abuse problem. Of the 31 females, 45.2% indicated that their partner has an alcohol abuse problem. These percentages were not significant ($\bar{X} = 4.99$, $df = 2$, $p < .08$). On the basis of this analysis, the null hypothesis that there will be a
significant difference between males and females on whether their choice of partner has an alcohol problem was accepted.

Hypothesis 12. There will be no significant difference between males and females and whether their choice of intimate partner is also an ACOA.

Groups were compared using a Chi-square analysis. Forty five subjects were assessed by a forced question on whether their choice of intimate partner is also an ACOA. Of the 14 males, 78.6% indicated that their partner was an ACOA. Of the 31 females, 54.8% indicated that their partner was an ACOA. These percentages, although they approached significance, were not significant ($\bar{x} = 5.48$, $df = 2$, $p < .06$). On the basis of this analysis, the hypothesis that there will be no significant difference between males and females and whether their intimate partner was also an ACOA was accepted.

Hypothesis 13. Hypothesis from 1-9 will not differ as a function of gender of the alcoholic parent.

A two-way ANOVA was applied with gender of the alcoholic parent and sex of subject as the independent variables. Results of the following dependent variables—self-esteem, trust, desire/expression for control behaviorally and emotionally, desire/expression for inclusion behaviorally and emotionally, desire/ expression for affection behaviorally and emotionally—indicate that
the interaction between independent and dependent variables was not significant. Also, the interaction of the degree of symptomology experienced by the ACOA with the independent variables was not significant. On the basis of these analyses, the null hypothesis that there will be no significant difference between sex of subject and gender of the alcoholic parent on all major variables was accepted.

Hypothesis 14. The hypotheses from 1-9 will not differ as a function of the number of alcoholic parents.

Significant results were obtained on the following dependent variables in which two-way ANOVAs were applied with sex of subject and number of alcoholic parents as the independent variables.

Results indicate that the interaction between sex of subject, number of alcoholic parents, and expression of control emotionally (FIROF-CE) was significant (SS = 16.74, F = 6.60, p>F=.01). This result indicates that males with two alcoholic parents have more difficulty in feeling they are able to make decisions or take on responsibility than females with two alcoholic parents do. On the basis of this analysis, the null hypothesis that there will be no significant difference between sex of subject and number of alcoholic parents on expression of control emotionally was rejected (see Table 7).
Results indicate that the interaction between sex of subject, number of alcoholic parents, and expression of inclusion on an emotional level (FIROF-IE) was significant ($SS = 40.75, F = 7.76, p > F = .007$). This indicates that males with two alcoholic parents feel significantly more uncomfortable around people than do females with two alcoholic parents. Those females with two alcoholic parents, as opposed to having only one alcoholic parent, feel more comfortable in social settings. On the basis of this analysis, the null hypothesis that there will be no significant difference between the sex of subject and number of alcoholic parents on expression of inclusion emotionally was rejected (see Table 7).

Results indicate that the interaction between sex of subject, number of alcoholic parents, and expression of affection on a behavioral level (FIROB-AE) was significant ($SS = 36.16, F = 0.59, p > F = .006$). This indicates that males with two alcoholic parents express affection on a behavioral level much less than do females with two alcoholic parents. On the basis of this analysis, the null hypothesis that there will be no significant difference between sex of subject and number of alcoholic parents on expression of affection on a behavioral level was rejected.

Finally, results indicate that although there is no significant difference with sex of subject and gender of
alcoholic parents in symptomology associated with being an ACOA, there is a significant difference between the number of alcoholic parents and symptomology ($SS = 190.92, F = 5.11, p>F = .02$). This indicates that those subjects with two alcoholic parents suffer a higher degree of symptoms than those subjects with only one alcoholic parent.

A two-way ANOVA was applied with sex of subject and the number of alcoholic parents as the independent variables. Results of the following dependent variables --self-esteem, trust, desire/expression for control behaviorally (FIROB-CE & FIROB-CW), desire for control emotionally (FIROF-CW), desire/expression for inclusion behaviorally (FIROB-IE & IW) and desire for inclusion emotionally (FIROF-IW), desire for affection behaviorally and desire/expression for affection on an emotional level --indicate that the interaction between the independent variables and the above dependent variables were not significant. Also, the interaction of the degree of symptomology experienced by the ACOA with sex of subject and gender of alcoholic parent was not significant. On the basis of these analyses, the null hypothesis that there will be no significant difference between sex of subject and gender of alcoholic parent on the above mentioned variables was accepted.

Hypothesis 15. There will be no differences in perceived changes in the family environment as measured
by the four subscales on the FES and the significant dependent variables with sex of subject, gender of alcoholic parent, and number of alcoholic parents.

Testing of the hypothesis was done using the Moos FES to assess if there would be any further significant effects in relation to sex of subject and having two alcoholic parents.

Means and standard deviation and a one-way ANOVA were completed on the following subscales of the FES: cohesion, conflict, expressiveness, and control and were compared by sex of subject and having two alcoholic parents. Results indicate that the interaction between sex of subject and possession of two alcoholic parents with the subscale "cohesion" was significant ($SS = 37.45$, $F = 7.15$, $p > F = .015$). Males scored significantly higher ($\bar{X} = 4.75$, $SD = 2.7$) than did females ($\bar{X} = 2.00$, $SD = 2.0$); which means that males found a higher level of inclusion in their two alcoholic parent households than did females with two alcoholic parents (see Table 6). Results indicate that the interaction between sex of subject and having two alcoholic parents with the subscale "conflict" approached significance but was not significant ($SS = 32.89$, $F = 4.50$, $p > F = .047$) (see Table 7). Results indicate that the interactions between sex of subject and having two alcoholic parents with the subscales expressiveness and control were not significant. On the
basis of this analysis, the null hypothesis that there will be no difference between males and females and their having two alcoholic parents on the FES subscales of "conflict", "expressiveness", and "control" is accepted. However, the hypothesis that there will be no difference between males and females and their possession of two alcoholic parents on the FES subscale cohesion was rejected (see Table 7).

