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AN EXAMINATION OF THE RELATIONSHIP BETWEEN SELF-ESTEEM AND
THE ABILITY OF THE FAMILY OF ORIGIN TO PROMOTE AUTONOMY,
EXPRESSION OF FEELINGS, AND TRUST DEVELOPMENT IN
ADULT CHILDREN OF ALCOHOLICS

by

Paula Andrasi

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
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and Counseling Psychology

Western Michigan University
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AN EXAMINATION OF THE RELATIONSHIP BETWEEN SELF-ESTEEM AND
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Paula Andrasi, Ed.D.

Western Michigan University, 1986

Several theories have been proposed in the last 5 years suggesting that adult children of alcoholics (ACAs) comprise a unique population in need of specialized treatment services. The purpose of this study was to test two of the basic assumptions underlying the various theories. The first assumption considered was that ACAs have poorer self-esteem than adults who are not children of alcoholics (non-ACAs). The second assumption was that an alcoholic home is less facilitative in the promotion of trust development, autonomy, and expression of feeling than the nonalcoholic home. The researcher proposed that poor self-esteem in ACAs would be positively correlated with low levels of facilitation of trust, autonomy, and feeling expression in the family of origin.

The sample consisted of graduate students from 10 classes in nine different departments within a Midwestern university. Each student completed the Children of Alcoholics Screening Test (CAST), the Rosenberg Self-Esteem Scale, the Family-of-Origin Scale, and an information sheet. Using the CAST as a classification tool, the sample consisted of 44 ACAs and 110 non-ACAs.

A one-way analysis of variance was used to determine mean differences both for the self-esteem scores and family of origin ratings. There was no difference in self-esteem scores between ACAs and non-ACAs. There was a significant difference ($p < .001$) in family of origin ratings indicating the ACAs experience their families as less facilitative in the promotion of trust, autonomy, and feeling expression. A Pearson product-moment correlation was used to determine the relationship between self-esteem and family of origin ratings. It was significant for both ACAs ($p < .01$) and non-ACAs ($p < .001$).

The results of this study could not support the premise that ACAs have significantly lower self-esteem than the normal population. Recommendations for research in the area of self-esteem and other ACA subgroups were made and therapists were encouraged to complete thorough assessments with each ACA requesting treatment. Recommendations were also made regarding prevention and early intervention strategies that might be employed with alcoholic families to promote healthy development in the children.

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DEDICATIONS

This dissertation is lovingly dedicated to the memory of my mother, Rosemary Andrasi, who had eagerly anticipated typing this document so she could share in some way my accomplishment and show me her love and support. Although her life has ended, her gifts to me have sustained me through this process. She always believed I could do anything and that I had the right to strive for any goal I might desire. She was a model to me in more ways than she could ever know, and I am eternally grateful for the lessons she taught me.

From lessons of the past comes hope for the future, and the future is dedicated to Nicole Andrasi.

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My thanks go first to my family for supporting me in this endeavor even when they didn't completely understand it. And a special thanks to my dad, who always understood when I couldn't be there for him, and did his best to make things easier for me.

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I am very grateful to work with an outstanding staff who understood when I needed to miss a supervision session or when I was preoccupied with gathering data or analyzing results. They were always there to listen to me and share ideas and, most important, share in my excitement. Thanks to Judy, Craig, Jeff, Dave, Art, Marilyn, and Joan, without whom I could not get along. And to my boss, David, who always supported me.

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Paula Andrasi

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CHAPTER I

INTRODUCTION

Background

Alcoholism is a disorder of great destructive power . . . it will afflict between 3 and 10 percent of all Americans. . . . The damage it causes falls not only on alcoholics themselves, but on their families as well--as this damage touches one American family out of three. (Vaillant, 1983, p. 1)

With these opening comments Vaillant (1983) began his acclaimed book on alcoholism which is the culmination of the 40 year study, the Harvard Medical School's Study of Adult Development.

The alcoholism field has long recognized the importance of treating the entire family to overcome the effects of alcoholism in the home (Bailey, 1968; Jackson, 1954; Wegschieder, 1976). Children of alcoholics have been recognized as being at risk for numerous social and emotional problems. Newell (1950) compared the child of an alcoholic with an experimental animal which is continuously tempted by food and repeatedly frustrated by barriers to the food. This process produced convulsions in the animal. Newell suggested that the "roller-coaster" behavior of an alcoholic parent, who could be affectionate and understanding when sober and offensive and rejecting when drunk, could have a devastating effect on a child. Numerous studies have examined the impact of an alcoholic parent on their children and suggest that children of alcoholics exhibit

several dysfunctional symptoms ranging from learning disabilities (Haberman, 1966) to suicide attempts (Bosma, 1972; Parson, 1976) and suffer from poorer self-esteem than control groups (Aronson & Gilbert, 1963; Baraga, 1977/1978; Cork, 1969; Hughes, 1977; MacKay, 1961; Mik, 1970; Wilson & Orford, 1978).

In recent years there has been an increased awareness that many alcoholics in treatment are adult children of alcoholics, and that they seem to be at a higher risk than normals to develop alcoholism (Cotton, 1979; Goodwin et al., 1974; Winokur, Reich, Rimmer, & Pitts, 1970). In attempting to determine if alcoholics who were raised in an alcoholic home demonstrated a unique pattern of pathology from other alcoholics, Frank and Thacker (1979) administered the Minnesota Multiphasic Personality Inventory to subjects from both groups. Their results indicated that alcoholics raised by an alcoholic parent have a specific pattern of pathology that is different from other alcoholics.

In the last 5 years there has been an even greater awareness that many adult children of alcoholics experience problems other than alcoholism and are beginning to request services to treat these psycho/social problems (Black, 1981; Cermak & Brown, 1982; Woititz, 1983; Worden, 1984). As early as 1973, however, Hecht (1973) found that 20% of the individuals requesting assistance from human service agencies came because of a drinking problem in their family of origin although that was not given as the presenting problem. Springs and Rothgery (1984) found that patients with dysthymic disorder or secondary depression showed low familial incidence of affective

disorders but a significantly high incidence of familial alcoholism.

Theories have been proposed describing the personality of the adult child of the alcoholic. Four main types are proposed. According to Black (1981), they are (a) the responsible one, (b) the adjuster, (c) the placater, and (d) the act-outer. These four roles were supported by Booz-Allen and Hamilton, Inc. (1974) and Wegschieder (1976) in their respective theories. Briefly, the responsible one is the overachiever who is an adult by mid-childhood and makes sure everything is done right. The adjuster takes whatever comes without making a fuss, and sometimes seems to disappear into the background. The placater is always trying to keep everyone free from tension and make life easier for others. The one who acts-out is constantly in some type of trouble and usually identified as being responsible for the problems experienced by others (Black, 1981).

Despite these differences the theories on adult children of alcoholics suggest they are more alike than they are different (Ackerman, 1978). The common and most significant trait suggested is poor self-esteem (Woititz, 1983). The theories propose this comes from inconsistent/absent nurturing in the family of origin. Most notable of the deficient nurturing tasks are those relating to the development of trust, the recognition and expression of feelings, and the development of an autonomous, individuated identity (Beletsis & Brown, 1981; Black, 1981; Brooks, 1983; Cermak, 1984; Gravitz & Bowden, 1984; Woititz, 1983).

Despite the theorizing, little empirical research has been undertaken to confirm these theories. Assumptions have been based on

clinical observations (Black, 1981; Cermak & Brown, 1982) or have been derived from research on adolescents (Woititz, 1983). As Roy (1984) stated, "the problem that plagues this area of inquiry [children of alcoholics] is a common one--lack of research based information" (p. 2).

Statement of Problem

The number of adult children of alcoholics (ACAs) requesting emotional/social services seems to be increasing (Cermak, 1984). Therapists and educators are looking to existing theories on ACAs to help them in developing treatment plans and intervention programs. These theories, however, are clinically derived and have not been validated for the ACA population as a whole.

The purpose of this study is to do basic research to determine if the following questions derived from ACA theories can be answered.

1. Do adult children of alcoholics possess lower self-esteem than adults who are not children of alcoholics?
2. Do adult children of alcoholics experience their family of origin as having been less facilitating in the promotion of the development of trust, the expression of feelings, and the development of autonomy than adults who are not children of alcoholic parents?
3. Is there a relationship between self-esteem and experiences with the family of origin for adult children of alcoholics?

Significance of the Study

In a field where little definitive research has been done, and yet theories are arising suggesting that adult children of alcoholics are a unique client population deserving of a differential diagnosis and treatment approach (Cermak, 1984), basic research of this type is essential. The results of this study may be applicable in the treatment of adult children of alcoholics as well as in the development of strategies for working with families of alcoholics. It may also benefit those looking to the present theories on adult children of alcoholics in determining their usefulness. Finally, this study may serve as a foundation on which more rigorous research can be built.

Definitions of Terms

Alcoholism: A chronic disease manifested by repeated drinking that produces injury to the drinker's health or to his or her social or economic functioning (American Psychiatric Association, 1975).

Alcoholic: An excessive drinker whose dependence on alcohol has attained such a degree that he or she shows a noticeable mental disturbance or an interference with his or her health, interpersonal relations, or social and economic functioning (World Health Organization, 1979).

Alcoholic home: A home in which at least one parental figure is an alcoholic.

Child of an alcoholic (CoA): A child who is being raised in an alcoholic home.

Adult child of an alcoholic (ACA): An individual over 18 years of age who grew up with an alcoholic parent/parental figure.

Self-esteem: The evaluation an individual makes of himself or herself. It is a judgment of worthwhileness that is expressed in the attitudes the individual holds toward himself or herself and acts as a determinant of behavior.

Limitations of the Study

A limitation to this study may be that all of the subjects will be college graduate students. This assumes a higher IQ and a greater degree of motivation than may be found in the general population. The impact of this cannot be specifically identified as it relates to the findings of this study. A significant difference at this level of functioning, however, would be especially meaningful.

Summary

Alcoholism is a problem that effects not only the life of the individual suffering from the disease but family members as well. Research has indicated that children growing up in an alcoholic home exhibit numerous behavioral and emotional problems and possess lower self-esteem than normal children. Clinical experience has indicated that an increasing number of adult children of alcoholics are seeking services not only for their own substance abuse problems but for psycho/social concerns as well. Several theories have been developed to explain the phenomenon of adult children of alcoholics. The most prominent theories indicate that adult children of alcoholics

experience low self-esteem, have difficulty trusting, have difficulty expressing their feelings, and do not experience themselves as autonomous.

Since little research has been done to validate any of these theories, the purpose of this study is to determine if there is evidence to support them. The questions to be investigated are:

1. Do ACAs have lower self-esteem than non-ACAs?
2. Do ACAs experience their family of origin as having been less facilitating in the promotion of trust, feeling expression, and autonomy than non-ACAs?
3. Is there a relationship between self-esteem and experiences with the family of origin?

CHAPTER II

REVIEW OF LITERATURE AND RESEARCH

Alcoholism and the Family

Originally, the literature presented a picture of the alcoholic as a male social misfit and isolate, incapable of maintaining any ongoing interpersonal ties (Bailey, 1968). The field then evolved to a place where it recognized a major proportion of alcoholics function consistently within a family system (Steinglass, 1976). The family, like any other system, is always trying to maintain stability. When the unhealthy element of alcohol abuse is introduced by a family member, the whole system becomes unhealthy in order to maintain its balance (Wegschieder, 1981).

