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ADULT CHILDREN OF ALCOHOLICS: AN EXPLORATION OF HETEROGENEITY UTILIZING CHILDHOOD ROLES, FAMILY OF ORIGIN HEALTH AND ADULT ATTACHMENT STYLES

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ADULT CHILDREN OF ALCOHOLICS: AN EXPLORATION OF HETEROGENEITY UTILIZING CHILDHOOD ROLES, FAMILY OF ORIGIN HEALTH AND ADULT ATTACHMENT STYLES

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Dedication

This work is dedicated to all the people who continue to support one another in recovering from the family disease of addiction.

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There are so many people to whom I want to offer my thanks and gratitude for supporting me throughout my academic career.

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ADULT CHILDREN OF ALCOHOLICS: AN EXPLORATION OF HETEROGENEITY UTILIZING CHILDHOOD ROLES, FAMILY OF ORIGIN HEALTH AND ADULT ATTACHMENT STYLES

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Research reports that an estimated forty-three percent of adults, or seventy-six million people, in the United States have relatives who are alcoholic. In addition, one in eight individuals, or an estimated 30 million adults, has an alcoholic parent. The literature suggests that the impact of growing up in an alcoholic family system may affect psychological functioning well into adulthood. Adult children of alcoholics (ACOAs) are at increased risk for a myriad of psychological symptoms including substance abuse/dependency, problems in interpersonal relationships, depression, anxiety, and low self-esteem. However, research has also indicated that there may be more heterogeneity within this group than previously reported. It has been suggested that while patterns of maladjustment and increased risk for psychological distress may be evident, no clear "syndrome" related to this population was supported. This study explored whether an

ACOA's childhood family role (i.e. Hero, Scapegoat, Mascot and Lost Child) explained variance within this population, using adult attachment and family of origin health as outcome measures. Results did not support this hypothesis. This study also examined between group differences in adult attachment styles and family of origin health between a sample of ACOAs and Non-ACOAs. Analysis indicated that ACOAs reported significantly more Fearful attachment styles than Non-ACOAs. As well, post-hoc analyses indicated that ACOAs described their families of origin as promoting significantly less personal responsibility, as well as, having lower support for the expression of emotions and constructive conflict resolution than Non-ACOAs. This study provides information which may be utilized by clinicians working with this population. The impact of less secure attachment styles within the therapeutic relationship should be considered. As well, this study provides evidence that a specific pattern of maladjustment secondary to the dynamics created by the disease of addiction may be present within alcoholic family systems that may differentiate them from other "dysfunctional" families.

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Chapter One

Introduction

Research suggests that the impact of growing up in an alcoholic family system may affect psychological functioning well into adulthood. These assertions are further supported by clinical observations and recognition by institutions such as Al-Anon Family Groups (Al-Anon Family Groups, 1997; Woititz, 1983). Alcoholic family systems are often characterized as chaotic and unstable due to the unpredictable and sometimes volatile nature of an alcoholic parent or caregiver, which may impact the development and personality of children within the system. The literature reports that adult children of alcoholics (ACOAs) are at increased risk for a myriad of psychological symptoms including substance abuse/dependency, problems in interpersonal relationships, depression, anxiety, and low self-esteem. However, research has also indicated that there may be more heterogeneity within this group than previously reported (Scharff, Broida, Conway & Yue, 2004). Harter (2002) suggested that while patterns of maladjustment and increased risk for psychological distress may be evident, no clear "syndrome" related to this population was supported.

Alcoholic Family Systems - The role of family system factors on the range of adjustment reported in children living with an alcoholic parent/caregiver (COAs) has been examined in several studies. For example, research has indicated that the variance in negative childhood outcome variables reported in a sample of elementary school children living within alcoholic family systems, including internalization, externalization and social problems, was significantly increased by increasing levels of maternal depression, parent-child and marital conflict noted in the home (El-Sheikh & Flanagan,

2001). Ellis and Zucker (1997) examined several alcohol specific and non-alcohol specific factors present within a sample of alcoholic family systems. This study sought to determine the extent to which these factors would affect the development of substance abuse and other comorbid mental health problems in children of alcoholics. Results indicated that there may be subtypes of alcoholic family systems in which children are at an increased risk of developing mental health concerns based on a composite of both alcohol related and non-alcohol related family factors (Ellis & Zucker, 1997). Such studies suggest that the variance seen within ACOAs may be, in part, related to a range of factors within their families of origin.

Family Roles - In ACOAs, Scharff et. al. (2004) suggested a potential explanation for the variance of psychological issues observed in this population may be the existence of prescribed adaptive roles children often assume within an alcoholic family system. Based on family systems theoretical principles, Wegsheider (1981) introduced the idea that children growing up in alcoholic homes often assume adaptive role, specific to alcoholic family systems, to cope with stressors within the family system. These roles included: the Hero, a child who attempts to attract positive attention through overachievement, the Mascot, who tries to draw attention away from family conflict created by the alcoholic caregiver's behavior through the use of "rambunctious, clown-like behaviors" (Scharff et. al.,2004, p3), the Lost Child, who is often described as quiet and withdrawn, and the Scapegoat, who attempts to draw attention away from family conflict through the use of negative behaviors (Scharff et. al, 2004).