Summary of the Findings Related to the Hypotheses

Twelve of the hypotheses were tested using ANOVA procedures to determine group differences as a function of various personality measures. Six instruments were used: (a) self-esteem; (b) level of trust in intimate relationships; (c) desire and expression of control, inclusion, and affection on both a behavioral and an emotional level; (d) symptomology experienced while growing up in an alcoholic home; and (e) perceptions of the family environment. The results of these analyses indicated that there were significant differences between male and female ACOAs and number of alcoholic parents on the emotional expression of control (FIROF-CE); on the emotional expression of inclusion (FIROF-IE); and on the behavioral expression of affection (FIROB-AE). There were significant differences between number of alcoholic parents and symptomology experienced by the ACOA. Those individuals (both male and female) with two alcoholic
parents experienced more symptoms related to living in an alcoholic environment than did those individuals with only one alcoholic parent. Also, males with two alcoholic parents found a higher level of inclusion in their alcoholic families than did females with two alcoholic parents.

There were no sex of subject differences on all the major variables. Perhaps this is a reflection of the characteristics of the sample as a whole in terms of age of respondents, level of education, and/or socio-economic status. However, there is an impact on some level in one's having one or two alcoholic parents. All significant results were relative to having two alcoholic parents as compared to having one alcoholic parent.

Three of the hypotheses were tested using a Chi-Square analysis to determine if a relationship existed between the subjects being an ACOA and either (a) having an alcohol abuse problem, (b) choosing a partner who had an alcohol abuse problem, or (c) choosing a partner who was also an ACOA. Significant differences were found between males and females having an alcohol problem; however, hypotheses 11 and 12 failed to be rejected as no significant correlation was obtained between sex of subject and choice of partner.

The participants involved in this study were males (43.1%) and females (56.9) who had attained at least 14
years of education and who were in their middle thirties at the time of the data collection. More females (75.6%) than males (45.2%) were currently involved in an intimate relationship at the time of the study and had partners who were also ACOAs.

A greater percentage in both groups (51.4%) had a father who was alcoholic and a larger percentage of females had two alcoholic parents. A large proportion of subjects (75.6%) rated their parents' marriages as unhappy and both males (67.7%) and females (82.9%) had suffered some form of abuse (verbal, physical, and/or sexual) as a child.

The results of the analyses indicated that there were only significant differences between males and females in relationship to number of alcoholic parents but not in relation to gender of alcoholic parent or sex of subject. Significant differences were found on the following dependent variables: emotional expression of control, the behavioral expression of affection, and the emotional expression of inclusion as measured by the Fundamental Interpersonal Relationship scale. There was also a significant difference in more symptomology experienced as a child raised in an alcoholic home consisting of two alcoholic parents rather than only one alcoholic parent.

In conclusion, there were no sex of subject differences on any of the major dependent variables
although more males than females admitted to having an alcohol problem and more females than males had a partner who was also an ACOA. Also, males with two alcoholic parents found a higher level of inclusion in their alcoholic families than did females with two alcoholic parents. All significant results obtained in this study were related to number of alcoholic parents rather than sex of subject or gender of alcoholic parent.

Post_Hoc_Analyses

In a follow up examination to determine whether there were any significant differences between those subjects who identified themselves as having an alcohol problem with those who did not, there were no gender differences among the major dependent variables. However, given those subjects who identified themselves as alcoholic, males and females did differ on one major dependent variable. There was a significant difference in trust in intimate relationships in that women scored higher in trust in intimacy than the men.

Correlational_Analyses

Correlational analyses were done on the major dependent variables with sex of subject and gender/number of alcoholic parents as the independent variables to determine if there were any relationships between them. Two significant relationships are of note: (the FIROB-CE and self-esteem) in which a negative correlation (-.82)
was observed for females with two alcoholic parents; and (FIROB-CE and FIROF-AE) where a negative correlation (−.78) was observed for males with two alcoholic parents. See Table 8 in the Appendixes for the correlational matrix of significant relationships.

Correlational analysis on the major independent variables yielded significant differences in terms of subjects' possession of one or two alcoholic parents with gender of alcoholic parent. Correlational coefficients on several variables in a positive and negative direction will be discussed further in Chapter Five.
CHAPTER V
SUMMARY, DISCUSSION, AND IMPLICATIONS

Introduction

This study examined the difference between male and female ACOAs as a function of the personality variables of self-esteem, trust, need for control, desire and expression for inclusion and affection, degree of symptomology experienced in an alcoholic family environment, and perceptions of the family environment. This chapter will include (a) a summary of the major findings, (b) a discussion of these findings, and (c) implications related to theory, research, and treatment.

Summary of the Major Findings

Sample

The subjects were 72 people who resided in Columbus, Ohio, who had at least one alcoholic parent and who were either in psychotherapy or in a self-help group (AA, ACOA). The average length of time in a self-help group for both males and females was approximately 1 year. Over half of the respondents, 57% (n = 41), were female and 43% (n = 31) of the respondents were male. All participants were between the ages of 25-45. The average age for both groups was in the middle 30s, one-third of the sample had
attained a four year college degree, and over one-third of the sample from both groups had achieved graduate and/or professional training. The mean annual income for both groups was approximately $20,000.

The majority of the participants identified their father as the alcoholic, 54.8% (n = 17) for males and 48.8% (n = 20) for females. Both groups had proportionately the same percentage of mothers who were alcoholic (19%) and the same percentage of both parents who were alcoholic (28%).

A larger percentage of males, 80.6% (n = 25) vs. 53.6% (n = 22), than females stated that they had an alcohol abuse problem. A greater percentage of females than males were currently involved in an intimate relationship, 76% (n = 31) vs. 45% (n = 14). A similar percentage existed between groups in relationship to whether their intimate partner was either an ACOA, males 78.6% (n = 11) and females 54.8% (n = 17), or had an alcohol abuse problem, males 64.3% (n = 9) and females 45.2% (n = 14).

An overwhelmingly greater percentage, 43% (n = 31), of the participants rated their parents' marriage as unhappy and stated that their parents had engaged in abusive behavior of some type, 78% (n = 56). Seventy six percent (n = 56) of the respondents stated they had been
abused as children either psychologically, emotionally, and/or physically.