This section of the review of the literature will focus on four main points. Initially, selected theories regarding the importance of the family in child development will be presented. Next, an examination of the theories regarding how alcoholism in the home affects the children will be undertaken. Third, research studies on the impact on children of alcoholism in the home will be examined. Finally, the literature that pertains specifically to the impact of familial factors on adult children of alcoholics (ACAs) will be reviewed.

Importance of Family in Child Development

Lidz (1976) suggested that a person's development cannot be understood properly without consideration of the critical role of the family in the child's development. He stated that the family is entrusted with not only meeting the biological needs of the children but also with transmitting techniques for adaptation to society. All subsequent life experiences are perceived, understood, and reacted to emotionally according to the foundations established in the family. Subsequent influences will modify but never undo or fully reshape the early core experiences with the family of origin (Lidz, 1976). He went on to state that the quality and nature of the parental nurturance which children receive will profoundly influence their emotional development. It affects the quality of the basic trust children develop, influences their sense of autonomy, contributes to how they learn to relate to others, and lays the foundation in the reliability and worth of verbal communication. Lidz (1976) stressed the most important factor is the atmosphere of the home.

Erikson (1963) placed a great responsibility on parents in molding the development of a child. The role of the mother is to create a sense of trust in her children by combining sensitive care to the child's needs with a firm sense of personal trustworthiness. Her consistency and continuity provide the basis for the child to develop confidence in the environment. This stage of development is identified by Erikson as basic trust vs. basic mistrust. Both parents must give firm reassurance knowing when to hang on and when

to let go as the child begins to "stand on his own feet" (Erikson, 1963). Support and encouragement are essential as well as age appropriate limits for the healthy development of the child. Erikson labels this stage as autonomy vs. shame and doubt. Parents must also be able to communicate the importance of their rules and rewards in a meaningful way to the child. As Erikson (1963) stated, "parents must not only have certain ways of guiding by prohibition and permission; they must also be able to represent to the child a deep, and almost somatic conviction that there is a meaning to what they are doing" (p. 249). Erikson went on to specify six more stages of development. They include initiative vs. guilt, industry vs. inferiority, identity vs. role confusion, intimacy vs. isolation, generativity vs. stagnation, and ego integrity vs. despair.

In discussing their findings on healthy--optimally functioning--families, Lewis, Beavers, Gossett, and Phillips (1976) identified several characteristics which seem to coexist in healthy families. The authors stated there is "no single thread" which directly predicts healthy functioning but rather they viewed the various characteristics as forming a unique family tapestry. They reported that a healthy family operates from an attitude of basic trust with the expectation that all encounters will be caring. It shows respect to individual family members by being open and honest in both agreements and disagreements. The healthy family is flexible in solving problems, recognizing the complexity and multiplicity of motives. The family members show initiative in reaching out and being involved both within and beyond the family. The healthy family expects

individual members to exhibit high levels of personal autonomy. This is demonstrated through acceptance of responsibility for thoughts, feelings, and actions. The acceptance of others' feelings through a well developed capacity for empathy is present. The prevailing mood is one of warmth, affection, and safety. The family structure is close but with clear boundaries between members. Conflict is handled through respectful negotiation. The healthy family demonstrates a strong parental coalition but with a balance of power among family members. Finally, a healthy family possesses humor and free flowing spontaneity. The authors stated that the children in the healthy families they studied had little or no emotional social problems (Lewis et al., 1976).

Theories on Effects of Alcoholism on Children

"Outside of residence in a concentration camp, there are very few sustained human experiences that make one the recipient of as much sadism as does being a close family member of an alcoholic" (Vaillant, 1983, p. 20).

As early as 1950 theories were being postulated in an attempt to explain why children of alcoholics (CoAs) seemed to have more problems than "normal" children. Newell (1950) suggested that the more subtle implications of the alcoholic father differ qualitatively from those of the father who is just rough, unkind, or indifferent. He stated this difference occurs because when the alcoholic father is sober he is capable of being affectionate, understanding, and charming. He will then naturally inspire the love of his child who will

build up an ideal father image of omnipotence and loving kindness. When the father again becomes drunk and possibly creates some scene, the frail superego structure of the child is shattered.

Jackson (1954) saw the onset of alcoholism in a family member as the precipitant to a cumulative crisis for the entire family. She stated the family members find themselves in an unstructured situation undefined by the culture. The unpredictability of the situation in addition to the trial and error method of problem solving is seen to engender anxiety in the family members which gives rise to personality difficulties. The inability to come to any resolution of the family crisis as long as the alcoholic continues to drink means the family's "adjustment" appears abnormal to society as a whole.

Recognizing this abnormal adjustment, Clinebell (1968) identified four factors which he believed can produce emotional damage in CoAs. The first is the shift or reversal of parent's roles which cause confusion and complicate the task of developing a strong sense of sexual identity. Second is the belief that the inconsistent and unpredictable relationship with the alcoholic is emotionally depriving. The third factor is that the nonalcoholic parent might be disturbed or preoccupied with the alcoholic and, therefore, inadequate to parent. And finally, that the family's increased social isolation, as an attempt to hide the problem and prevent embarrassment, will interfere with peer relationships and emotional support from adults outside the family.

The probable impact of an alcoholic mother is identified by Bailey (1968), whom she suggested might often neglect her children in

terms of basic care and emotional support. Bailey suggested that the children are expected prematurely to assume adult responsibilities depriving them of the opportunity to develop as children. She believed that the most hurtful result to the children comes from the distorted role model which will interfere with their own development.

Hecht (1973) suggested that CoAs have difficulty with structure and obeying limits. She hypothesized that since the family forms the basic matrix on which the child learns to relate to others, that inconsistency on the part of the parents will naturally lead to the pushing of limits in his or her attempt to discover where the limits lie. This knowledge of limit setting seems important for the child to establish some sense of security which is necessary for growth.

Hamilton (1975) cited the common characteristics of CoAs as possessing feelings of loneliness and utter helplessness for their family situation. He stated these children often have to assume family responsibilities they are not mature enough to handle. This impacts their relationships with other adults whom they expect to be like their parents and with peers whom they must now give up to fulfill their family responsibilities.

In the first book devoted to CoAs, Ackerman (1978) suggested that alcoholic behavior by a parent can prohibit intimate involvement and impede the development of essential family bonds. He stated that the major problem for CoAs is the lack of trust and feelings of insecurity. He suggested this insecurity comes from parental inconsistency. A second problem for CoAs is their inability to express and cope with their feelings. He suggested this is due to the

inappropriate expression of feelings by the parents and the limited opportunities the children have to learn how to ventilate their own feelings. Ackerman (1978) indicated the CoAs seem to have two ways of coping. They either withdraw or act out. The acting out may be "positive" by gaining attention from others for social, athletic, or academic achievement, or it may be "negative" involving self-defeating, attention getting behaviors like abusing substance or getting in trouble at school or sexually acting out. Ackerman concluded by suggesting that the damage inflicted on the child by inadequate nurturing by the alcoholic parental system is not limited to pre-adolescence or adolescence but has long range implications.

Richards (1979) suggested that CoAs are often conflicted and confused by the blackout phenomenon because behavior that has occurred during the blackout is subsequently denied by the parent. This leads to a lack of trust in the self and a disturbed ability to test reality.

Wegschieder (1981) drew from her experience as a family therapist and alcoholism counselor as well as from her personal experience as a CoA in the development of her theory about the roles children assume in an alcoholic family. She suggested these roles are types of defense mechanisms that allow the child to survive what would otherwise be an intolerable situation. The first role is the hero. This is the high achiever whose success is meant to prove to the world that the family must be okay. The hero is generally the oldest child and the one who assumes adult responsibility early in life. This "workaholic" mentality follows the hero throughout his or her

life. School is often the place the hero shines as he or she may be able to get needed adult recognition from teachers.

The second role of the CoA is the scapegoat (Wegschieder, 1981). This child usually learns early on that the role of the hero is taken. The scapegoat uses negative behavior to gain attention and a more direct means of escaping from the family--peer group affiliation. The consequences of being the scapegoat can be quite dangerous due to the illegal, promiscuous, and/or volatile behaviors that are acted out. A chronic attitude of hostility masks the more painful feelings of hurt, rejection, and loneliness.

Wegschieder's (1981) third role is that of the lost child. With parents often at odds with each other and older siblings gaining attention for achievement or acting out behaviors, this child is generally ignored. As the lost child retreats behind a wall of isolation, he or she often builds a fantasy world, a safe place--secure, predictable, and over which he or she has control. This child is not, however, learning to deal with reality.

The last role that Wegschieder (1981) suggested is the mascot. Clowning becomes his or her way to deal with tension and family denial. This behavior is generally reinforced at home but may cause problems in other areas of the mascot's life. School problems are common as the clowning is often seen as disruptive. The mascot deprives himself or herself of real friends because he or she never takes off the clown face and relates as another person. The clown is enjoyed by others but never taken seriously.

In exploring further the roles that Wegschieder (1981) proposed, Whitfield (1980) suggested that specific emotional problems that might require treatment can be identified. Since the feeling of inadequacy in not being able to "cure" the family underlies the success of the hero, he or she may be unable to cope with failure or mistakes causing anxiety and depression. The anger and defiance of the scapegoat may result in delinquency in school and work problems as an adult. The lost child's introversion may cause isolation and loneliness leading to depression. Finally, the mascot's compulsion for attention and total inability to handle stress may lead to various forms of learning disabilities and, most probably, chemical abuse.

Research Studies

One of the earliest and most noted studies on CoAs is that done by Nylander (1960). In his study of 229 children of alcoholic fathers he reported that CoAs are significantly more likely to be identified as "problem children" by their teachers than are the control children (48% versus 10%). They are also more likely to be described as emotionally disturbed by mental examiners (29% versus 5%). Finally, he reported that there is more severe family disorganization in the alcoholic homes. The problem with this study is that the teachers and mental health examiners knew which children had alcoholic parents. There is no way to account for any prejudice factor which might be involved with the findings.

In his study on adolescent substance abusers, MacKay (1961) reported that the majority of the adolescents came from alcoholic homes. Sexual confusion and difficulty forming relationships due to lack of trust is common among female abusers. MacKay reported that when the mother is alcoholic--especially during the first few years of the child's life--that the inconsistent expression of affection and nurturing produces long lasting feelings of rejection, abandonment, and isolation in the children.

A landmark study on CoAs (Cork, 1969) reveals the emotional damage suffered by the children. From interviewing 62 sets of parents and their 115 children (aged 10-16 years), Cork found that 43% of the children were rated as very seriously damaged, 49% as fairly seriously damaged, and 8% as slightly damaged. The clinical assessment on which these ratings are based examines such factors as trust, hostility, depression, and uneasiness with the opposite sex. Since no standardized measures were used and no control group was employed, it is difficult to interpret these findings as validation that alcoholism causes emotional damage in CoAs. There is evidence to suggest, however, that alcoholism contributes to tension, abuse, and neglect in the home.

A Polish study (Obuchowska, 1974) revealed that when children of alcoholic fathers have positive emotional relationships with their mothers, they have dominant needs for achievement and affiliation. Without positive maternal contact, the children show negative attitudes toward social values and are resigned or aggressive.