Adult Attachment - One significant area of dysfunction reported consistently throughout the ACOA literature is difficulty in interpersonal relationships (Harter, 2000).

Recently, research has begun investigating the adult attachment styles of ACOAs to further explore the interpersonal challenges often reported within this population. In a comparison of female ACOAs/non-ACOAs, Jaeger, Hahn & Weinraub (2000) found that adult daughters of alcoholics reported a greater level of insecure attachments than the non-ACOA group. In a similar study of males and females, Kelley, Cash, Grant, Miles & Santos (2004) found in their sample that ACOAs reported more anxiety, greater avoidance in romantic relationships and a more fearful style of adult attachment. This research suggests that there may be some relationship between the interpersonal difficulties reported by many ACOAs and their style of adult attachment.

Introduction to the Study

Part I - Utilizing this paradigm of alcoholic family roles, the present study will explore the heterogeneity within ACOAs in the area of adult attachment style. In addition, this study examined further the role family of origin factors may play in the variance of ACOAs. It is plausible that an ACOA's identification with one of the family roles associated with alcoholic family systems, may differentiate him/her on domains of adult attachment.

Part II - A second goal of this study is to replicate earlier findings in which ACOAs have been found to have significantly less secure attachment styles than Non-ACOAs. As such, the research presented here will include a between groups comparison of a sample of ACOAs with group of Non-ACOAs on a measure of adult attachment styles. It is hypothesized that ACOA participants will report significantly less secure attachment styles than the Non-ACOA group.

Contributions to Existing Literature - It is the goal of this research to identify some potential factors that influence the reported heterogeneity within ACOA in the hopes that such constructs may be informative to clinicians working with this population. In addition, this study will explore between group differences, ACOAs versus Non-ACOAs, to replicate previous findings related to adult attachment styles in this population to provide professional working with ACOAs additional support to consider the attachment style of a client who presents with this family background.

Chapter Two

Review of the Literature

In 2002, The National Institute of Health (NIH) reported that 17.6 million adults in the United States met criteria for alcohol abuse or alcohol dependence, as determined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (American Psychiatric Association, 2000: National Institute of Health, 2004). Other government agencies estimate the prevalence rate in the United States at 21.6 million people classified with substance dependence or abuse (Substance Abuse and Mental Health Services Administration, 2004). In addition, The World Health Organization has identified the excessive use of alcohol and other substances as a significant public health problem, reporting an estimated 185 million current substance users worldwide (Fernandez, Begley & Marlatt, 2006). In actuality, alcoholism currently impacts an estimated 30 million additional individuals in the United States, including approximately 6.6 million children living within alcoholic family systems (Gordis, 1990; Woodside, 1988). Research reports that an estimated 43 percent of adults, or 76 million people, in the United States have relatives who are alcoholic, and that one is eight individuals, or an estimated 30 million adults, have an alcoholic parent (Hall & Webster, 2002; Domenico & Windle, 1993).

Historical Context

Throughout history, alcoholism has been identified as occurring across cultures, classes, geographic areas and age groups (Peele, 1985). While the existence of alcoholism is noted within a broad historical context, attitudes towards alcohol have been

fluid over time. In the United States, social and political ideals regarding the use and abuse of alcohol have included a range of views from alcohol as a benign substance, to "demon rum," as well as, a romanticized elixir signifying independence and high spiritedness (Peele, 1985, p. 30). As a result of the temperance movement, in the 1920's the United States ratified the prohibition amendment to the constitution, resulting in the polarization of individuals on either side of this issue. Due to the resistance to this law, the increase in illegal trafficking in alcohol, and an increase in other social issues the prohibition amendment to the United States constitution was repealed in 1933 (Peele, 1985).

Throughout the 1930's and 1940's, researchers, clinicians and lay people began to identify the pathogenic consequences of alcohol abuse on individuals. The development of a "primary" disease model of alcoholism began during this time and may be described as:

> Addiction, especially alcoholism…is not the result of another condition. This is usually taken to mean that the disease is not caused by heavy drinking or drug use, stress or psychiatric disorders; rather, it is thought to be the cause of these very conditions. In other words, heavy drinking/drug use, stress, psychiatric disorders, and so forth are secondary symptoms or manifestations of an underlying disease process known as addiction (Thombs, 1999, p. 32).

In 1935 Alcoholics Anonymous (AA) was founded by two chronic alcoholics, Bill W. and Bob S. to assist individuals in recovering from the disease of alcoholism (Emrick, 2001; Alcoholics Anonymous, 2000).