Findings Related to the Hypotheses

Fifteen hypotheses were tested in this study to compare the impact of growing up in an alcoholic home in relation to the (a) sex of subject, (b) number, and (c) gender of alcoholic parent in terms of selected personality variables. These hypotheses were also tested to determine the degree of relationship between the independent and dependent variables and perceptions of the early family environment.

No differences were found between males and females on their self-esteem; level of trust; and desire/expression for control, inclusion, and affection. There were no significant sex of subject differences on any of the major variables. However, when comparing number and gender of alcoholic parent, some differences did occur in the emotional expression of inclusion and control, the behavioral expression of affection, and the relationship to symptomology. The results indicated that women with two alcoholic parents scored higher and in a more positive direction in regards to the emotional expression of control and inclusion than men with two alcoholic parents. Therefore, women with two alcoholic parents emotionally expressed their capability to make decisions and assume responsibility (control) and were more comfortable in
social situations (inclusion) than men with two alcoholic parents. Also, women in the sample behaviorally expressed affection by becoming emotionally involved with others more than did men in the sample with two alcoholic parents.

Those individuals who have two alcoholic parents had more negative experiences related to the alcoholic environment than did individuals who grew up with only one alcoholic parent. The hypotheses concerning sex of subject and alcohol abuse were significant, indicating that the men in the sample were more apt to identify themselves as having an alcohol problem than women.

Discussion

In the past five years, ACOAs have received attention as a distinct population (Cermak & Brown, 1982). It has become important to understand the environment and interactional patterns in the alcoholic family. It is also important in understanding the family dynamics in treating individual clients (Moos et al., 1979). ACOAs have been misdiagnosed and inappropriately treated especially in psychotherapy. These individuals have entered therapy typically because of such problems as relationship difficulties, anxiety, and depression; all of which are undeniably linked to their childhood and adult experiences with an alcoholic parent (Brown, 1985).
According to a family systems perspective, the level of denial that operates within an alcoholic home causes the child not to learn that the alcoholic's drinking is independent of any family member's behavior to control it. Children thus take on a similar struggle as the codependent (nonalcoholic spouse) which results in their coping with conflict in their adult life by exerting control over themselves and others (Brown, 1985). An example is the FIROF-CE, which was a statistically significant result on the expression of control on an emotional level. It is typical for an ACOA to feel out of control in his/her environment, but his/her actual behavior often does not reveal this (Black, 1981; Woititz, 1983). There is much energy expended to deny all feelings by ACOAs because of an extreme concern with issues of control (Brown, 1985).

As a result of their family of origin, ACOAs often replicate their relationship with the alcoholic parent by choosing a dependent or alcoholic partner. The emphasis on denial in the alcoholic family and the inconsistent and unpredictable behavior experienced by the ACOA makes it difficult to assess personality strengths and weaknesses, to trust, and to express one's emotions appropriately (Beletsis & Brown, 1981).
Discussion of the Sample

The mean age of male respondents was 34.5 years with a range from 25 to 45 years. The mean age of females was 33.9 years. The literature suggests that adults who have grown up in an alcoholic home are not usually aware of how it has affected them until their late twenties (Black, 1981). Therefore, the sample's mean age range is appropriate to the findings in the literature.

Attained level of education and annual individual income were proportionately spaced throughout all categories in the sample. There was no significant predominance of one group over another in any category on questions in both the demographic and descriptive data.

At the time of the study, 45% (n = 14) of the males and 76% (n = 31) of the females were currently involved in an intimate relationship. However, the length of time one had been involved ranged from less than 1 month to over 20 years. In response to the question of overall satisfaction with either present or past relationships, the mean response for all participants was in the "mixed" category. However, in a post hoc analysis, females showed a greater trust level in their intimate relationships than males.

The percentage of male subjects (n = 31) who identified themselves as having an alcohol problem was 80.6% while the percentage of female subjects (n = 40) who
identified themselves as having an alcohol problem was 53.6%. The strength of the percentages in relation to the total sample gives evidence of intergenerational alcoholism.

**Self-Esteem: The Tennessee Self-Concept Scale**

Males with an alcoholic father scored higher on the self-esteem index ($\bar{X} = 324.24$) than women with an alcoholic father ($\bar{X} = 306.15$). However, males with alcoholic mothers scored lower on self-esteem ($\bar{X} = 312.33$) than did females with alcoholic mothers ($\bar{X} = 323.87$). Although both sets of results were not significant, there was an interesting relationship in terms of gender of alcoholic parent. Means were similar between males and females in having two alcoholic parents (see Table 4).

The self-esteem means for the whole sample ($\bar{X} = 314.01$, $SD = 34.80$) were relatively low in comparison to the general population norm ($N = 626$, $X = 345.57$, $SD = 30.70$) and the personality integrated population ($N = 75$, $\bar{X} = 376.01$, $SD = 25.46$) (Fitts, 1964). However, the total positive score, which is the criteria for overall self-esteem, reported for a psychiatric patient group ($N = 363$, $\bar{X} = 323.0$) is similar to the whole population mean ($\bar{X} = 314.01$) represented by this sample which reinforces the concept of a troubled population (Fitts, 1964). An ACOA's low self-esteem comes from not trusting oneself, not knowing one's own feelings, and a belief that one was
somehow responsible for the problems in the family (Gravitz & Bowden, 1985).

Without regard to sex differences, the assumption is that having two alcoholic parents is more debilitating than only having one alcoholic parent. Research suggests that if one has two alcoholic parents, the child will be younger the first time he/she gets drunk, will have more behavioral problems, and will tend to develop alcoholism much more rapidly (McKenna & Pickens, 1983). Statistics show that women alcoholics are more likely to have a family history of alcoholism, and are more than twice as likely as men alcoholics to have been brought up by two alcoholic parents (Cotten, 1979; Sexias & Youcha, 1985). An explanation to the question of why female respondents in this study appear to have a higher self-esteem than did the male respondents may be found in an ACOA's degree of over-responsibility. Socialization practices for females have typically reinforced a high degree of responsibility. Typically, women are more likely to be more responsible in interpersonal relationships than men. Perhaps this study is a reflection of a female socialization in which she felt in charge of her alcoholic home which resulted in her feeling more competent about herself (Gravitz & Bowden, 1985).
Parents serve a primary function in the development of self-esteem. However, few studies have explored self-esteem as a function of the relationship with parents and even fewer have focused on the association of self-esteem and the quality, frequency, and intimacy of an individual's relationship with a parent.