In his study of adolescent heroin addicts, Haastrup (cited in Harbin & Maziar, 1975) reported a high incidence of alcohol abuse among the subjects' fathers. He also reported that a significant factor in determining the onset of addiction is the absence of a warm, masculine model with which the adolescent can bond.

Goodwin et al. (1974), in their study of sons from alcoholic families where one son stayed in the home and another son was adopted out, found the same rate of alcoholism in both groups of sons as adults. As children, however, the sons raised by the alcoholic parent had more problems in school and came in contact more often with youth care organizations. Once again, no control group families were examined so these findings could be validated. It may well be that some other variable of dysfunction may account for the differences.

As part of a study for the National Institute for Alcohol Abuse and Alcoholism, Booz-Allen and Hamilton, Inc. (1974) conducted interviews with 50 CoAs. The subjects were equally divided between males and females with 74% being over 18 years old. They were evenly divided between Catholic and Protestant, 52% had some college, 66% were middle to upper class, 60% had never married, 20% had received psychiatric care, and another 30% had some other type of professional help. The subjects reported emotional neglect by their parents as the most common problem in their family of origin. The findings of this study indicate that the primary problem for ACAs is with establishing and maintaining relationships--especially with members of the opposite sex. Other problem areas include overachievement,

underachievement, and lack of self-confidence. Since the case study method was used, no statement can be made regarding their relationship to the normal population.

In a comparison of 39 CoAs whose parents were in treatment with 39 children whose parents were not diagnosed alcoholic but were being treated in a counseling center for other psychological problems, CoAs were found to demonstrate significantly more emotional detachment, dependency, and social aggression. The Devereux Behavior Scales were used as the measure. The findings also indicated the CoAs are less able to concentrate, more prone to emotional upset, more fearful, more anxious, and more preoccupied with their inner world than reality (E. Fine, Yudin, Holmes, & Heinemann, 1976).

Adolescent CoAs were studied by O'Gorman (1975/1976) using subjects from Alateen meetings with matched controls coming from a parochial school in the same area. Subjects were given the Siegleman-Roe Parent-Child Questionnaire. In the measurement of the factors of love-reject, casual-demand, and attention getting, CoAs perceived themselves as experiencing significantly less love and less attention than controls.

A study from Portugal compared 100 children with alcoholic fathers to 100 children with nonalcoholic fathers (Mendonca, cited in Ackerman, 1986). Mendonca reported that CoAs experience delayed psychomotor development, neurotic reactivity, reduced effectiveness at school, and language problems. In addition, these children exhibit disturbed parental relations. The author suggested that many of these behaviors and mental health issues are due to psychological

neglect on the part of the parents. He did not, however, provide research findings to support this conclusion.

In a 1978 review of the literature on CoAs, Jacob, Favorini, Meisel, and Anderson (1978) reported there were few well controlled studies of the psychosocial status of CoAs. They confirmed that most of the literature is based on interviews or case histories and most of the designs are characterized by no control group or a normal control group. Despite this, the authors suggested the available research provides modest to moderate support for the view that CoAs exhibit significant difficulties in psychosocial, social, and family functioning. In particular, CoAs have problems in identity formation, personality development, role performance, and the ability to form relationships. The authors suggested the probable cause for these problems comes from the child's attempt to meet the needs of the parents and siblings when there is family disorganization or breakdown. "The greater inconsistency and unpredictability of parental support and expectations in alcoholic versus nonalcoholic families is thought to affect the children's sense of trust, security, self-esteem, and confidence in others" (Jacob et al., 1978, p. 1235).

Unlike the studies reviewed above where alcoholism in the family of origin was considered a significant factor in causing problems for CoAs, three studies suggest different conclusions. Chafety, Blane, and Hill (1971) reported on their sample of 100 CoAs who were compared with 100 non-CoAs whose parents were receiving psychiatric treatment. Subject designation was a result of parental alcoholism being mentioned in the child's medical chart. There is no difference

in demographic variables between the two groups except there is more marital instability in the alcoholic group. Using a retrospective review the authors suggested that CoAs do not differ in serious pathology from controls but are more likely to have had a serious illness or conduct problems. The authors were unable to conclude if even these problems relate directly to the alcoholism or occur because of the family instability. This study is limited due to its retrospective review design as there were no preexisting criteria for what or how the data were to be recorded. It is quite possible that significant information was omitted from the charts either because of the families' denial or the practitioners' negligence.

Kammeir (1971) studied subjects from stable homes where parental alcoholism was not significantly interfering with the family's economic or social functioning. The author reported that there are no significant differences in emotional characteristics, social relationships, or school performance as measured by routine achievement and psychological tests and academic records.

In a review of family interactions in disturbed families, Jacob (1975) reported there were no factors found in the parent-child interaction of schizophrenics, neurotics, or behavior disorders (including alcoholics) which can be considered unique to them or which can distinguish one group from the other or any group from controls. The main factors which seem to be present in all groups include dominance, affect, and communication clarity.

El-Guebaly and Offord (1977) reviewed prior studies on CoAs and found that although there was evidence that CoAs are at a higher risk

for emotional disturbance than normals the specific factors responsible for this cannot be clearly identified. They identified problems with the research as being unclear definition of terms, sample groups selected because they are already "in trouble," inadequate use of control groups, and inappropriate research designs to identify nature of causal links.

In an attempt to answer some of their own concerns, El-Guebaly, Offord, Sullivan, and Lynch (1978) presented their own study. Data were collected on 90 inpatients starting with 15 female alcoholics and 15 male alcoholics who had at least one child under 21 years old. Researchers then matched by sex, age, and time of admission a schizophrenic and a depressive patient. Data collected included information in the patients' charts and a structured interview with the spouse. The Rutter's Parental Questionnaire on Children's Behavior, the Randall-McClure Behavior Checklist, and a medical history was obtained for the 231 children involved. El-Guebaly et al. reported that 55% of the children were perceived as emotionally disturbed but there was no significant difference between diagnostic categories. The authors did express some concern about interpreting their findings since the parents filled out the evaluation of the children used to determine disturbance, and there may have been a tendency on the part of some parents to distort or deny the child's actual problems. Denial is especially common in alcoholic homes.

The need for additional studies from nondisturbed samples using standardized instruments and appropriate control groups seems to be

clearly indicated. Specific family of origin factors need to be identified and investigated.

Theories About Adult Children of Alcoholics

Although Black (1979) first gained fame for her inventive work with young CoAs, it was she who led the field in promoting a theory regarding ACAs (Black, 1981). In keeping with the precedent set by the Booz-Allen and Hamilton, Inc. (1974) report and Wegschieder (1976), Black identified four roles that are assumed by CoAs as coping mechanisms. The responsible child, like Booz-Allen and Hamilton's super-coper or Wegschieder's hero, is the individual who takes care of everyone and everything as well as appearing mature beyond his or her years. As adults the responsible ones continue to exercise control over everyone and to push themselves to carry the weight of the world on their backs. They cannot admit to any weakness or ask others for help. Along with this burden is the guilt the responsible ones feel for never getting everything perfect and meeting everyone else's needs all the time.

Black's (1981) second role of the adjuster is comparable to Booz-Allen and Hamilton's (1974) flight child and Wegschieder's (1976) lost child. The adjusters simply stay out of the way and accept everything that happens. They depend on no one for assistance, take what is offered when it is there, and don't expect something when its not available to them. They survive by denying all their wants and feelings. As adults the adjusters continue to exist on the fringe of life--detached from others, and not really knowing

who they are or what they want. They don't even know it is possible to ask for help.

The third role that Black (1981) suggested is the placater, Booz-Allen and Hamilton's (1974) perfect child and Wegschieder's (1976) mascot seem to correspond here. The placater is the one who keeps the peace by trying to fix everyone else so as to lessen the tension. They are often the favorite child in the family and generally the youngest. As adults the placaters show similarity to the responsible ones because they continue to take care of everyone else's needs and not pay attention to their own. The difference is that the placater does not share the responsible one's need for control but rather continues to be used by others.

Black's (1981) final role is that of the acting out child. This well-known role is found in Booz-Allen and Hamilton's (1974) fighter and Wegschieder's (1976) scapegoat. These children are acting out their anger and frustration all the time. These would be the juvenile delinquents, conduct problems, and school failures mentioned in so many of the studies on CoAs. They are the children who "look bad." As adults, those who act out continue doing so but with more serious consequences. Job failures, legal difficulties, and abusive relationships are all associated with the individuals who act out.

Black (1981) does not give specific reasons as to why different children adopt the different roles that they do, but rather, presents a theory as to the underlying cause for all the roles. Black proposes that children in alcoholic homes are taught three rules which deprive them of healthy development. The rules are: Don't talk,

don't trust, and don't feel.

The don't talk rule is implicitly taught in the alcoholic home through modeling and through punishment if it is attempted. The don't talk rule is meant to help the family remain in denial about the alcoholism and to protect the family from disgrace. Going against the don't talk rule is considered a betrayal of the family (Black, 1981).

The don't trust rule is learned from experience. After several broken promises and unpredicted emotional outbursts the child learns that adults cannot be depended on to keep their word, give sound advise, or be available for support or council (Black, 1981).

The don't feel rule becomes a matter of survival. Children of alcoholics don't have the opportunity to learn how to appropriately handle their feelings since parental modeling is often substance induced. They are also deprived of the comfort or support of the parent when their feelings are confusing or overwhelming. Finally, the children do not allow themselves to feel because they have no way to express the hurt, fear, and anger that is felt towards the parents (Black, 1981).

Black (1981) suggested that these roles are carried into adulthood causing numerous problems for ACAs. These individuals often have problems forming intimate relationships, asking others to help in meeting their needs, and carrying their "survival" behaviors to extremes.

Beletsis and Brown (1981) suggested that children in alcoholic homes learn to "manage" the actions of others in an attempt to insure

security and ward off disaster. With this managing comes the belief by CoAs that they are responsible for the behaviors of their parents and others. They soon lose their ability to distinguish their own needs and feelings from those of their parents. The authors suggested that CoAs are caught early on in the conflict of joining the family's denial process or facing threats to their own perception of reality. The authors stated that most ACAs report that they have never been able to separate emotionally from their parents and continue to feel trapped, responsible, and guilty. ACAs report they see themselves as lonely and isolated because of control conflicts and lack of trust.

Beletsis and Brown (1981) concluded that ACAs experience problems with unresolved emotional bonds with their family of origin, fear and denial of feelings, poor communication skills, role confusion and problems of identification, a sense that life is meaningless, and a belief that they are inadequate and failures.

Cermak and Brown (1982) offered observations from their work with ACAs at the Stanford University Medical Center where psychiatrists reported the majority of adults seeking treatment for psychiatric problems eventually mention an alcoholic parent. The authors reported that ACAs come into treatment in an attempt to break out of an enmeshed family of origin so they can be free to develop intimate relationships without feeling like they are abandoning their parents. The issues of control, trust, recognizing personal needs, understanding limits of responsibility, and acknowledging feelings are found by the authors to be common to ACAs.