AA is a lay person, peer lead, anonymous, mutual help group developed to assist individuals suffering from the disease of alcoholism. Currently, AA is a worldwide organization that continues to be a part of treatment and recovery maintenance for over 2,000,000 active members in approximately 99,000 groups (Emrick, 2001). AA's goal is to assist actively drinking alcoholics to enter "recovery," starting with complete abstinence from alcohol and to other drug use, as well as to provide ongoing support to those already in recovery. AA is based on a 12-step model which encourages individuals to cope with their addictions through the development of personal awareness, intra-member sponsorship, community support and spiritual work in an anonymous setting with other alcoholics in various stages of recovery (McNeese & Dinitto, 1998; Emrick, 2001; Alcoholics Anonymous, 2000). The 12-steps are designed to address both the intra and interpersonal aspects and costs of alcoholism, including identifying and admittance of "wrongs" to others and making of amends to others for those "wrongs" (Alcoholics Anonymous, 2000). Today, the disease model of addiction remains as the predominant paradigm through which alcoholism is understood, researched and treated and the AA model is integrated into most chemical dependency treatment programs (Thombs, 1999; Emrick, 2001).

As the addiction, and alcoholism specifically, disease model developed it became clear that the negative affects of alcohol abuse and dependency did not only impact the individual afflicted with the disease. Rather, systemic and equally dysfunctional consequences were noted within family members and others close to the alcoholic that could be traced directly and indirectly back to the primary disease of addiction (Woititz, 1983; Bowen, 1991; Ellis & Zucker, 1997; Al-Anon Family Groups, 1997). The primary

acknowledgment of this need for support for family members and friends of individuals with alcoholism was noted by the wives of the founders of AA (Room & Greenfield, 1993; Al-Anon Family Groups, 1997; Haaken, 1993). As a result, in 1951 they founded Al-Anon Family groups an organization similar to AA, but with a distinctly different purpose. Al-Anon was founded to assist family and others close to an alcoholic cope with the systemic impact of the disease of addiction, rather than to prevent the alcoholic from drinking (Read, 1995; Haaken, 1993; Miller, Meyers & Tonglen, 1999; Al-Anon Family Groups, 1997). Family systems theorists, clinicians and researchers began to construct a model describing alcoholism as a family disease. As a result, one area of exploration has investigated the long term impact of growing up with an alcoholic caregiver.

Al-Anon Family Groups

Concurrently with the development of AA was an awareness of the systemic impact of alcoholism on individuals close to the alcoholic, particularly family members. As a result, Al-Anon Family groups was started to support individuals affected by the "family disease" of alcoholism. While several other treatment modalities have been utilized in the treatment of members of alcoholic family systems, Al-Anon remains the predominantly accepted model. Al-Anon is a 12-step program which follows the Alcoholics Anonymous (AA) model. Similar to AA, Al-Anon groups have a modified core of 12-steps and 12 traditions:

Al-Anon 12-Steps

1. We admitted we were powerless over alcohol-that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, *as we understood Him,* praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs. (Al-Anon Family Groups, 1997)

As in AA, Al-Anon membership is anonymous, and groups are peer led. However, unlike AA, Al-Anon groups and literature focus on the impact of alcoholism on family

and friends as well as advocating for self care while not attempting to change the alcoholic (Humpreys & Kaskutas, 1995; Al-Anon Family Groups, 1997).

> Alcoholism is a family disease. Living with the effects of someone else's drinking is too devastating for most people to bear without help. In Al-Anon we learn individuals are not responsible for another person's disease or recovery from it. We let go of our obsession with another's behavior and begin to lead happier and more manageable lives… (Al-Anon Family Groups, 1981, p.1)

While the 12-steps parallel those in AA, Al-Anon principles value the role of detachment in friends and family members' recovery (Fernanadez, et. al, 2006; Rychtarik & McGillicuddy, 2005). Detachment is defined as the knowledge that individuals are not responsible for another person's disease or recovery stating detachment, "…is neither kind nor unkind. It does not imply judgment nor condemnation…" (Al-Anon Family Groups, 1981, p. 1). Al-Anon principles attempt to provide benefit to its members by allowing them to support each other through pain, rather than help them avoid discomfort. Members share their stories with each other, highlighting an atmosphere of nonjudgmental mutual experience. Al-Anon literature states "…Al-Anon does not wish to blame but rather understand the family disease concept of alcoholism...we are not here to take your pain away, we are here to support you as you go through it…" (Al-Anon Family Groups, 1997, p.5).