Trust in Intimate Relationships: The Interpersonal Relationship Scale

Trust is an important component to being able to establish and maintain an intimate relationship. The mean response by the entire sample on the Interpersonal Relationship Scale (IRS) was only 181 which falls below the pretreatment mean of 225.9 in the experimental group and 227.6 in the control group found in a relationship enhancement study (Guerney, 1977).

Means for the IRS in both groups, and in all subgroups, were similar. The mean for males, (n = 17), with an alcoholic father was 170.41 while the mean in having an alcoholic mother (n = 6) was 172.83. The mean for females with an alcoholic father (n = 20) was 194.55 while the mean in having an alcoholic mother (n = 8) was 173.62. The means for both groups with two alcoholic parents were the same (ι = 183). These means are relatively low compared to the general population (ι = 225.9), as reported in Guerney (1977).
Children of alcoholics have learned from the environment in which they grew up to not trust that others will be there for them—psychologically; emotionally; and, often times, physically (Black, 1981). Because of the inconsistency and unpredictability of alcoholic homes, children rarely feel safe and secure for any length of time (Wegscheider, 1981). Because of the pervasiveness of denial in an alcoholic system, honesty does not seem to exist. No child can learn "to trust, or be expected to trust, unless those around him are also open and honest about their own feelings" (Black, 1981, p. 42). Adult Children of Alcoholics do not seem to be able to allow themselves to believe in other people's motivations and therefore pull back in order to feel safe (Sexias & Youcha, 1985). This withdrawal does little to enhance intimacy, which is reflected in the overall means in this study.

*Affection, Inclusion, and Control (FIROB & FIROE)*

The FIROs' applications are in the areas of individual personality dynamics, family and couples therapy, or other forms of group/individual counseling; and can also be used as a screening instrument for personnel selection (Schutz, 1970). The emphasis is not on development of norms for a specific population, but rather upon interpretations that are applicable regardless of the population (Ryan, 1977).
There were three significant differences between sex of subject and number of alcoholic parents. One of these was on affection-expressed (FIROB-AE). The means were significantly different in relationship to having one or two alcoholic parents. Males scored higher than females on having one alcoholic parent, however, females scored higher in having two alcoholic parents. This result suggests that those women in this study with two alcoholic parents can readily become emotionally involved and establish intimate relationships with others more than the men in the sample with two alcoholic parents. Also, females tend to behaviorally express their emotions more easily than males because of socialization practices (Block, 1976; Hoffman, 1977).

Another significant result with the FIRO occurred with the FIROF-IE (inclusion-expressed). Females with two alcoholic parents felt they expressed more observable behavior in terms of general social orientation (inclusion) than did males with two alcoholic parents. Therefore, the females in this study were significantly higher on feeling comfortable in social settings than were the males. Perhaps this is also a reflection of socialization practices in which males learn to view themselves as separate individuals. However, growing up in a dysfunctional family, especially one with two alcoholic parents, may create an extreme response such as
social withdrawal rather than maintaining a healthy individuation in social settings (Meisner, 1984).

The FIROF-CE (control-expressed) was also significant between sex of subject and number of alcoholic parents. Once again, females with two alcoholic parents scored higher than males with two alcoholic parents. Perhaps an explanation lies in the hypervigilant behavior ACOAs become accustomed to which is a pervasive fear of being "out of control". The hypervigilant behavior manifests itself by ACOAs continually scanning the environment for cues in order not to feel anxiety about loss of control (Gravitz & Bowden, 1985). The females in this study with two alcoholic parents feel that they behaviorally take on more responsibility and leadership roles than do the males in this study with two alcoholic parents. Presumably, super-responsible females would feel a higher sense of control over their environment than males who feel uncomfortable making decisions and accepting responsibility.

Perceptions of the Family Environment (FES)

The Family Environment Scale (FES) by Moos & Moos (1981) contains 10 subscales with three dimensions which are relationships, personal growth, and systems maintenance. Normative data in the Form R subscales were collected on 1125 normal families and on 500 distressed families. Some sources of distressed families, among
others, were collected from psychiatric populations; families with alcohol abuse; and families with delinquent adolescents. In testing the FES on families with an alcoholic member, Moos and Moos (1981) found below-average scores on the Cohesion and Expressiveness subscales and above-average scores on the Conflict and Control subscales. They defined cohesion as the degree of commitment and support family members provide for one another.

In their examination of gender differences, Moos and Moos (1981) found that husbands and wives and boys and girls viewed their families similarly. Their results indicated that there are few overall gender differences in perceptions of family social environments.

In the present study, there was a significant difference in sex of subject with two alcoholic parents on the Cohesion subscale. Males perceived their family of origin as having more cohesion than did females. Perhaps the males in this study were more enmeshed within their family systems and felt a false sense of cohesion; whereas the females in the study maintained more outside social support and therefore were not as enmeshed in the alcohol system. Therefore, they did not perceive it as a cohesive family system. Overall, the family environment was perceived negatively by both groups. The subscale means and standard deviations of Cohesion and Expressiveness,
for this population compared with a normal population, were slightly below the norm; while the Conflict subscale mean was higher than the norm, which is the same as found by Moos and Moos (1981).

A general description of the family environment can only be used to provide a guideline for understanding an alcoholic family. Individual differences and experiences must be taken into account and understood (Brown, 1985).

**Correlation Coefficients**

Correlation coefficients were done on the major independent and dependent variables. In the correlation for females with two alcoholic parents and expressing control and self-esteem (FIROB-CE*TNNTOT) there was a negative correlation which implies that those females with high self-esteem do not behaviorally express control (see Table 8, Appendix G). In the relationship between wanting control and wanting affection on an emotional level (FIROF-CW*FIROF-AW) those males and females with alcoholic mothers who had a high need for control also had a high need for affection. However, males with two alcoholic parents who had a high need for control did not have a high need for affection; whereas females with two alcoholic parents had a high need for both control and affection. Other significant relationships among variables can be found in Table 8, Appendix G.
Implications

Theory

Family researchers are just beginning to examine family process—specifically the family as a system. General systems theory offers new perspectives and concepts in studying family relationships, in particular, the alcoholic family (Jacob et al., 1978). The effectiveness of a system is tied to the permeability of the boundaries. Open boundaries exist if members have a relatively high degree of exchange outside the system and are closed if the family members keep more to themselves (Broderick & Smith, 1979). Unless the dynamics of the family system are understood, unhealthy behavior tends to repeat itself (Wegscheider-Cruse, 1985).