Cermak and Brown (1982) went on to suggest that ACAs fear that trusting others is tantamount to giving others control over them. They have no trust in themselves because their own feelings and perceptions have usually been discounted by parents who are attempting to secure their own denial. The ACAs' over assumption of responsibility for the feelings and actions of others comes from a fundamental blurring of boundaries with no separate sense of self having been promoted between the parent and child. The children in an alcoholic home are taught that their feelings, behaviors, or confrontations "cause" the alcoholic to drink. Finally, feelings are viewed as bad because affect is experienced as lack of control. Feelings are also denied because ACAs learn as children to survive by being less in touch with feelings of anger, abandonment, loss, sadness, rejection, and hurt.

Cermak (1984) reasserted the findings of Cermak and Brown (1982) and went on to suggest that on an interpersonal level ACAs need to be in control to maintain their security, but at the intrapsychic level they develop chronic stress through the expectation that feelings ought to be under conscious control. The author concluded his findings by stating that ACAs suffer from Post Traumatic Stress Disorder (PTSD).

Worden (1984) supported Cermak's (1984) theory of ACAs suffering from PTSD. He expressed the belief that they have been exposed to a prolonged series of events of human origin with the stress being outside the range of ordinary human behavior. Worden identified the stressors in the following ways: stress of arbitrariness, chaos, and

instability; use of denial and mobilization of willpower as coping strategies; stress of reacting to the virtually inexplicable, unpredictability of the alcoholic; physical abuse; inattention or absence of focused attention to emotional needs; and stress of reacting to the nondrinking but dysfunctional parent. He concluded by saying that ACAs bring their negative survival strategies into adulthood and try to make them work. Failure to be successful using these strategies contributes to poor self-esteem.

The negative survival strategies were discussed further by Gravitz and Bowden (1984). They identified the coping behaviors of ACAs as the need to assume control—over self, others, and the environment, no development of trust in others, ignoring personal needs, denying feelings, and over assuming responsibility. The authors suggested that these behaviors are learned because of the unpredictability and inconsistency within the family of origin. They also suggested that CoAs are doing their best to survive. For adults these behaviors, such as having learned to disassociate feelings so as not to experience the pain of disappointments and betrayals, have become inappropriate. This is not recognized by the ACA who continues to employ self-defeating behavior.

Summary

The importance of the family of origin in forming the foundation for adult life cannot be understated. General theories on development stress the impact of the family's promotion of trust and autonomy. Expression of feelings is considered essential for the

individual to get his or her needs met and to recognize himself or herself as a separate being. The role that alcoholism plays in inhibiting the family of origin from accomplishing its task is less clear. There seems to be both clinical and experimental evidence to suggest that alcoholic families are more dysfunctional and less able to produce fully functional children, but there are no clear findings explaining why this is true. Several factors have been identified as potential sources of the dysfunction, but the concept of a multi-determined explanation seems most appropriate. Several theories attempting to clarify reasons for the existence of psychosocial problems in ACAs suggest that the alcoholic family is less facilitating in the promotion of trust and autonomy and in encouraging the expression of feelings.

Self-Esteem

It is commonly accepted that possession of a positive self-concept and high self-esteem are positively correlated with an emotionally healthy person and may be the basis for that health. It is also commonly recognized that a negative self-concept and poor self-esteem are positively correlated with emotional dysfunction and may be a significant factor in maintaining dysfunctional behaviors. Ever since the 1890s when James proposed the theory that self-concept is acquired through human interaction, rather than being an inborn character trait (James, 1950), much research and theorizing has been devoted to determining how self-concept and self-esteem develop.

This section of the review of the literature will focus on three main points. Theories regarding the development of self-esteem will be examined first followed by research on self-esteem in CoAs. The final focus will be on theories of the relationship of self-esteem to ACAs.

Development of Self-Esteem

Sociological Studies

Rosenberg (1965) stated that one possesses high self-esteem when the feeling exists that one is good enough--a person of worth. Positive self-esteem suggests that the individual respects himself or herself for what he or she is without holding the self in awe. Deficiencies are recognized and worked on with a confident belief that they can be overcome. Low self-esteem, on the other hand, implies self-rejection, self-dissatisfaction, self-contempt, and a lack of respect for self.

A person's self-esteem is influenced by what others think of him or her (Rosenberg, 1965). Rosenberg suggested that deficiencies in the development of self-esteem appear to be due in large part to the parent-child relationships. The two most important variables which effect the development of self-esteem are determined to be the stability of the parents' marriage and parental interest in the child. Parental indifference seems to be the greatest contributor to poor self-esteem--even more than punitive parental reactions. Rosenberg (1965) stated the belief that in order to develop self-worth a child

needs to experience consistent love, to be treated with respect, to be encouraged, and not to be treated as a nuisance or irritation.

Coopersmith (1967) stated that conditions which lead an individual to regard himself or herself as a person of worth can be summarized by the terms parental warmth, clearly defined limits, and respectful treatment. Individuals with low self-esteem are easily discouraged and sometimes depressed; feel isolated, unloved, and unlovable; and are incapable of expressing themselves or defending their inadequacies. Coopersmith suggested that children can develop self-trust, venturesomeness, and the ability to deal with adversity if they are treated with respect and if they are provided with well-defined standards of values, demands for competence, and guidelines for solutions to problems.

Psychological Theories

In addressing the issue of self-esteem and its ability to impact personal effectiveness, Horney (1950) indicated that the antecedent to poor self-esteem and reduced personal effectiveness is a disturbance in the relationship between the parent and the child. This disturbance is generally associated with the parents' preoccupation with themselves.

Rogers (1951) proposed that all individuals develop a self-concept of themselves which serves as a guide to them in their adjustment to the external world. He suggested this self-concept develops as a result of the child's interactions with the parents. He emphasized the importance of parents being able to provide an

atmosphere of acceptance and support from which the child comes to be able to respect and trust himself or herself and see himself or herself as a person of worth.

The need for parental emotional support and involvement in the development of a child's autonomy and self-esteem are stressed by Winnicott (1965). He suggested an "ordinary devoted mother" can increase the child's healthy love of self. He further stressed the importance of having access to an accepting father when the child is learning to move away from the mother and towards autonomy.

In his theory regarding the process of becoming self-actualized, Maslow (1954) postulated that individuals must progress through various stages where critical needs must be met. The first stage involves the satisfaction of the physiological needs of hunger, thirst, and sexual gratification. It is necessary that parents accept responsibility for filling these needs in young children. The second stage involves the establishment of safety and security. Here again parents must take the primary role in establishing a safe environment for children so they can feel secure. Feeling loved or having a sense of belonging is the third stage and is dependent on others to give the individual feedback on their worth. Only when all of these are accomplished in their successive order can individuals acquire self-esteem--a true acceptance of their value. The final stage of self-actualization is a state of optimal emotional health where the individual becomes the best that he or she can be.

Research Related to Self-Esteem and CoAs

Aronson and Gilbert (1963) compared 41 preadolescent sons of male alcoholics with matched controls from the same school. Teachers who were "blind" to the students' classifications rated both groups in classroom situations. Sons of alcoholics were rated significantly higher on being dependent and impulsive, evading or denying unpleasant reality, and exhibiting low self-esteem and poor frustration tolerance.

McLachlan, Walderman, and Thomas (1973) reported they found no significant difference in school performance, substance use, or personality disturbance in teenagers whether or not they were CoAs. Fifty-four adolescents whose parents had received treatment for alcoholism in a nationally recognized treatment center were compared with 54 normal controls from the community surrounding the treatment center. Each subject completed the Social Competence Scale. Despite no difference in problem behaviors, CoAs reported significantly lower self-esteem scores.

Adolescent CoAs were given the Piers-Harris Children's Self-Concept Scale by O'Gorman (1975/1976) in her study cited above. She reported that children of an actively drinking alcoholic parent have significantly poorer self-concepts than controls or children of recovering alcoholics.

Baraga (1977/1978) studied 149 children between the ages of 9 and 12 years. Of these, 40 were children of alcoholics. Baraga also used the Piers-Harris Children's Self-Concept Scale as well as an

examination of the child's self-evaluation system. She reported that CoAs registered significantly lower self-concept scores than non-CoAs.

The Rosenberg Self-Esteem Scale was used by Hughes (1977) as he compared adolescent children of alcoholic parents who were in Alateen with adolescent children of alcoholics not in Alateen and a control group of adolescents. Hughes's findings were that CoAs not in Alateen have significantly lower self-esteem scores than either of the other two groups.

Woititz (1976/1977) studied sixth through ninth graders who had at least one parent in Alcoholics Anonymous or Alanon. A control group was matched for sex, grade, and if they lived with one or both parents. A personal data sheet was used to gather demographics and the Coopersmith Self-Esteem Inventory was used to measure self-esteem. Woititz reported that CoAs had significantly lower self-esteem, and demographic variables proved nonsignificant in determining this.

A 20-year study of 259 children reared in lower-class, multi-problem, urban families, of whom 147 had alcoholic parents, revealed that CoAs experience a significantly greater number and more severe family problems, greater socialization problems, and lower self-esteem than children whose parents have no official record of alcoholism (Miller & Jang, 1977). These CoAs, who were interviewed as adults, were also more apt to fail in their marriages and jobs than adults who do not have an alcoholic parent. Path analysis indicated that the greater the degree of parental alcoholism, the greater the

negative impact on the children. This is true both during their developmental years and in terms of their adult social and psychological adjustment.

Blanchard (1983/1984) studied 108 subjects between 12 and 29 years old. All of the subjects volunteered and identified themselves as CoAs. Results of the Tennessee Self-Concept Scale were non-significant between groups for the total score. By examining each subscale individually, CoAs exhibited significantly lower scores on factors of identity, behavior, physical self, and family self. They had higher scores on self-acceptance. Blanchard interpreted this later finding as a "tolerance for deviance."

Although the studies to date on self-esteem are suggesting that CoAs possess lower self-esteem than non-CoAs, the results are confusing. While Hughes (1977) reported that CoAs in Alateen have higher self-esteem scores than CoAs not in Alateen, Woititz (1976/1977) found just the opposite. Several of the studies are unclear as to the variables used to match subjects in the control groups (Aronson & Gilbert, 1963; O'Gorman, 1975/1976; Woititz, 1976/1977), and two studies used totally normal populations as their controls (Blanchard, 1983/1984; McLachlan et al., 1973). A major problem with the Miller and Jang (1977) study is that they did not use a standardized measure of self-esteem. A final problem is that none of the studies used a valid instrument to identify CoAs. Rather they used client populations or individuals who identified themselves as CoAs. No attempt was made to insure that the control groups were not composed of some CoAs who might have been undetected or in denial. Adolescents

attending Alateen or children whose parents are in some form of treatment might easily be experiencing poor self-esteem due to some dysfunctional component in their family other than alcoholism. Since these subjects were compared to adolescents who were not identified as having any kind of family dysfunction, it cannot be assumed that parental alcoholism was the primary factor in the development of poor self-esteem. Further research which employs a standardized measure of self-esteem, a nonclinical population, and an appropriate control group is needed to clarify prior findings.

Self-Esteem in ACAs

Woititz (1983) saw poor self-esteem as the primary problem underlying all other issues for ACAs. She suggested that one alcoholic home is like another because an undercurrent of tension and anxiety is ever present. This tension comes from inconsistent and unpredictable parenting. The alcoholic parent's behavior is affected by the chemicals within, and the nonalcoholic parent's behavior is affected by reaction to the alcoholic. Little emotional energy remains to fulfill consistently the many needs of children who become victims to the family illness-alcoholism. Woititz suggested that the way the self-attitude manifests itself will change over time but not the self-perception.