As in AA, Al-Anon seeks to help its members cope with both the intra and inter-relational impacts of addiction. While Al-Anon is a lay-person, peer lead organization, in psychological terms, the principles, texts and structure of this organization may support an individual systemically impacted by alcoholism, in developing a stronger and more

positive sense of self through the advocating of self-care (Rychtarik & McGillicuddy, 2005; Room & Greenfield, 1993; Friedmann, 1996; Read, 1995). Given its predominance in the field, relatively few empirical studies have been conducting on Al-Anon groups, perhaps in part because of the anonymous nature of the organization. However, the limited research completed has shown that Al-Anon participation is associated with reduced reports of personal problems, improvement in marital adjustment and self esteem, reduction in depression, anger, family conflict and increases in reports of family cohesion and relationship happiness (Fernandez et. al, 2006; Barber & Gilbertson, 1996; Dittrich & Trapold, 1984; Keinz, Schwartz, Trench & Houlihan, 1995; Kingree, 2000: O'Farrell & Fals-Stewart, 2003; Woititz, 1983: Humphreys & Katsukas, 1995). Additionally, Miller and colleagues found that family members benefit from Al-Anon membership regardless of improvement in the drinking behaviors of the alcoholic (Miller et. al., 1999). Some researchers suggest that these improvements are related to the building of new and more adaptive coping mechanisms within Al-Anon members (Fernandez et. al., 2006). From family systems and attachment perspectives, the Al-Anon model may support the development of a more positive sense of self and others, while promoting a healthy balance of autonomy and intimacy within significant interpersonal relationships through an increase in self-care behaviors and the introduction of the Al-Anon concept of detachment.

Adult Children of Alcoholics

Previous research has provided evidence that having an alcoholic caregiver can negatively impact children well into adulthood. Clinicians have suggested that ACOAs

present in psychotherapy with similar issues. In her widely cited book, Woititz (1983) stated that while there is some variability in ACOAs more often than not there are:

> …certain generalizations that recur in one form or another at virtually every meeting…
>
> 1. Adult children of alcoholics guess at what normal behavior is.
> 2. Adult children of alcoholics have difficulty following a project through to the end.
> 3. Adult children of alcoholics lie when it would be just as easy to tell the truth.
> 4. Adult children of alcoholics judge themselves without mercy.
> 5. Adult children of alcoholics have difficulty having fun.
> 6. Adult children of alcoholics take themselves very seriously.
> 7. Adult children of alcoholics have difficulty in intimate relationships.
> 8. Adult children of alcoholics over-react to changes over which they have no control.
> 9. Adult children of alcoholics constantly seek approval and affirmation.
> 10. Adult children of alcoholics usually feel that they are different from other people.
> 11. Adult children of alcoholics are super responsible or super irresponsible.
> 12. Adult children of alcoholics are extremely loyal, even in the face of evidence that the loyalty is undeserved.
> 13. Adult children of alcoholics are impulsive. (Woititz, 1983, p 5)

In addition to clinical observations, research has explored several areas of functioning in adult children of alcoholics (ACOAs) including: representations of self, interpersonal

relationships, relationship satisfaction, susceptibility to and prevalence of mental illness, vulnerability and prevalence of chemical dependency and adult attachment styles (Beesley & Stoltenberg, 2002; Harter, 2000; Scharff, Broida, Conway & Yue, 2004; Menees, 1997). However, while several studies and clinicians have argued that ACOAs are a relatively homogeneous group, based on common experiences with alcoholic caregivers, recently many researchers have proposed that there is more heterogeneity within this group than originally thought (Harter, 2000; Kashubek & Christensen, 1992; Menees, 1997; Alford, 1997; Hall & Webster, 2002). As a result of this debate, current research often focuses on challenging or explaining not only between groups comparison, between ACOAs and non-ACOAs, but additional study is beginning to explain the variance within this population.

Constructs related to the representation of the self have been examined in several ACOA studies. Primarily, the construct of self-esteem has been explored and research has indicated that overall, ACOAs are at risk for lower levels of self-esteem than non-ACOA samples (Woititz, 1983; Harter, 2000). Additionally, Cermak (1986) depicted ACOA self esteem as requiring an exaggerated sense of control over oneself and others, which may lead to a distorted relationship to willpower, a confusion of identity, denial and low self-esteem. However, more recent research also argues that low self-esteem is not a unilateral outcome for all ACOAs. Menees (1997) reported that other factors may influence the relationship between ACOA status and self-esteem. Results from this study suggested that ACOA coping style, perceived social support and family communication styles moderated the relationship between ACOA status and self-esteem. This study found no direct relationship between parental drinking status and self-esteem (Menees,

1997). Harter (2000) stated that while larger, more representative studies suggest a relationship between parental alcoholism and lowered self-esteem, further research is need to assess the potential influence of other factors within the family of origin on this outcome variable.

Several studies with ACOAs have focused on the prevalence and patterns of maladjustment and psychopathology. When compared with non-ACOAs across multiple studies, research has indicated that ACOAs report relatively higher levels of general psychological distress than control groups (Hall & Webster, 2002; Harter, 2000; Hawkins & Hawkins, 1995). Several studies have measured distress utilizing personality or broad symptom scales, such as the MMPI, SCL-90 and the MCMI (Harter, 2000). Results from such research has reported that within samples ranging from college students, VA wives, community and mixed samples, ACOA respondents reported higher use of mental health services, increased rates of psychiatric illness and higher levels of variables related to psychological maladjustment when compared to non-ACOA samples (Harter, 2000; Hinkin & Kahn, 1995; Belliveau & Stoppard, 1995).