The family as a social system consists of interdependent parts consisting of interacting personalities, each having his/her own expected function. Due to the central function the alcoholic plays within a family, the mood of the alcoholic governs the family interactions at any given time (Brown, 1985). The nonalcoholic's relationship to the children is governed by the way that individual feels for the alcoholic at any given time and may range from over protectiveness to rejection of the children. This adaptation becomes a dominating force around which rules and roles are enacted (Black, 1981; Brown, 1985, Wegscheider, 1981).
Communication revolves around dishonesty and denial which prevents emotional intimacy and restricts a healthy expression of feelings (Black, 1981; Wegscheider-Cruse, 1985).

Children of an alcoholic are vulnerable to the poor role modeling of the alcoholic parent and to the unattentiveness and denial of the nonalcoholic parent (Black, 1981; Cork, 1969; Wegscheider, 1981). The issue of having one or two alcoholic parents raises questions about compensation family members make in order to have some sense of support and self-esteem. The current literature states that the parent is the main source in the developmental outcome of a child; in which case, what are the resources children have to compensate for parental dysfunction? If the nonalcoholic spouse is aware of the problems confronted by the children and is consistent and gives them emotional support, there seems to be less psychological damage in the children (Jackson, 1958). If neither parent is adequately available, then the children find other support systems in terms of friends' parents, teachers, etc. The norm for a family with two alcoholic parents is alcoholism (Brown, 1985). Children in a family in which both parents are alcoholic learn that alcohol is used to cope with everyday events and/or problems in life.

Wilson and Orford (1978) point out that children have different personalities and, therefore, can be affected
differently by the alcoholic family situation. Analysis by Moos and Billings (1982) demonstrated that the emotional status of the children was related to the emotional, physical, and occupational functioning shown by the alcoholic and nonalcoholic parent. Both the research of Wilson and Orford (1978) and Moos and Billings (1982) demonstrated that the child's personality and identification with the alcoholic parent are affected by the drinking style of the alcoholic parent and the coping ability of the nonalcoholic parent.

The lack of gender differences in the present study may be a result that males who attend self-help groups, such as AA, ACOA, etc., may be more androgynous than the general population. Perhaps, in dysfunctional families, gender differences become less significant and/or pervasive.

In a study by Harburg, Davis, and Caplan (1982) it was found that offspring generally imitate their perceptions of same-sex parent's drinking levels more than that of the opposite sex parent. In the present study, male subjects did have a higher identification as alcoholic than the female subjects, and the identified alcoholic in the present study was primarily the father \( (n = 37) \). Therefore, there may be credence to the issue of gender of alcoholic parent and gender of the child.
ACOAs have a tendency to replicate their relationship with the alcoholic parent by choosing a dependent and/or alcoholic partner (Brown, 1985). Another trend that has emerged in the Children of Alcoholics' literature was a higher rate of alcoholism in the families of women rather than men alcoholics (Cotton, 1979). Findings from the present study cannot adequately ascertain a higher rate of alcoholism in the families of women in the study, however, women in the present study did have a higher rate of partners who were alcoholic or ACOA (n = 31) than males (n = 20).

There is no agreement in the literature as to whether an alcoholic mother or father is more damaging for children. However, there is overwhelmingly more data on the husband/father as alcoholic rather than wife/mother as alcoholic (El-Guebaly & Offord, 1979). There is also not much literature on the effects of having two parents who are alcoholic. It is assumed that having two alcoholic parents is more detrimental for a child, yet there is little reference to gender differences in relationship to number of alcoholic parents.

Almost all of the significant findings in the present study related to the number of alcoholic parents. Males with two alcoholic parents were consistently worse off than females with two alcoholic parents. However, all the scores on the questionnaires for the entire sample were
generally lower when compared with the norms used in each questionnaire. This gives support to the clinical research which states dysfunctional families score consistently lower than 'normal' families in psychological and/or sociocultural areas. Therefore, the findings suggest that gender may be an erroneous issue when the family is as dysfunctional as in having two alcoholic parents.

However, the following may provide an explanation to how females with two alcoholic parents in this study appear to be better off than males with two alcoholic parents. A child who grows up in a troubled family is dependent upon parents who, at the very least, are distracted and at the worst are completely overwhelmed by problems. Due to socialization practices and/or societal pressures, women seem to suffer more than men from feelings of inadequacy, incompetence, and low self-esteem (Sanford & Donovan, 1984). Therefore, a female in an alcoholic family who is acutely aware that her parents cannot be relied on to meet her needs may feel tremendous pressure to justify her existence. In order to prove she is worth keeping around, a daughter would try harder to be a source of help to her parents than would a son. Consequently, a female would learn to manipulate and control her environment which would increase her self-worth and feelings of competence. This would explain how
women with two alcoholic parents in this study appear better off than the men with two alcoholic parents.

Unfortunately, as adults they would need continuing adversity to keep proving their worth; whereupon, life would become a series of ordeals which must be overcome. This would produce an even greater need for control and a greater pursuit of affection in order to maintain a high sense of self-esteem.

Overall, the subjects in the present study appear to have been clearly affected to some degree in having been raised in an alcoholic home in relation to self-esteem and social orientation. However, these subjects were not as dysfunctional as the clinical literature has suggested. These individuals have good jobs with substantial incomes, are in relationships, and seem to have an awareness of the problems they've experienced, related to growing up in an alcoholic home, through their participation in self-help groups and/or psychotherapy. Granted, this may be a reflection of the sample collected. However, there is credence to the implication that in having an awareness of ones problems an individual may not be as dysfunctional as an individual who has no such awareness.

Research

1. The first recommendation would be to replicate the study using the same measures. However, the addition of a clinical interview would perhaps provide insight into
the personality variables of self-esteem and trust in intimate relationships.