Parents who are preoccupied with their own or their spouse's drinking are unable to give their children the attention they need or the encouragement they deserve (Woititz, 1983). Children growing up in this environment believe that their parents don't care about them.

CoAs begin to think that if they were better somehow they would be loved. Since their efforts to "be good" are not consistently rewarded by their preoccupied parents, Woititz suggested that the CoA believes there is something wrong with him or her. The belief "I am not worth loving" forms the basis of the child's identity. Woititz (1983) further suggested that it is difficult for the CoA to look outside the family for support and a validation of his or her worth because it is hard for the child to believe he or she is worth having as a friend.

The concept of ACAs possessing poor self-esteem is supported in the theories of Cermak and Brown (1981) and Gravitz and Bowden (1984). Cermak (1984) stated that ACAs try to build their self-esteem based on their ability to exert willpower--to exercise control. They are destined to fail because they base their success on being able to control their own feelings and the behaviors of others. They obtain this desire to control from their experience with their family of origin where they were taught they were responsible for controlling the alcoholic's behavior. Worden (1984) supported Cermak and suggested that the negative survival strategies, used by CoAs to gain some control in childhood, are brought into adulthood and tried out. Failure to be successful leads to further reduction in self-esteem.

Summary

The inconsistency and unpredictability in an alcoholic home coupled with the parents' preoccupation with the drinking seem to

prevent--or at least inhibit--the development of positive self-esteem in CoAs. Once the child incorporates the belief that he or she is unworthy of being loved and nurtured, he or she will not reach out to alternate resources to compensate for what is missing in the family of origin. As self-esteem is seen as a crucial prerequisite to healthy adult functioning, individuals with poor self-esteem are expected to have numerous psychosocial problems.

Although the theories seem clear in professing that poor self-esteem can be found in all ACAs, the research is less than definitive. More controlled studies with nonclinical populations and standardized measures are in order to determine if poor self-esteem is a primary factor to be dealt with by ACAs.

CHAPTER III

METHOD

Population and Sample

Population

The population for this study was adult children of alcoholics (ACAs) who were graduate students at Western Michigan University in Kalamazoo, Michigan, during the Fall Semester of 1986.

Sample

Selection

The sample was determined by selecting 10 graduate classes from various departments throughout the university. An effort was made by the researcher to select departments which might represent different interest areas and, therefore, different roles of ACAs. Specific classes within each department were selected based on the professor's willingness to participate in the study.

The departments selected were Communication Arts and Sciences, Counselor Education and Counseling Psychology, Education and Professional Development, English, Finance and Commercial Law, Geology, Mathematics, Psychology, Sociology, and the Specialty Program in Alcohol and Drug Abuse. Due to the cancellation of the English class and the inability to schedule in a timely way the use of another

English class, a second class from Counselor Education and Counseling Psychology was selected.

A total of 213 subjects participated in the study. Of these, 32 had to be eliminated because they did not completely fill out all of the questionnaires. Using the Children of Alcoholics Screening Test (CAST) to classify ACAs from adults who are children of nonalcoholic parents (non-ACAs), a final sample of 44 ACAs and 110 non-ACAs was established. For the purpose of this study, ACAs were those subjects who scored a 6 or more on the CAST. The non-ACA control group was determined by using subjects whose scores were zero. Another 27 subjects were eliminated from the original total because their scores on the CAST fell in the 1-5 range leaving a final sample of 154 subjects.

Demographic Characteristics

Each subject was given an information sheet covering various demographic items as well as variables relating to their parents. The results of these questions for the 181 subjects who completed the information sheet can be found in Appendix A. The mean age group of the sample was 31-35 years old with ages ranging from 18 years to 51 plus. The majority of the subjects were white (85%), female (56%), and married (57%). Subjects were most often either the oldest child in their family of origin (32%) or the youngest (26%).

Instruments

Children of Alcoholics Screening Test

The CAST is a 30-item inventory that purports to measure offspring's feelings, attitudes, perceptions, and experiences related to their parent's drinking behavior. All yes answers are tabulated to yield a total score. According to the established standards of the CAST, a 0-1 score indicates children with nonalcoholic parents, a 2-5 score indicates children with a parent who is a problem drinker, and a score of 6 or more indicates children of alcoholics. The CAST has a reliability coefficient of .98 and a validity coefficient of .78 ($p < .0001$). A copy of the CAST can be found in Appendix B.

Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale (RSE) is made up of 10 questions using a Guttman format. Each question can be answered in graded responses from strongly agree, agree, disagree, to strongly disagree. A total score of 40 may be obtained. The RSE has a reliability coefficient of .85 and a validity coefficient of .83 ($p < .001$). A copy of the RSE can be found in Appendix C.

Family-of-Origin Scale

The Family-of-Origin Scale (FOS) purports to measure an individual's perception of levels of health in one's family of origin. The definition of the family of origin is the family in which an individual has his or her physiological, psychological, and emotional

beginnings (Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985). The FOS specifically looks at the issues of the development of autonomy and the ability to form intimate relationships. The authors suggest that:

The healthy family develops autonomy by emphasizing clarity of expression, personal responsibility, respect for other family members and openness to others in the family, and by dealing openly with separation and loss. . . . The healthy family develops intimacy by encouraging the expression of a wide range of feelings, creating a warm atmosphere in the home, dealing with conflicts without undue stress, promoting sensitivity in family members, and trusting in the goodness of human nature. (Hovestadt et al., 1985, p. 290)

The FOS is comprised of 40 items on a 5-point Likert scale (see Appendix D). A total score of 200 may be obtained. A test-retest reliability coefficient of .97 was obtained by Hovestadt et al. (1985). Although no construct validity studies have been undertaken with the FOS, empirical studies (M. Fine, 1982; Holter, 1982) suggest the usefulness of this instrument in identifying varying levels of perceived health in subjects' families of origin.

Procedure

Selected professors at Western Michigan University who had indicated a willingness to participate in the research were contacted by the researcher, first through a letter and then by phone, to set a time when the data could be collected from the identified classes.

In all but two cases the researcher went to the scheduled classes and personally distributed the packets of questionnaires. For two of the selected classes the researcher gave the packets of

the questionnaires to the instructor, per their request, along with a typed copy of the instructions and statement about anonymity. In all cases the students were given the packets of questionnaires in their classrooms during their first class session for the semester. The standardized statement of instructions along with the assurance of anonymity was read to the total class before the packets were distributed (see Appendix E). Each packet contained the information sheet, the FOS, the RSE, and the CAST. The questionnaires were randomly ordered in each packet to assure there was no ordering effect. As each subject returned the packet of completed forms to the researcher (or instructor) a debriefing sheet was distributed (see Appendix F). Students were informed that if they wished to know their individual scores, they could copy down the identification number on their packet of questionnaires and contact the researcher at a later date.

Statistical Hypotheses

The research questions for this study were derived from the assumptions that ACAs possess lower self-esteem than non-ACAs; that ACAs are not encouraged in their family of origin to develop autonomy, to form trusting relationships, or to recognize and express their feelings; and that there is a relationship between self-esteem levels in ACAs and their experience with their family of origin. The following hypotheses were formulated from these assumptions and are presented here in the null form.

Hypothesis 1: There is no difference between self-esteem scores for ACAs and non-ACAs as measured by the Rosenberg Self-Esteem Scale.

Hypothesis 2: There is no difference in perception of the ability of the family of origin to promote the development of trust, the expression of feelings, and the development of autonomy between ACAs and non-ACAs as measured by the Family-of-Origin Scale.

Hypothesis 3: There is no relationship between self-esteem and perceptions of family of origin in ACAs as measured by the RSE and FOS.

Statistical Analyses

A one way analysis of variance (ANOVA) was used to evaluate the differences in means for RSE scores between ACAs and non-ACAs.

An ANOVA was used to evaluate the differences in means for FOS scores between ACAs and non-ACAs.

A Pearson product-moment correlation was employed to determine what relationship existed between self-esteem scores and family of origin scores for ACAs. Correlations on the RSE and FOS were also run on the non-ACA scores and on scores for the total group of subjects participating in the study.

The minimum level of significance accepted for these analyses was $p < .05$.

Summary

This study was designed to examine whether ACAs differ significantly from non-ACAs in self-esteem scores and in perceptions of the

ability of the family of origin to promote autonomy, trust, and expression of feelings. This study was also designed to examine any relationship between self-esteem and perceptions of the family of origin in ACAs.

The subjects were graduate students from selected classes in 10 departments at Western Michigan University. Subjects who scored a 6 or more on the CAST formed the experimental group. The control group was comprised of graduate students from the same classes as the experimental subjects but who scored a zero on the CAST.

A one-way analysis of variance was used to evaluate the differences in means for both self-esteem scores and family of origin scores between ACAs and controls. A Pearson product-moment correlation was employed to determine the relationship between self-esteem and the perception of the family of origin's ability to promote autonomy, trust, and expression of feelings in ACAs.

CHAPTER IV

RESULTS

The Data and Their Analyses

In this chapter each hypothesis of the study will be examined in relation to the statistical analysis of the data. Findings will be reported in order to determine if the assumptions of the study may be supported.

Hypothesis 1

There is no difference between self-esteem scores for adult children of alcoholics (ACAs) and adults who are not children of alcoholics (non-ACAs) as measured by the Rosenberg Self-Esteem Scale (RSE).

A one-way analysis of variance (ANOVA) was employed to determine mean differences. The analysis of data for this test is shown in Table 1 and Table 2.

The findings of this analysis proved to be nonsignificant ($F_{crit} = 6.83, p > .05$). The null hypothesis could not be rejected. No difference was found between ACAs and non-ACAs in self-esteem scores.

Table 1

Mean Scores and Standard Deviations on the Rosenberg Self-Esteem Scale for Adult Children of Alcoholics and Adults Who Are Not Children of Alcoholics

Group	<u>N</u>	Mean	<u>SD</u>
ACA	44	31.95	5.935
Non-ACA	110	33.05	5.965

Table 2

One-Way Analysis of the Rosenberg Self-Esteem Scale Scores for Adult Children of Alcoholics and Adults Who Are Not Children of Alcoholics

Source of variation	<u>df</u>	<u>MS</u>	<u>F</u>
Between	1	38.98	1.098*
Within	152	35.48	

* $p > .05$.

Hypothesis 2

There is no difference in perception of the ability of the family of origin to promote the development of trust, the expression of feeling, and the development of autonomy between ACAs and non-ACAs as measured by the Family-of-Origin Scale.

An ANOVA was employed to determine mean differences. The analysis of data for this test is shown in Table 3 and Table 4.

Table 3

Mean Scores and Standard Deviations on the Family-of-Origin Scale for Adult Children of Alcoholics and Adults Who Are Not Children of Alcoholics

Group	<u>N</u>	Mean	<u>SD</u>
ACA	44	122.7	28.96
Non-ACA	110	139.9	30.12

Table 4

One-Way Analysis of the Family-of-Origin Scale Scores for Adult Children of Alcoholics and Adults Who Are Not Children of Alcoholics

Source of variation	<u>df</u>	<u>MS</u>	<u>F</u>
Between	1	9868.0	10.44*
Within	152	887.9	

* $p < .001$.