Research conducted by Hall and Webster also supported the notion that ACOAs are at a higher risk for stress related issues. In their study comparing a sample of ACOAs, adults who had experienced some childhood trauma and a control group, significant between group differences were reported. Primarily, results identified that ACOA respondents showed a "pattern of risk" including higher levels of stress and dysfunction than either the trauma experience or control groups (Hall & Webster, 2002). Additional comparison of results from the Trauma Symptom Inventory found the ACOA group and the trauma experience group expressed similar levels of anxious arousal, anger

irritability, defense avoidance and intrusive experience and significantly higher levels than the control group. In contrast some research has found few differences for ACOAs in maladjustment or use of mental health services. For example, one study exploring within group differences found significantly higher levels of psychological distress in a sample of ACOAs attending 12-step support groups than a university sample of ACOAs (Kashubek & Christensen, 1993). Overall, however, studies suggest an increase in generalize distress and maladjustment within this population, across symptom and personality dimensions (Harter, 2002).

Research has also suggested that ACOAs are at a higher risk for developing substance abuse disorders than non-ACOAs (Jacob, Windle Seilhamer & Bost, 1999). Additionally, several studies have reported higher incidence of substance abuse in ACOAs than non-ACOA groups overall (Harter, 2000; Sher, Walitzer, Wood & Brent, 1991). Studies in this area have identified both environmental and genetic factors to support this assertion and heritability is generally thought to be stronger in male ACOAs (Harter, 2000). In addition to increased vulnerability for development of substance abuse disorders, research has indicated that as a result of drug or alcohol use ACOAs may experience more negative consequences for such use, have stronger expectancies for beneficial affects from alcohol, and significantly fewer negative associations about alcohol (Harter, 2000; Erblich, Earlywine & Erblich, 2001). Domenico & Windle (1993) also reported that ACOAs utilize alcohol as a tool to cope with stressful events with greater prevalence than a non-ACOA control sample.

Further research has focused on the likelihood and rate of specific psychiatric disorders in ACOAs. Depression and anxiety disorders are among the most studied areas

of psychopathology for this group. Harter (2000) reported that ACOAs appear to report more anxiety, particularly when more specific anxiety disorders or interpersonal anxiety are considered, than subjects with no history of parental alcoholism. Additionally, Cuijpers, Langendoen & Bijl (1999) found that when compared to a sample of non-ACOAs, ACOA respondents reported a significantly higher life-time, 12-month and 1-month prevalence of mood and anxiety disorders. Researchers noted that in their sample this discrepancy was particularly high for children of alcoholic fathers. Additionally, results indicated that the first onset of mood and anxiety disorders in the ACOA sample took place at a younger age than non-ACOAs. This study also reported respondents were at an increased risk of developing a psychiatric disorder when additional stressors in their family of origin were present, including childhood trauma or non-alcohol related problematic parental behaviors (Cuijpers et. al., 1999). In another study, Lease (2002) investigated the relationships between level of depression in a sample of ACOAs and non-ACOAs and patterns of parental drinking behaviors, intergenerational family interactions, attachment behaviors and self-esteem. Results supported the assertion that certain parental drinking patterns may disrupt family functioning and negatively impact self-esteem. These findings potentially provide support for the notion that other family of origin factors aside from the dichotomous determination of ACOA/non-ACOA may help explain some of the reported heterogeneity in this group (Lease, 2002). Overall, studies suggest that ACOAs are at a greater risk of experiencing depression

Researchers continue to call for additional study of the factors that may explain the variation in outcome measures and resiliency within ACOAs. Jacob and colleagues presented several factors which may in part explain the variance in ACOAs. In their

study comparing the drinking, psychiatric and social status of a sample of ACOAs, psychiatric patients and a control group, Jacob et. al. (1999) proposed several moderators of risk within this population including; social class, gender, family environment factors and non-alcohol parental characteristics such as, compromised marital or parent-child relationships. ACOAs were differentiated from control groups regarding alcohol and drug abuse, personality characteristics associated with behavioral undercontrol (Jacob et. al., 1999). The authors reported that the only significant moderator variable was paternal socioeconomic status, noting that results were less robust than anticipated.

Additional areas of study have been proposed to attempt to explain the heterogeneity in this population including further study of parental drinking styles, other family stressors, co-morbid parental psychiatric disorders and other general family of origin factors (Harter, 2000). While studies have explored a range of specific outcome variables in respect to ACOA functioning, very few studies have examined the impact that specific family factors may play. Two such factors examined in this study included exploring the relationship between an ACOA's childhood prescribed family role and his/her adult attachment style and the impact of how an ACOA's family of origin was able to support his/her development of interpersonal and intrapersonal development.

Family Systems Theory

The origin of family systems theory can be traced from multiple schools of thought and paradigms both in and outside psychology. Influenced by general systems theory, this theoretical perspective defined a system as:

> …a group of interrelated parts plus the way they function together. Thus, a family can be understood as a group of family members, plus the ways they

interact. (Nichols & Schwartz, 2001, p.104)

Early family systems theory was linked to movements in the natural sciences early in the 20th century, such as ecology, in which biologists began studying animals and plants n the context of their community rather than in isolation (Nichols & Schwartz, 2001).