2. The second recommendation would be to include the subject's intimate partner in the study design. Considering that ACOAs' primary issues revolve around intimacy, the partner could provide valuable insight into the personality variables of the intimate interaction. Also, the quality of the intimate relationship could be addressed to give a more detailed account of the intimate interaction between partners. Finally, the definition of intimacy in terms of this study may have been confusing to the participants considering the ambiguity of the categories concerning involvement.

3. The third recommendation would be to gather more extensive demographic and descriptive data in order to provide a better comparison of participants. An example would be to investigate birth order and age of onset of parental alcoholism of the ACOAs.

4. Since the length of time taken to complete the questionnaire was not adequately supervised, the fourth recommendation would be to limit the amount of time subjects could have in order to complete the questionnaires. Perhaps this would give a more standardized testing procedure.

5. Since the results are based on a nonrandomized sample of males and females who have already identified
themselves as ACOAs, a recommendation would be to assess participants by how long they had identified themselves as an ACOC. This may provide different considerations in terms of generalizing to the population at large.

6. The recommendation would be to include other ethnic and socioeconomic groups in order to make adequate generalizations.

7. The final recommendation is a need for a systematic individuation approach to measuring/assessing the parental roles. An examination of specific interactions with one or both alcoholic parents may shed some light on the issue of number/gender of alcoholic parent and sex of subject.

Intervention

A developmental process of recovery with ACOAs begins with the relinquishment of denial in terms of giving up responsibility for the family of origin and/or the alcoholic. It becomes a shift from a reactive position to an active one, which is a focus on the self rather than the family and/or alcoholic (Brown, 1985). The most common form of intervention apparently comes from word of mouth, literature, and the helping professions (Wegscheider-Cruse, 1985). A combination of education and structured group therapy are the primary modes of intervention. Also, support groups such as AA, Al-Anon, and ACOA groups are becoming more and more a natural part
of an individual's treatment. Many ACOAs enter treatment with severe problems in interpersonal relationships, difficulties establishing trust, and depression (Cermak & Brown, 1982). They have learned not to trust, build up expectations, nor to depend on anyone to gratify their needs. In relationships, these individuals have difficulty setting limits to their responsibility for the other person's needs and feelings. This difficulty with separation and individuation is a cornerstone to an ACOA's inability to sustain healthy and trusting intimate relationships (Wood, 1984). Individual treatment modes may contribute to a rebuilding of a self-identity in which the ACOA can learn to feel secure with a certain sense of separateness one needs to obtain to feel worthwhile and competent (Meisner, 1984). It is a process of reconstructing personal identities from a new set of learned behaviors outside the alcoholic family system (Brown, 1985). Adults who have grown up in an alcoholic family have missed their childhood (Black, 1981; Brown, 1985; Cermack & Brown, 1982). The ultimate process is the retrieval of the "child within" because ACOAs typically did not have a real childhood, but rather became adults too early (Beletsis & Brown, 1981; Black, 1981; Wegscheider, 1981).

Data from this research indicate that intervention with ACOAs is perhaps more optimistic than the clinical
research has shown. Areas of focus for intervention with these adults should include a developmental review of parent-child relationships and interactions as well as a contemporary analysis of interactions with intimate partners. Issues of trust, expression of emotions, and control need to be addressed within the framework of close personal relationships. Those individuals with two alcoholic parents, rather than those with only one alcoholic parent, may be more motivated to address their issues of personal growth due to their overwhelming fears of isolation and loss of control.
REFERENCES


APPENDIX A

STUDY APPROVAL FORM
RESEARCH PROTOCOL:

8680143 SOCIAL/PSYCHOLOGICAL DIFFERENCES BETWEEN MALE AND FEMALE ADULT CHILDREN OF ALCOHOLICS, Barbara M. Newman, Patrick C. McKenry, Robelyn S. Marlow, Family Relations and Human Development.

presented for review by the Behavioral and Social Sciences Review Committee to ensure proper protection of the rights and welfare of the individuals involved with consideration of the methods used to obtain informed consent and the justification of risks in terms of potential benefits to be gained, the Committee action was:

X APPROVED

DEFERRED*

APPROVED WITH CONDITIONS*

DISAPPROVED

NO REVIEW NECESSARY

*CONDITIONS/COMMENTS:

Subjects were deemed NOT AT RISK and the protocol was unanimously APPROVED.

COMMENTS: The HS-027 consent form should be used. The oral instructions should inform the subjects how they were selected; should give an estimate of the time involvement, should clarify whether the questionnaires will be administered at the meetings, and should include the directions of the Tennessee Self-Concept Scale which ask subjects to answer all questions.
Research Involving Human Subjects

ACTION OF THE REVIEW COMMITTEE

With regard to the employment of human subjects in the proposed research protocol:

86B0143 SOCIAL/PSYCHOLOGICAL DIFFERENCES BETWEEN MALE AND FEMALE ADULT CHILDREN OF ALCOHOLICS, Barbara M. Newman, Patrick C. McKenry, Robelyn S. Marlow, Family Relations and Human Development

THE BEHAVIORAL AND SOCIAL SCIENCES REVIEW COMMITTEE HAS TAKEN THE FOLLOWING ACTION:

X APPROVED _____DISAPPROVED
_____ APPROVED WITH CONDITIONS* _____ WAIVER OF WRITTEN CONSENT GRANTED

* Conditions stated by the Committee have been met by the Investigator and, therefore, the protocol is APPROVED.

It is the responsibility of the principal investigator to retain a copy of each signed consent form for at least four (4) years beyond the termination of the subject's participation in the proposed activity. Should the principal investigator leave the University, signed consent forms are to be transferred to the Human Subjects Review Committee for the required retention period. This application has been approved for the period of one year. You are reminded that you must promptly report any problems to the Review Committee, and that no procedural changes may be made without prior review and approval. You are also reminded that the identity of the research participants must be kept confidential.

Date: August 15, 1986 Signed:  (Chairperson)

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APPENDIX B

CONSENT FORM
CONSENT FOR PARTICIPATION IN
SOCIAL AND BEHAVIORAL RESEARCH

I consent to participating in (or my child's participation in) research entitled:

"The Social-Psychological Differences Between Male and Female Adult Children of Alcoholics"

Robelyn Marlow or her/his authorized representative has explained the purpose of the study, the procedures to be followed, and the expected duration of my (my child's) participation. Possible benefits of the study have been described and alternative procedures, if such procedures are applicable and available.