The findings of this analysis proved to be significant ($F_{crit} = 6.83$, $p < .001$) and indicated that the null hypothesis should be rejected. Adult children of alcoholics perceive their family of origin as being less able to promote the development of trust, the expression of feeling, and the development of autonomy than do non-ACAs.

Hypothesis 3

There is no relationship between self-esteem and perceptions of the family of origin in ACAs as measured by the RSE and FOS.

A Pearson product-moment correlation was employed to determine what relationship existed between RSE scores and FOS scores for ACAs. The results of the analysis were significant ($r = .41$, $p < .01$) and indicated that the null hypothesis should be rejected. There was a positive relationship between self-esteem scores and family of origin scores for ACAs.

Additional Analyses

The positive correlation between self-esteem scores and family of origin scores was surprising since there was no difference in self-esteem scores between ACAs and non-ACAs but they did differ significantly in the perception of their family of origin. To clarify these findings a Pearson product-moment correlation was employed to determine the relationship between self-esteem scores and family of origin scores for non-ACAs. The result of this analysis was significant ($r = .33$, $p < .001$). There was a positive relationship between self-esteem scores and perceptions of the family of origin for non-ACAs.

Summary

The results of this study indicated that ACAs do not differ significantly in self-esteem scores from non-ACAs but there is a

significant difference in the way ACAs perceive their family of origin. ACAs perceive their families as having been less facilitative in the promotion of trust, feeling expression, and the development of autonomy than do non-ACAs. A further result of this study indicated that there is a positive relationship between self-esteem scores and perceptions of the family of origin for both ACAs and non-ACAs.

CHAPTER V

DISCUSSION, RECOMMENDATIONS, AND SUMMARY

Discussion

Adult children of alcoholics (ACAs) have become a topic of interest in the last 5 years, and several theories have been developed to explain what problems they have and why they have them. Because more ACAs are requesting services for their interpersonal and intrapsychic problems, therapists and educators are looking to these theories to give direction for treatment and prevention programs. The theories on ACAs, however, are based primarily on clinical observation with little or no research supporting them. The intent of this study was to look at selected factors from the various theories and to determine if empirical support could be provided.

The common theme found in ACA theories is that the experience of growing up in an alcoholic home has negative consequences on healthy development and functioning not only in childhood but in adult life as well. It is recognized that alcohol, in and of itself, does not cause problems for offspring; but rather, it contributes to a dysfunctional family system. Black (1981) suggested that alcoholism in the home creates three family rules which seriously inhibit healthy development. These rules are: don't talk, don't trust, and don't feel. Cermak and Brown (1982) saw the family's need to deny the seriousness of the alcoholism as a contributing factor to the

enmeshment of family members and lack of autonomy in ACAs. This occurs because family members are given the responsibility of "controlling" the alcoholic through their own thoughts and behaviors. The consistent "failure" at this task along with the inconsistent and inappropriate nurturing associated with the alcoholic family are the determined causes of low self-esteem in ACAs (Woititz, 1983).

The first hypothesis of this study was formulated to determine if there is evidence to support the theory that ACAs have significantly lower self-esteem than individuals who were not raised in an alcoholic home. No evidence was found to support this. Because this finding is inconsistent with prior studies and clinically derived theories, further exploration is in order.

Although there have been several studies which found that children of alcoholics (CoAs) possess a lower self-esteem than their respective control groups, numerous design flaws can call these findings into question. A major problem with the studies is that subjects were already identified as "troubled" in some way, and the mere fact of being troubled may have contributed to poor self-esteem. Another problem is the infrequent use of standardized measures of self-esteem. Subjective reporting may be influenced by numerous factors and should not be used to draw definitive conclusions. Finally, the studies which purport to be reflective of CoAs as a whole may, in fact, only be examining the scapegoat or acting-out child (Black, 1981). The other CoAs living out their respective roles may be looking good as their defenses are more functional.

The Rosenberg Self-Esteem Scale (RSE) was chosen because of the research on its validity. This was again confirmed by Demo (1985) as he determined the RSE is valid in measuring experienced self-esteem. There have not been, however, any studies validating the RSE on ACAs. Because alcoholic families teach denial (Vaillant, 1983) and because CoAs are theorized to possess poor reality testing due to the family denial (Woititz, 1983), one might question the ability of ACAs to answer accurately. This might be especially true on a measure such as the RSE where face validity is so high. Knowing what the correct answers should be, the hero or responsible child might have trouble admitting to any problems (Wegschieder, 1981).

The use of graduate students in this study may be producing findings for a unique subpopulation of ACAs. It may be that in order to make it to graduate school a high level of self-esteem is necessary. ACAs with similar IQs and abilities may not pursue a graduate education because of poor self-esteem. Lynch and Clark (1985) found that self-esteem is significantly related to performance independent of the covarying effect of intelligence in college students. Comparable findings by Reddy (1983) were obtained in his study of 200 graduate students. As Woodside (1983) indicated, some ACAs are super-copers (or heroes in Wegschieder's, 1976, terms) and are very successful until midlife when they can no longer tolerate the stress of being constantly responsible and always in control. Graduate students may be a too homogeneous sample of super-copers to draw conclusions for the entire ACA population.

The findings of this study suggest the need to explore alternate theories regarding the development of self-esteem for ACAs. Jacob et al. (1978) called for a multidimensional and multidetermined explanation of the effects of alcoholism on CoAs. In examining the dimension of self-esteem a multidetermined explanation of its development is appropriate (Wiggins, Renner, Clore, & Rose, 1971). According to Wiggins et al., self-esteem is what one thinks about oneself after evaluating what he or she thinks he or she should be able to do compared to what is actually achieved. Self-esteem is achieved when "instrumentality" is high. By instrumentality the authors mean the degree of felt competence one possesses. This competence is gained as a result of several interrelated factors. One factor impacting competence is capacity--the biological restrictions and potentialities of the individual organism. Enrichment or deprivation of biological needs both pre- and postnatal have profound effects. A second factor impacting competence is social interaction. Observing others and receiving feedback allows for competencies to develop. Cognitive development is a third important factor as it allows for comparisons with others and perceptions of the self. Individuals will differ in the goals they set and in what they achieve depending both on what they have learned to value and on their awareness of their ability to achieve the goals.

It is easy to see how an alcoholic parent might have varying degrees of impact on each of these factors. Genetically alcoholism is related to fetal alcohol syndrome, affective disorders, and substance abuse in offspring (Warner & Rossett, 1975). An alcoholic

mother may be neglectful of proper nutrition for an infant in her care thus causing protein deficiency and minimal brain dysfunction (MacKay, 1961). The modeling provided by an alcoholic parent or a parent obsessed with the behaviors of a drinking spouse may promote behaviors in the child that are self-defeating. Reinforcement from the parents for the child's behavior may be inconsistent or inappropriate (Bosma, 1972). The child's perception of himself or herself and others may be tainted by the family's denial (Richards, 1979). Depending on the degree of pathology within the family and the compensatory resources outside the family, the child in an alcoholic home may feel incompetent and depressed or quite competent and care-free.

Another explanation of the differing effects of an alcoholic family on the child's self-esteem can be found in developmental theory. Several ACA theorists have used Erikson's (1963) stages of development to understand the varying degrees of dysfunction in ACAs. Ackerman (1978) first examined how parental alcoholism could inhibit development at each stage so that the individual would be totally unprepared for adulthood. He concluded that some CoAs seem to survive if they have the "ability within themselves to establish positive primary relationships outside the home" (p. 21).

Beletsis and Brown (1981) emphasized that the development of what Erikson (1963) called basic trust is most important for a healthy personality. Because of inconsistency/inadequacy of care due to a mother's drinking or preoccupation with the father's drinking, the young child learns to adapt his or her needs to the random

availability of care. The child not only learns not to trust the environment, but also not to trust himself or herself to elicit parental nurturing. From this the child learns to develop a lack of confidence in himself or herself which lays the foundation for a poor self-concept. The authors also suggested that a demoralizing of trust can occur at later stages in the child's life when he or she is confronted with consistently increasing parental neglect. Failures at subsequent stages of development will also contribute to poor self-esteem.

Brooks (1983) stated that many CoAs make it through the first few stages of development rather successfully because the parent is not yet disabled by the alcoholism. They often get stuck in the industry stage (Erikson, 1963) as the parent begins to be dysfunctional and so does the family. It is at this stage a child learns to become a worker and provider. He or she now learns to win recognition for productivity. These children are often identified as the heroes or responsible ones and continue to strive to achieve recognition for their accomplishments. This is done to ward off feelings of inferiority. Self-esteem is related to their ability to constantly gain recognition for their achievements. ACAs who enter the intimacy stage (Erikson, 1963) before parental alcoholism is disabling may experience positive self-esteem. This means they would have developed an integrated sense of self and confidence in their abilities which prepares them to commit themselves to others with the willingness to make sacrifices and compromises.

The developmental theories on dysfunction in the alcoholic home were echoed by some of the subjects of this study who commented to the researcher that they believed the impact of their parents' alcoholism had a differential effect on them from both their older and younger siblings. Some subjects also reported that a parent's recovery was having a differential effect on younger siblings. A final comment was obtained regarding the effect of disassociating from the alcoholic parent and establishing a nurturing relationship with a stepparent. In each case, the subject was attempting to lend support to the assumption that living in an alcoholic home affects self-esteem but not in a unilateral way.

One can conclude with Wilson and Orford (1978) that there are many neglected themes which may be crucial in determining how alcoholism produces an environment which may result in impairment of the child's self-esteem.

The second hypothesis of this study was formulated to determine if there is evidence to support the theory that an alcoholic family is significantly different from a nonalcoholic family as perceived by their offspring in promoting trust, autonomy, and the expression of feelings. These factors are considered important in the development of a healthy individual. Evidence was obtained in this study to support the theory that the family of origin of an ACA is less likely to promote trust, autonomy, or the expression of feelings. This concurs with Black (1981), Beletsis and Brown (1981), and Cermak and Brown (1982).

The question now to be asked is: What specific difference does it make if alcoholic families are less healthy than nonalcoholic families? Since there is no difference in self-esteem scores other factors need to be explored. Cermak and Brown (1982) suggested that a common problem for ACAs is difficulty in establishing and maintaining intimate relationships. Poor reality testing is another trait commonly attributed to ACAs (Woititz, 1983). The issue of control seems to underly many of the other problems (Cermak & Brown, 1982). The intense emphasis on control is thought to be a rigid defense to protect against acknowledging the overwhelming threat of the unfulfilled neediness of the ACA. Further studies will need to be undertaken before an answer can be found identifying the effects of the dysfunctional alcoholic family on its adult offspring.

Hypothesis 3 was formulated to determine if there is a relationship between self-esteem and experiences with the family of origin. Evidence was found indicating a positive relationship between self-esteem and experiences with the family of origin for both ACAs and non-ACAs. The interesting aspect of this finding is the correlation holds true for both groups even though self-esteem scores were not significantly different between ACAs and non-ACAs. The reason for this seemingly illogical finding may rest in the statistical analyses. The difference in self-esteem scores between groups is not large enough to be significant in an ANOVA, but the correlation is sufficient to be significant.