Cybernetics, the study of the regulation within systems, originating in engineering and technical realms, also had a significant impact on the evolution of family systems theory. The cybernetics paradigm introduced the concept that systems have an internal set of rules and that they self-correct, utilizing information from internal feedback loops to provide information necessary to maintain a level of homeostasis, or a steady state (Nichols & Schwartz, 2001). These principles were integrated in family systems theory, suggesting that like other systems, families; have rules "…governing the range of behavior that a family system can tolerate" (Nichols & Schwartz, 2001) which include negative and positive feedback loops to provide information to help the family return to and maintain a homeostatic state. In other words, in a family system, verbal and nonverbal communicative mechanisms exist that continuously monitor and provide information about the family state to each member of the group. That information is used by family members, implicitly or explicitly, to maintain or return the family to its usual level of functioning (Beesley & Stoltenberg, 2002; Larson & Reedy, 2004). Additional influences on the development of family systems theories included such disciplines as; functionalism, general systems theory, structuralism and social constructivism (Nichols & Schwartz, 2001). Such diverse influences have resulted in the development of several family therapy theoretical models, many with their origin in family systems theory.

Concepts of Autonomy and Intimacy and The Family of Origin

The family of origin is defined as the system from which an individual has his/her physiological, emotional, and psychic beginnings (Hovestadt, et. al., 1985). Many theorists posit that establishing an independent identity from one's family of origin is a major developmental task of adolescence and earlier adulthood (Crespi & Sabatelli, 1997). Some argue that the majority of this task involves focusing on one's relationship to his/her family.

Family systems theorist Murray Bowen, MD emphasized the concept of differentiation, defined as the constant process of negotiating distance and closeness between two people or within oneself (Bowen, 1978). The first aspect of differentiation is interpersonal, referring to the way one manages individuality and togetherness within a relationship. The second aspect is intrapersonal and describes the degree to which one is able to distinguish between his/her own emotions and intellect, or in other words the level of emotional reactivity they display in interpersonal situations. Bowen argued that differentiation from one's family of origin is a significant part of the developmental tasks negotiated during young adulthood.

Other development and family theorists have stressed the importance of the similar balance between separateness and togetherness in regards to individual development. Framo (1976) discussed the significance of both closesness and separation in a child's relationship with his/her parents. This argument suggested that a balance between the two was necessary to develop relationships with significant others, so as to avoid alienation and loneliness. In addition, within the context of his developmental

stages, Erikson argued that the task of identity is negotiated before intimacy, both of which are based on earlier stages related to autonomy and development of trust in others (Hovestadt, et. al., 1985). In addition, research has suggested that some degree of intimacy and autonomy is necessary for healthy personal development (Hovestadt, et. al., 1985). Basing their research on earlier investigation identifying constructs which describe families with a greater degree of health, Hovestadt and colleagues argued that a major task of a family is to assist its members in the development of both autonomy and intimacy.

Several constructs have been operationalized within family systems that support the development of autonomy and intimacy within members (Lee, Gordon & O'Dell, 1989; Hovestadt, et. al., 1985). Autonomy is conceptualized as being supported by families who emphasize clarity of expression, personal responsibility, respect for other family members, openness to others within the family and by dealing openly with separation and loss (Hovestadt, et. al., 1985). The develop of intimacy is theorized to be engendered within families who encourage expression of a wide range of feelings, create a warm atmosphere in the home, deal with conflict without undue stress, promote sensitivity in members, and trusting in the goodness of human nature.

Several studies have suggested that individuals who grew up in families that supported the development of these two constructs are likely to report; stronger current marital adjustment and be more open to communication, healthier current family systems, have more positive perceptions of marriage and less stress associated with the transition to parenthood (Ryan, Kawash, Fine & Powell, 1994). However, as will be discussed later

in this chapter, dynamics many suggest are specific to alcoholic family systems may prevent children from developing a healthy balance of autonomy and intimacy.

Attachment Theory

Attachment theory has its origin in the work of John Bowlby (Bowlby 1969; 1973; 1980). Observing the characteristics of infant/caregiver bonds, Bowlby suggested this relationship could not only affect the physical survival of a child, as was argued by evolutionary theory, but also a child's emotional experience and behavior (Bowlby, 1969). Bowlby (1969) theorized that interactions within the infant/caregiver relationship provide a child with information about his/her level of safety and security in the world. This information, Bowlby suggested, is used by the child to create working models or cognitive expectations about how frequently and to what extent his/her caregivers will meet his/her needs, as well as, his/her own ability to effectively communicate those needs (Bowlby, 1973). Bowlby (1973) suggested that a child develops two different working models, one to represent the self and one for others. A fluid cognitive representation, a working model of self represents how the child sees him/herself within the context of the primary attachment relationship. This cognitive schema includes one's beliefs about one's value and abilities as an individual. Bowlby theorized that working models of others are developed based on the information a child possesses from his/her relationship with a primary caregiver early in life. It is argued that children take the model of other, developed through their original attachment relationship, and generalize these expectations to others and the world.