I acknowledge that I have had the opportunity to obtain additional information regarding the study and that any questions I have raised have been answered to my full satisfaction. Further, I understand that I am (my child is) free to withdraw consent at any time and to discontinue participation in the study without prejudice to me (my child). The information obtained from me (my child) will remain confidential unless I specifically agree otherwise by placing my initials here.

Finally, I acknowledge that I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: ___________________ Signed: ___________________

Signed: ___________________

Signed: ___________________
(Principal Investigator or his/her Authorized Representative)

Signed: ___________________
(Person Authorized to Consent for Participant - If Required)

Witness: ___________________
APPENDIX C

ORAL INSTRUCTIONS TO SUBJECTS
Dear Adult Child of an Alcoholic,

I am a Doctoral student in the department of Family Relations and Human Development and am doing my dissertation on the social-psychological differences between male and female adult children of alcoholics. A particular interest is in the relationship between self-esteem, issues of trust, control, affection, need for inclusion, and perceptions of the family of origin environment for ACOAs.

The study entails completing a screening instrument called the C.A.S.T. which is the Children of Alcoholics Screening Test; a descriptive questionnaire; and three personality inventories: a) the Tennessee Self-Concept Scale, b) the Fundamental Interpersonal Relationship Orientation (FIRO-B & FIRO-F), and c) the Interpersonal Relationship Scale. The Moos Family Environment Scale, Form R will be used to ascertain any significant differences between the two groups. All of these scales will be given at one time.

Confidentiality is guaranteed and only code numbers will be used. The only requirement of the subject is to be as honest and open as possible while completing the inventories/questionnaire. If interested, results can be obtained and forwarded to the interested individual. One can stop taking the instruments at any time, however, I would encourage you to finish all the inventories for the benefit of the study being conducted.

I hope that you will be willing to participate in this project. Those individuals who have worked on such a project before have found it enjoyable and have also learned a great deal about themselves and their families. If you have any questions I will be glad to answer them.

Sincerely,

Robelyn Marlow, M.A. C.A.C.
APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE
1. Age__________________

2. What is your sex? ______ male _______ female

3. How many years of schooling have you completed? (check one)
   ______ less than high school
   ______ high school graduate
   ______ some college or vocational school
   ______ college graduate
   ______ some graduate school
   ______ graduate or professional degree

4. What is your occupational status? (check one)
   ______ unemployed
   ______ employed parttime; how many hours? _______
   ______ employed fulltime

5. If employed, what is your occupation?_____________________________________

6. What is your personal individual income? (check one)
   ______ Less than 8,000
   ______ 8,000 to 12,000
   ______ 12,000 to 16,000
   ______ 16,000 to 20,000
   ______ 20,000 to 25,000
   ______ 25,000 to 30,000
   ______ 30,000 to 40,000
   ______ 40,000 to 50,000
   ______ over 50,000

7. Are you currently married or otherwise involved in an intimate relationship with one person of the same or opposite sex? ______ Yes (go onto question 8) ______ No (go onto question #9).

8. How long have you been involved in this relationship?________________________

9. Are you sharing a residence with this person? ______ Yes ______ No

10. Are you currently dating? ______ Yes ______ No (go onto 10b).

   a. In general, how would you describe the nature of your current dating relationship/s? (check one)
      ______ Casual
      ______ Semi-intense, but with no possibility for commitment
b. If no, how long has it been since you've dated?

11. How would you rate the satisfaction with either your present relationship or relationships you've had in the past? (check one)
   - Very satisfied
   - Satisfied
   - Mixed
   - Dissatisfied
   - Very Dissatisfied

12. Which of your parents have you considered to be alcoholic?
   - Mother
   - Father

13. Is the parent you consider to be alcoholic still drinking? Yes No

14. If not, when did he/she stop drinking? Year

15. How old were you at the time? Age

16. How many years were/are your parents married to each other?

17. Did your parents' marriage end in divorce? Yes No
   a. If yes, how old were you when your parents divorced?
   b. If yes, did either or both your parents remarry? Yes No
   Which parent? How old were you?

18. Did your parents' marriage end in death? Yes No
   a. If yes, how old were you?
   b. If yes, which parent?

19. How would you rate your parents' marital happiness while you were growing up? (check one)
   - Very happy
   - Semi-happy
   - Neutral
   - Unhappy
   - Very unhappy

20. Did your parents engage in any abuse between the two of them? Yes No
   a. If yes, what type? physical emotional/psychological
b. Were you ever abused by your parents? Yes No

c. If yes, what type? (check one)
   ___ physical
   ___ emotional/psychological
   ___ sexual

d. If yes, was the parent who abused you the alcoholic? Yes No

21. Have you ever been in counseling/therapy before? Yes No

22. Are you presently in therapy/counseling? Yes No

23. Do you consider yourself to have a problem with alcohol/drugs? Yes No

24. Are you in a recovery program? Yes No
   a. If yes, for how long?
   b. If yes, which one/s?

25. If you are presently in a significant/intimate relationship, is your partner an alcohol/drug abuser? Yes No; an ACOA? Yes No

26. If yes, is he/she in a recovery program? Yes No
APPENDIX E

CHILDREN OF ALCOHOLICS SCREENING TEST
1. Have you ever thought that one of your parents had a drinking problem?
2. Have you ever lost sleep because of a parent's drinking?
3. Did you ever encourage one of your parents to quit drinking?
4. Did you ever feel alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking?
5. Did you ever argue or fight with a parent when he or she was drinking?
6. Did you ever threaten to run away from home because of a parent's drinking?
7. Has a parent ever yelled at or hit you or other family members when drinking?
8. Have you ever heard your parents fight when one of them was drunk?
9. Did you ever protect another family member from a parent who was drinking?
10. Did you ever feel like hiding or emptying a parent's bottle of liquor?
11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
12. Did you ever wish that a parent would stop drinking?
13. Did you ever feel responsible for and guilty about a parent's drinking?
14. Did you ever fear that your parents would get divorced due to alcohol misuse?
15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?