These findings suggest that some CoAs look outside the family of origin to supplement the development of positive self-esteem. What

accounts for these actions are unknown. Realizing that specific experiences in the family of origin can affect self-esteem, it seems crucial that further studies be undertaken to sort out which subgroup of ACAs are able to break out of the course that leads to poor self-esteem.

Recommendations

Therapy

It would be unwise to assume that all ACAs seeking treatment are suffering from poor self-esteem. One also cannot assume that poor self-esteem in an ACA is the sole result of growing up in an alcoholic home. Individual assessments should be undertaken to determine the specific problems a client is experiencing and the sources of those problems so that an individualized treatment plan may be developed. One needs to be cautious in applying ACA theories in the treatment of ACAs until more definitive research findings are available.

Families of alcoholics should be assessed with recognition given to the probability that these families are not promoting healthy development in their children. Treatment agencies may want to plan programs which teach trust formation and the recognition and expression of feelings. Educational and experiential activities should be provided to promote personal responsibility and to teach the benefits of being autonomous and allowing others to be so as well.

Educational and treatment programs also need to seek out and be open to future findings regarding familial behaviors, characteristics, and alternate resources which allow some CoAs to compensate for their family of origin in the building of self-esteem. These factors may be able to be transmitted to other CoAs.

Therapists outside of the substance abuse field need to be sensitive to ACA issues and informed of research in the area since many ACAs are requesting services at traditional mental health settings (Musello, 1984).

Research

This study has identified several areas in need of research. In order to answer the question of whether graduate students represent the population of ACAs or are a unique subgroup, procedures identical to this study should be undertaken with a variety of subgroups within the population. If the results of such studies confirm these findings then consideration should be given to concluding that growing up in an alcoholic home has no bearing on self-esteem in adults, or that the self-esteem measure needs to be changed.

The Rosenberg Self-Esteem Scale would benefit from being validated with a population of ACAs. This could provide evidence on the status of denial in ACAs. If their self-esteem scores positively correlate with behaviors that are associated with high self-esteem, then confidence can be placed in the findings on self-esteem for the subgroups sampled.

The question of what adult behaviors, problems, or achievements result from growing up in an alcoholic home have yet to be answered. Studies might be undertaken to explore the relationship between the family of origin and satisfying intimate relationships in adulthood. Another study might explore if family of origin factors contribute to poor reality testing. Examining personality traits of the parents and how they interact with alcoholism in the home and how they predict ACA behaviors is yet another worthy study. The age of the child when the parent becomes dysfunctional and the sex of the dysfunctional parent may be important factors in understanding ACAs' adjustments. An exploration of alternate resources to the family of origin for the developing child might prove significant in understanding ACAs who appear problem free.

Results of studies such as those mentioned above may be beneficial to the clinician and educator as they attempt to provide services which can prevent and remediate problems associated with growing up in an alcoholic home. Such findings may also impact existing theories causing some to be discarded while others may be supported and clarified.

Summary

The purpose of this study was to provide basic research to determine if there is support for selected theories about adults who have grown up in an alcoholic home. The first theory that was examined was whether ACAs have lower self-esteem than non-ACAs. Second, the belief that alcoholic families are less likely to promote

trust, autonomy, and expression of feeling was explored. Finally, the question of whether growing up in an alcoholic home that does not promote trust, autonomy, and feeling expression is related to poor self-esteem in adulthood was examined.

As more and more ACAs are requesting services from human service agencies, therapists and educators are searching out information on how best to treat these clients. Several theories have arisen purporting to be guides in working with ACAs, but there is no research to confirm or deny their propositions. The results of this study may be helpful in deciding which theories might be useful in making treatment and prevention decisions regarding programs for ACAs. It is also important in pointing out what research is needed before definitive conclusions can be drawn.

Two hundred and thirteen graduate students from various departments within the university were selected by classes to act as subjects. Each person was administered the Children of Alcoholics Screening Test (CAST), Rosenberg Self-Esteem Scale (RSE), Family-of-Origin Scale (FOS), and a personal information sheet. Depending on their scores on the CAST subjects were assigned to the ACA or non-ACA group or discarded because of nondefinitive scores. Forty-four subjects were identified as ACAs and 110 as non-ACAs. There were no significant demographic differences between the two groups.

An analysis of mean scores revealed that there is no difference in self-esteem scores between ACAs and non-ACAs. There is a significant difference between mean scores on the FOS suggesting that alcoholic families are less likely to promote trust, autonomy, and

feeling expression than nonalcoholic families. Finally, the correlation between self-esteem and family of origin scores is significant. Adults who come from homes where trust, autonomy, and feeling expression are promoted have higher self-esteem than individuals who don't. This is true for both ACAs and non-ACAs.

The findings of this study suggest the need for additional research with a more heterogeneous sample of ACAs to determine if self-esteem levels are related to growing up in an alcoholic home. If ACA groups other than graduate students have lower self-esteem than control groups then it will be important to determine what allowed graduate students to have broken away from the effects of their family. If a more heterogeneous sample reveals no difference in self-esteem scores, then the theory that ACAs experience low self-esteem due to being raised in an alcoholic family must be dismissed.

Studies also need to be undertaken to identify the specific effects, if any, which are produced from growing up in a family which is negligent in promoting trust, autonomy, and feeling expression. If there are no significant effects, then it is irrelevant how the family of origin functions. If, however, there are specific effects, then intervention strategies can be developed.

The findings of this study indicate that there are still many unknown factors regarding the impact of growing up in an alcoholic home. At this time it is premature to make any definitive statements. It does seem important, however, to continue to ask research questions based on clinical observations. It also seems important to

be sensitive clinically to the potential effects of being an adult child of an alcoholic.

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APPENDICES

Appendix A

**Frequencies and Percentages for Items
on the Information Sheet**

Frequencies and Percentages for Items
on the Information Sheet

1. Age							
Re- sponses	Years						
	18-21	22-25	26-30	31-35	36-40	41-50	51+
Freq.	4	38	39	33	42	20	4
%	2.2	21.1	21.7	18.3	23.3	11.1	2.2

2. Race							
Re- sponses	White	Black	Native Amer.	Hispanic	Asian	Oriental	Other
Freq.	153	3	8	2	5	4	5
%	85.0	1.7	4.4	1.1	2.8	2.2	2.8

3. Sex			
Responses	Male	Female	Invalid response
Freq.	76	100	4
%	42.2	55.6	2.2

4. Marital status

Responses	Married	Single	Divorced	Widowed	Co-habiting	No response
Freq.	103	51	16	1	7	2
%	57.2	28.3	8.9	0.6	3.9	1.1

5. Birth order

Re-sponses	Oldest	Next to oldest	Next to youngest	Youngest	Only	Middle
Freq.	57	34	17	46	8	18
%	31.7	18.9	9.4	25.6	4.4	10.0

6 & 7. Graduate Major

Responses	Acctg.	Business	Science	Communications	Computer science	Counseling
Freq.	1	10	8	14	7	56
%	0.6	5.6	4.4	7.8	3.9	31.1

Responses	Economics	Education	Geology	Engineering	Management	Marketing
Freq.	1	28	13	2	2	1
%	0.6	15.6	7.2	1.1	1.1	0.6

Responses	Math	Psychology	Social Work	Sociology	Other
Freq.	1	16	5	8	8
%	0.6	8.9	2.8	4.4	4.4

8. Your age when your parents separated

Re- sponses	Under 1 yr.	1-3	4-6	7-10	11-15	16-18	18+	NA	No re- sponse
Freq.	1	3	2	4	9	4	6	144	6
%	1.1	1.7	1.1	2.2	5.0	2.2	3.3	80.0	3.3

9. Your age when your mother died

Re- sponses	Under 1 yr.	1-3	4-6	7-10	11-15	16-18	18+	NA	No re- sponse
Freq.	2	2	0	2	1	4	9	152	10
%	0.6	0.6	0.0	1.1	0.6	2.2	5.0	84.4	5.5

10. Your age when your father died

Re- sponses	Under 1 yr.	1-3	4-6	7-10	11-15	16-18	18+	NA	No re- sponse
Freq.	1	0	0	3	4	5	32	125	10
%	0.6	0.0	0.0	1.7	2.2	2.8	17.8	69.4	5.5

11. Which term best describes your mother (or woman who raised you)

Re- sponses	De- tached	Pas- sive	Jovial	Aggres- sive	Abusive	Control- ling	Loving	No re- sponse
Freq.	3	18	7	2	4	44	100	2
%	1.7	10.0	3.9	1.1	2.2	24.4	55.6	1.1

12. Which term best describes your father (or man who raised you)

Re- sponses	De- tached	Pas- sive	Jovial	Aggres- sive	Abusive	Control- ling	Loving	No re- sponse
Freq.	33	20	11	10	4	24	67	10
%	18.3	11.1	6.1	5.6	2.2	13.3	37.2	5.5

13. Was your mother ever treated as an outpatient
for emotional problems?

Responses	Yes	No	No response
Freq.	23	151	6
%	12.8	83.9	3.3

14. Was your mother ever hospitalized for a psychiatric
condition other than alcoholism?

Responses	Yes	No	No response
Freq.	10	167	3
%	5.6	92.8	1.7

15. Was your father ever treated as an outpatient for emotional problems?

Responses	Yes	No	No response
Freq.	13	162	5
%	7.2	90.0	2.8

16. Was your father ever hospitalized for a psychiatric condition other than alcoholism?

Responses	Yes	No	No response
Freq.	8	167	5
%	4.4	92.8	2.8

17. Have you ever received counseling or psychotherapy?

Responses	Yes	No	No response
Freq.	70	107	3
%	38.9	59.4	1.7

18. Have you ever gotten help for a substance abuse problem?

Responses	Yes	No	No response
Freq.	7	170	3
%	3.9	94.4	1.7

19. Did your mother ever receive treatment for drug or alcohol abuse or attend Alcoholics Anonymous?

Response	Yes	No	No response	Invalid response
Freq.	5	166	3	6
%	2.8	92.2	1.7	3.3

20. Did you ever think of your mother as having an alcohol or drug abuse problem?

Responses	Yes	No	No response
Freq.	18	156	6
%	10.0	86.7	3.3

21. Did your father ever receive treatment for drug or alcohol abuse or attend Alcoholics Anonymous?

Responses	Yes	No	No response	Invalid response
Freq.	7	165	3	5
%	3.9	91.7	1.7	2.8

22. Did you ever think of your father as having an alcohol or drug abuse problem?

Responses	Yes	No	No response	Invalid response
Freq.	35	140	4	1
%	19.4	77.8	2.2	0.6

Appendix B

Children of Alcoholics Screening Test

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20

Directions: Please select the answer that best describes your feelings, behaviors, and experiences related to a parent's alcohol use. Fill in the appropriate circle in the row at the end of each question. Answer all the questions. Disregard the numbers on the left of the grid.