Early research regarding attachment focused on young children and their parents. Some of the most influential research in this area was conducted by Mary Ainsworth and

her colleagues, utilizing an experiment called the Strange Situation Protocol (Ainsworth, Blehar, Waters and Wall, 1978; Ainsworth, 1989; Karen, 1990; Main, Kaplan & Cassidy, 1985). These studies enabled researchers to begin to conceptualize the different styles of attachment in children. These are currently known as secure, anxious-ambivalent, avoidant, and disorganized (Ainsworth et. al., 1978; Main et. al., 1985).

Models of Adult Attachment

Early conceptualizations of attachment in children have extended to include the development of models of attachment for adults. Grounded in the work of Ainsworth and Bowlby, two traditions of adult attachment theory and research have been identified in the literature. The first, which found its roots in psychodynamic theory and was based on the work of Main and her colleagues, focused on adult attachment within the confines of the adult's relationship with his/her children and its impact on parenting behavior (Bartholomew & Shaver, 1998). This paradigm favored attachment data collection through observation of parents and infants and interview techniques, and often utilized the Adult Attachment Interview (AAI) (Bartholomew & Shaver, 1998). Researchers in this tradition used Ainsworth's three category attachment model (i.e. secure, anxious and avoidant); eventually adding a fourth infant pattern, "disorganized" that described caregivers who had not dealt with losses and traumas in their attachment history (Bartholomew & Shaver, 1998).

The second, completely independent line of research started by Hazan and Shaver, attended to adult attachment as it related to romantic relationships and was influenced by personality and social psychology. This extension depicts adult attachment utilizing schematic cognitive working models. Similar to Bowlby's assertion that

children develop fluid cognitive working models about attachment based on their interaction with primary caregivers, adult attachment theorists suggest that as children develop into adulthood these models are adaptable when a person is in an emotionally healthy environment (Bartholomew & Horowitz, 1991). Hazan and Shaver developed a self-report questionnaire for adults based on Ainsworth's three patterns of childhood attachment: secure, avoidant and anxious. Through a combination of both traditions, Bartholomew and Horowitz (1991) developed their four-category model of adult attachment.

Bartholomew and Horowitz (1991) based their model on Bowlby's (1973) assertion that there were two key features of working models of attachment, the internal working models of self and that of others. Developed during early childhood relationships with their primary caregivers, these internal representations are described by Bowlby (1973) as:

> (a) whether or not the attachment figure is judged to be the sort of person who in general responds to call for support and protection; [and] (b) whether or not the self is judged to be the sort of person towards whom anyone, and the attachment figure in particular, is likely to respond in a helpful way (p. 204).

The first definition refers to one's working model of those outside oneself as positive or negative, based on the responsiveness of one's primary caregiver. The second definition describes one's internal representation of one's self as positive or negative.

Building on Bowlby's concepts of self and other internal working models, as well as Ainsworth's three category model of attachment, Bartholomew and Horowitz (1991)

proposed their four-category adult attachment theory. Based on an extensive review of the adult attachment literature from both traditions, Bartholomew:

> …noted that the dismissing-avoidant individuals identified by the AAI denied experiencing subjective distress and downplayed the importance of attachment needs, whereas the avoidant subjects identified by Hazan and Shaver's self-report measure reported relatively high levels of subjective distress and fears of becoming close to others. She argued that two distinct forms of avoidance were evident, one pattern motivated by a defensive maintenance of self-sufficiency (labeled "dismissing") and the other motivated by a conscious fear of anticipated rejection by others (labeled "fearful"). (Bartholomew & Shaver, 1998, p. 27).

Additionally, Bartholomew noted that the two traditions of attachment research focused on different domains, parent-child relationship and adult romantic relationships, and suggested that general adult attachment style could not be assumed from either paradigm (Bartholomew & Shaver, 1998). As well, she argued that the indirect AAI interview and the face valid self-report question developed by Hazan and Shaver may actually capture different information. In developing the four category model, Bartholomew and Horowitz utilized both traditions, incorporating the two categories of avoidant attachment (i.e. fearful and dismissing) and used both interview and self-report techniques (Bartholomew & Horowitz, 1991).

Figure 1 (see Appendix A) shows the four dimensions of adult attachment. Similar to the first category in the model by Ainsworth et. al. (1978), Bartholomew and Horowitz's (1991) *secure* dimension, describes a person with positive views of both themselves and others. The authors argue that a person whose attachment schema is

secure has an internalized sense of self-worth and is comfortable with intimacy in close relationships.

The second dimension of attachment is described as *preoccupied*. This dimension includes people with positive views of others, but negative views of themselves. People with preoccupied attachment schemas may feel a deep personal sense of unworthiness; however, as they hold positive expectations of others, they may look to external sources/relationships to define their sense of self. As a result, they may experience extreme levels of distress when their intimacy needs are unmet (Griffin & Bartholomew, 1994a).