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

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

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

19. Did you ever resent a parent's drinking?

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

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

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

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

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

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

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

27. Did you ever fight with your brother(s) and sister(s) about a parent's drinking?

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

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

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

INTERPERSONAL RELATIONSHIP SCALE
This is a questionnaire to determine the attitudes and feelings you have in your current love/significant relationship with your partner or if not in a significant/love relationship at this time - keep a specific love/significant relationship that you have had in mind. I am interested in the relationship as it is/as it was, not in the way you think it should be. Please answer the statements by giving as true a picture of your own feelings and beliefs as possible. Be sure to read each item carefully and show your beliefs by marking an X through the appropriate answer for each question.

If you strongly agree (SA) with each item, that is you feel it is very true of your relationship, place an X through SA. If you think an item is generally more true than untrue, place an X through MA (mildly agree). If you feel the item is about equally true and untrue, place an X through N (neutral). If you feel you mildly disagree (MD) with the item, place an X through MD. If you strongly disagree (SD) with an item—that is, you feel it is very untrue of your relationship—place an X through SD.

- Strongly Agree (SA)
- Mildly Agree (MA)
- Neutral (N)
- Mildly Disagree (MD)
- Strongly Disagree (SD)

1. When serious disagreements arise between us, I respect my partner's position.
   SA MA N MD SD

2. I feel comfortable expressing almost anything to my partner.
   SA MA N MD SD

3. In our relationship, I feel I am able to expose my weaknesses.
   SA MA N MD SD

4. In our relationship, I'm cautious and play it safe.
   SA MA N MD SD

5. I can express deep, strong feelings to my partner.
   SA MA N MD SD
6. I can accept my partner even when we disagree.
   SA MA N MD SD

7. I believe most things my partner says.
   SA MA N MD SD

8. I would like my partner to be with me when I receive bad news.
   SA MA N MD SD

9. I would like my partner to be with me when I'm lonely.
   SA MA N MD SD

10. I seek my partner's attention when I'm facing troubles.
    SA MA N MD SD

11. I feel comfortable when I'm alone with my partner.
    SA MA N MD SD

12. I'm afraid of making mistakes with my partner.
    SA MA N MD SD

13. I feel relaxed when we are together.
    SA MA N MD SD

14. I am afraid my partner will hurt my feelings.
    SA MA N MD SD

15. I face my life with my partner with confidence.
    SA MA N MD SD

16. I share and discuss my problems with my partner.
    SA MA N MD SD

17. I understand my partner and sympathize with his/her feelings.
    SA MA N MD SD

18. I listen carefully to my partner and help him/her solve problems.
    SA MA N MD SD

19. I feel my partner misinterprets what I say.
    SA MA N MD SD

20. My partner would tell a lie if he/she could gain by it.
    SA MA N MD SD

21. In our relationship, I am occasionally distrustful and expect to be exploited.
    SA MA N MD SD
22. I get a lot of sympathy and understanding from my partner.
   SA MA N MD SD
23. There are times when my partner cannot be trusted.
   SA MA N MD SD
24. We are very close to each other.
   SA MA N MD SD
25. My partner doesn't really understand me.
   SA MA N MD SD
26. I'm better off if I don't trust my partner too much.
   SA MA N MD SD
27. I do not show deep emotions to my partner.
   SA MA N MD SD
28. It is hard for me to act natural when I'm with my partner.
   SA MA N MD SD
29. My partner is honest mainly because of a fear of being caught.
   SA MA N MD SD
30. My partner pretends to care more about me than he/she really does.
   SA MA N MD SD
31. My way of doing things is apt to be misunderstood by my partner.
   SA MA N MD SD
32. I wonder how much my partner really cares about me.
   SA MA N MD SD
33. I sometimes wonder what hidden reason my partner has for doing something nice for me.
   SA MA N MD SD
34. It is hard for me to tell my partner about myself.
   SA MA N MD SD
35. I sometimes stay away from my partner because I fear doing or saying something I might regret afterwards.
   SA MA N MD SD
36. My partner can be relied on to keep his/her promises.
   SA MA N MD SD
37. The advice my partner gives cannot be regarded as being trustworthy.
   SA MAN MD SD

38. I don't believe my partner would cheat on me even if he/she were able to get away with it.
   SA MAN MD SD

39. My partner can be counted on to do what he/she says he/she will do.
   SA MAN MD SD

40. My partner treats me fairly and justly.
   SA MAN MD SD

41. My partner is likely to say what he/she really believes, rather than what he/she thinks I want to hear.
   SA MAN MD SD

42. It is safe to believe that my partner is interested in my welfare.
   SA MAN MD SD

43. My partner is truly sincere in his/her promises.
   SA MAN MD SD

44. There is no simple way of deciding if my partner is telling the truth.
   SA MAN MD SD

45. Even though my partner provides me with many reports and stories, it is hard to get an objective account of things.
   SA MAN MD SD

46. In our relationship, I have to be alert or my partner is likely to take advantage of me.
   SA MAN MD SD

47. My partner is sincere and practices what he/she preaches.
   SA MAN MD SD

48. My partner really cares what happens to me.
   SA MAN MD SD

49. I talk with my partner about why certain people dislike me.
   SA MAN MD SD

50. I discuss with my partner the things I worry about when I'm with a person of the opposite sex.
   SA MAN MD SD

51. I tell my partner some things of which I am very ashamed.
   SA MAN MD SD

52. I touch my partner when I feel warmly toward him/her.
   SA MAN MD SD
APPENDIX G

TABLE 8

CORRELATION TABLE
Table 8

Pearsonian Correlation Coefficients Between Dependent Variables and Number/Gender of Alcoholic Parent

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<th>Males w. alc. father n=17</th>
<th>Females w. alc. father n=20</th>
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</tbody>
</table>

Note: : $f = .01$

b : $f = .05$
APPENDIX H

ASSESSMENT INSTRUMENTS
Assessment Instruments

Western Psychological Services
12031 Wilshire Boulevard
Los Angeles, California 90025

Consulting Psychologists Press
577 College Avenue
Palo Alto, California 94306

Orientation: Behavior and Feeling Scales.
Consulting Psychologists Press
577 College Avenue
Palo Alto, California 94306