Key:
1 YES
2 NO

	YES	NO							
1	1	2	3	4	5	6	7	8	9
2	1	2	3	4	5	6	7	8	9
3	1	2	3	4	5	6	7	8	9
4	1	2	3	4	5	6	7	8	9
5	1	2	3	4	5	6	7	8	9
6	1	2	3	4	5	6	7	8	9
7	1	2	3	4	5	6	7	8	9
8	1	2	3	4	5	6	7	8	9
9	1	2	3	4	5	6	7	8	9
10	1	2	3	4	5	6	7	8	9
11	1	2	3	4	5	6	7	8	9
12	1	2	3	4	5	6	7	8	9
13	1	2	3	4	5	6	7	8	9
14	1	2	3	4	5	6	7	8	9
15	1	2	3	4	5	6	7	8	9
16	1	2	3	4	5	6	7	8	9
17	1	2	3	4	5	6	7	8	9
18	1	2	3	4	5	6	7	8	9
19	1	2	3	4	5	6	7	8	9
20	1	2	3	4	5	6	7	8	9
21	1	2	3	4	5	6	7	8	9
22	1	2	3	4	5	6	7	8	9
23	1	2	3	4	5	6	7	8	9
24	1	2	3	4	5	6	7	8	9

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 quit 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 their 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?-----

OVER

25-48 ON SIDE 2

INSTRUCTOR _____	COURSE NO _____	SECTION _____
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SIDE 2

- 15. Have you ever withdrawn from or 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?-----
- 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 drinking?-----
- 21. Have you ever been blamed for a parent's drinking?-----
- 22. Did you ever think your father was 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 a promise 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 brothers and sisters about a parent's drinking?-----
- 28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?-----
- 29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?-----
- 30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?-----

25	1	2	3	4	5	6	7	8	9
26	1	2	3	4	5	6	7	8	9
27	1	2	3	4	5	6	7	8	9
28	1	2	3	4	5	6	7	8	9
29	1	2	3	4	5	6	7	8	9
30	1	2	3	4	5	6	7	8	9
31	1	2	3	4	5	6	7	8	9
32	1	2	3	4	5	6	7	8	9
33	1	2	3	4	5	6	7	8	9
34	1	2	3	4	5	6	7	8	9
35	1	2	3	4	5	6	7	8	9
36	1	2	3	4	5	6	7	8	9
37	1	2	3	4	5	6	7	8	9
38	1	2	3	4	5	6	7	8	9
39	1	2	3	4	5	6	7	8	9
40	1	2	3	4	5	6	7	8	9
41	1	2	3	4	5	6	7	8	9
42	1	2	3	4	5	6	7	8	9
43	1	2	3	4	5	6	7	8	9
44	1	2	3	4	5	6	7	8	9
45	1	2	3	4	5	6	7	8	9
46	1	2	3	4	5	6	7	8	9
47	1	2	3	4	5	6	7	8	9
48	1	2	3	4	5	6	7	8	9

**DO NOT WRITE
IN THIS SPACE**

Appendix C

Rosenberg Self-Esteem Scale

Appendix D

Family-of-Origin Scale

<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40

<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
<input type="radio"/>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40

Directions: The family of origin is the family with which you spent most or all of your childhood years. This scale is designed to help you recall how your family of origin functioned. Each family is unique and has its own way of doing things. Thus, there are no right or wrong choices in this scale. What is important is that you respond as honestly as you can. In reading the following statements, apply them to your family of origin as you remember it. Using the following scale, fill in the appropriate circle in the row at the end of each statement. Disregard the numbers on the left of the grid. Please respond to each statement.

- Key:
- 5 (SA) Strongly agree that it describes my family of origin
 - 4 (A) Agree that it describes my family of origin
 - 3 (N) Neutral
 - 2 (D) Disagree that it describes my family of origin
 - 1 (SD) Strongly disagree that it describes my family of origin

1. In my family, it was normal to show both positive and negative feelings.-----
2. The atmosphere in my family usually was unpleasant.-----
3. In my family, we encouraged one another to develop new friendships.-----
4. Differences of opinion in my family were discouraged.-----
5. People in my family often made excuses for their mistakes.-----
6. My parents encouraged family members to listen to one another.-----
7. Conflicts in my family never got resolved.-----
8. My family taught me that people were basically good.-----
9. I found it difficult to understand what other family members said or how they felt.-----
10. We talked about our sadness when a relative or family friend died.-----
11. My parents openly admitted it when they were wrong.-----
12. In my family, I expressed just about any feeling I had.-----
13. Resolving conflicts in my family was a very stressfull experience.-----
14. My family was receptive to the different ways various family members viewed life.-----
15. My parents encouraged me to express my views openly.-----
16. I often had to guess at what other family members thought or how they felt.-----

1	1	2	3	4	5	6	7	8	9	10
2	1	2	3	4	5	6	7	8	9	10
3	1	2	3	4	5	6	7	8	9	10
4	1	2	3	4	5	6	7	8	9	10
5	1	2	3	4	5	6	7	8	9	10
6	1	2	3	4	5	6	7	8	9	10
7	1	2	3	4	5	6	7	8	9	10
8	1	2	3	4	5	6	7	8	9	10
9	1	2	3	4	5	6	7	8	9	10
10	1	2	3	4	5	6	7	8	9	10
11	1	2	3	4	5	6	7	8	9	10
12	1	2	3	4	5	6	7	8	9	10
13	1	2	3	4	5	6	7	8	9	10
14	1	2	3	4	5	6	7	8	9	10
15	1	2	3	4	5	6	7	8	9	10
16	1	2	3	4	5	6	7	8	9	10
17	1	2	3	4	5	6	7	8	9	10
18	1	2	3	4	5	6	7	8	9	10
19	1	2	3	4	5	6	7	8	9	10
20	1	2	3	4	5	6	7	8	9	10
21	1	2	3	4	5	6	7	8	9	10
22	1	2	3	4	5	6	7	8	9	10
23	1	2	3	4	5	6	7	8	9	10
24	1	2	3	4	5	6	7	8	9	10

25-48 ON SIDE 2

INSTRUCTOR _____	COURSE NO. _____	SECTION _____
------------------	------------------	---------------

SIDE 2

	SD	D	N	A	SA							
17. My attitudes and my feelings were frequently ignored or criticized in my family.-----	25	1	2	1	3	2	3	2	3	1	3	2
18. My family members rarely expressed responsibility for their actions.-----	26	1	2	3	1	3	2	3	2	3	1	3
19. In my family, I felt free to express my own opinion.-----	27	1	2	3	1	3	2	3	2	3	1	3
20. We never talked about our grief when a relative or family friend died.-----	28	1	2	3	1	3	2	3	2	3	1	3
21. Sometimes in my family, I did not have to say anything, but felt understood.-----	29	1	2	3	1	3	2	3	2	3	1	3
22. The atmosphere in my family was cold and negative.-----	30	1	2	3	1	3	2	3	2	3	1	3
23. The members of my family were not very receptive to one anothers views.-----	31	1	2	3	1	3	2	3	2	3	1	3
24. I found it easy to understand what other family members said and how they felt.-----	32	1	2	3	1	3	2	3	2	3	1	3
25. If a family friend moved away, we never discussed our feelings of sadness.-----	33	1	2	3	1	3	2	3	2	3	1	3
26. In my family, I learned to be suspicious of others.-----	34	1	2	3	1	3	2	3	2	3	1	3
27. In my family, I felt that I could talk things out and settle conflicts.-----	35	1	2	3	1	3	2	3	2	3	1	3
28. I found it difficult to express my own opinion in my family.-----	36	1	2	3	1	3	2	3	2	3	1	3
29. Mealtimes in my home usually were friendly and pleasant.-----	37	1	2	3	1	3	2	3	2	3	1	3
30. In my family, no one cared about the feelings of other family members.-----	38	1	2	3	1	3	2	3	2	3	1	3
31. We usually were able to work out conflicts in my family.-----	39	1	2	3	1	3	2	3	2	3	1	3
32. In my family, certain feelings were not allowed to be expressed.-----	40	1	2	3	1	3	2	3	2	3	1	3
33. My family believed that people usually took advantage of you.---	41	1	2	3	1	3	2	3	2	3	1	3
34. I found it easy in my family to express what I thought and how I felt.-----	42	1	2	3	1	3	2	3	2	3	1	3
35. My family members usually were sensitive to one anothers feelings.-----	43	1	2	3	1	3	2	3	2	3	1	3
36. When someone important to us moved away, our family discussed our feelings of loss.-----	44	1	2	3	1	3	2	3	2	3	1	3
37. My parents discouraged us from expressing views different from theirs.-----	45	1	2	3	1	3	2	3	2	3	1	3
38. In my family, people took responsibility for what they did.-----	46	1	2	3	1	3	2	3	2	3	1	3
39. My family had an unwritten rule: Don't express your feelings.---	47	1	2	3	1	3	2	3	2	3	1	3
40. I remember my family as being warm and supportive.-----	48	1	2	3	1	3	2	3	2	3	1	3

DO NOT WRITE
IN THIS SPACE

Appendix E

Instruction Sheet

My name is Paula Andrasi and I am a doctoral student in Counseling Psychology at the dissertation stage. I am studying how as adults we have been influenced by our families. I have three short questionnaires plus an information sheet that I would like you to complete. The instructions are simple and written at the top of each section. Your answers are to be marked on the right of the question in the grid area. Number 2 lead pencils will be provided. The entire packet will only take about 20 minutes to complete.

Let me assure you that your responses are completely anonymous and cannot be traced back to you. All results will be reported as group scores. The number that appears on the top of each answer sheet is the sole identification for your packet of responses. If, after you complete the packet of questionnaires, you decide you would like to know your individual scores, simply copy down the identification number at the top of the answer sheet. After October 10th you may call me at 372-2961 and give me your ID number and I will give you your test scores. The debriefing sheet that you will receive when you have completed the packet will contain my phone number. No one will be able to associate the ID number with you.

If you choose not to participate you are completely free to do so. Your participation is solely voluntary. I am encouraging you to participate because the design for my study is based on an unbiased sample of blocks of classes. But, no action will be taken against you if you decide you are unwilling to complete the questionnaires.

I really appreciate your willingness to assist me in this way and hope others are equally cooperative when you are at a similar point in your education.

When you have completed the packet of questionnaires, please bring them to me so that I may give you a debriefing sheet which provides more detailed information about this study.

Appendix F

Debriefing Sheet

Thank you for your participation in this study.

The purpose of this research is to examine the effect that growing up in an alcoholic home has on adults. I am attempting to determine if there are specific factors which occur in the family that contribute to poor self-esteem in adult children of alcoholics. I am also attempting to verify that adult children of alcoholics, as a whole, report lower self-esteem scores than adults who did not grow up in an alcoholic home.

If, after completing these forms, you have any questions about adult children of alcoholics, I would recommend the following books:

It Will Never Happen to Me by Claudia Black

Adult Children of Alcoholics by Janet Woititz

Guide to Recovery by Gravitz & Bowden

If you feel disturbed by your responses or would like to talk to someone about being an adult child of an alcoholic, there are several agencies in town which might be of service to you.

Borgess Midwest Recovery Center	388-6930
New Directions	349-1528
Woman Care	388-4477

Or, you may wish to write to the National Association for Children of Alcoholics, 31706 Coast Highway, Suite 201, South Laguna, California 92677.

You may attend any of the Adult Children of Alcoholics (ACA) meetings held in conjunction with Alcoholics Anonymous and Al-Anon. You can obtain the time, day, and location of these meetings by calling the Alano Club at 343-2711.

Also, remember, if you would like your individual test scores, you may obtain them by calling me in the evening or on weekends after October 10th and giving me your ID number which is located on the top of your answer sheet. My number is 372-2961.

Thanks again.

Paula Andrasi
 Doctoral Student
 Counseling Psychology

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