The third attachment dimension included in Bartholomew and Horowitz's (1991) four-category model is *fearful*. Those with this attachment schema possess negative working models of both the self and others. Individuals whose attachment style fits this dimension may be highly dependent on others for validation; however, because of their negative expectations of others they may avoid intimacy to avoid loss and rejection (Griffin & Bartholomew, 1994a).

The fourth dimension included in this theory is the *dismissing* attachment style, which includes a positive working model of the self and a negative working model of others. The dismissing attachment style is characterized by the avoidance of closeness because of negative expectations of others. However, it is argued that individuals with this style may maintain a high sense of self-worth by defensively denying the value of close relationships. In addition, this attachment dimension may be associated with an increased need for, and value of, independence (Griffin & Bartholomew, 1994a).

While theoretically, individuation and attachment are related, they are distinctly different constructs. Theory suggests that individuation is a primary developmental focus throughout adolescence and early adulthood and likely has implications for an individual's interpersonal relationships and attachment style into adulthood. However, the construct of individuation relates directly to that developmental task, and unlike adult attachment, does not capture an individual's current internal cognitive models of self and other. Therefore, this study will examine how well respondents' families of origin were able to engender higher levels of individuation in a retrospective measure of family of origin psychological health. However, as adult attachment measures aim to describe a person's current attachment schema, and as more secure levels of adult attachment have been related to several positive relational outcomes, a measure of adult attachment will be utilized to capture participants' current intrapersonal and interpersonal styles.

Alcoholic Family Systems

Growing up in an alcoholic home has been connected to disruptions in the development of autonomy and intimacy, and has been related to less secure attachment styles children of alcoholics. To understand the etiology of the potential disruption of these processes, an understanding of patterns and characteristics specific to alcoholic family systems is necessary.

Negative outcomes reported by ACOAs have been explained, by some authors, within the paradigm of family systems theory (Beesley & Stoltenberg, 2002). Within this context, alcoholism is conceptualized as a systemic process, through which the entire family is affected (Beesley & Stoltenberg, 2002). Bowen described alcoholic family systems as:

> From a systems viewpoint, alcoholism is one of the common human dysfunctions. As a dysfunction, it exists in the context of an imbalance in functioning in the total family system. From a theoretical viewpoint, every important family member plays a part in the dysfunction of the dysfunctional member. The theory provides a way for conceptualizing the part that each member plays. (Bowen, 1991, p. 97)

Alcoholic family systems are often described as chaotic, due to the unpredictability of the alcoholic parent's impulsive or unpredictable behavior and its consequences. The boundaries between family members may be characterized as fused and rigid, as all members of the system are deeply invested in compensating for the behavior of the alcoholic to keep the family at a homeostatic level of functioning (Harter, 2000; Woititz, 1983). This creates an atmosphere in which family members may have unrealistic or unhealthy expectations placed on them, as the system works to cope with the alcoholic member (Harter, 2000). Frequently, this may be expressed through implicit family rules related to how the system manages the alcoholic's behavior. For example, denial of a parent's alcoholism may become a central organizing principle within a family at the detriment to others members' needs (Harter 2000). Other prevalent implicit rules include the discouragement of direct communication of emotions and the encouragement of children to adhere to a fixed role inside as well as outside the family (Veronie & Fruestorfer, 2001). As a result, these systems may have an atmosphere of unpredictability, unspoken strict rules, and lack appropriate examples for children of how to experience and share emotions in a safe and appropriate manner.

Beesley & Stoltenberg (2002) argue that the utilization of such coping strategies may further prevent members of the family from confronting significant issues. Additionally, these behaviors work to maintain maladaptive family system patterns and create consistent pressure on children to continuously monitor and control their surroundings, including others in their world. For children of alcoholics, this cycle of coping strategies and systemic maintenance may interfere with individual growth, differentiation, individuation from their families of origin, and the development of healthy interpersonal relationships (Beesley & Stoltenberg, 2002; Harter, 2000; Scharff, Broida, Conway & Yue, 2003; Crespi & Sabatelli, 1997). For example, studies have found that alcoholic family systems often lack appropriate parent-child boundaries and children of alcoholics report difficulty finding "proper emotional distance" making the individuation process more difficult. Some suggest that because the parent-child roles are often flipped in alcoholic family systems, with the parent relying on the child in an inappropriate manner, individuation may actually be discouraged in these families (Crespi, 1990; Black, 1981). As they move into adulthood, children of alcoholics often continue to rely on the approval of others, much like they did in their alcoholic families, which may prevent them from developing a stable sense of self and personal control (Beesley & Stoltenberg, 2002).

Living in what may be characterized as a chaotic family system; children's developmental needs may be neglected. As the family system focuses energy, time and attention to managing the alcoholic parent's disease, a child's need for a stable, safe and attentive environment may not be available. Research has explored the long term effects of living in such an environment, studying the psychological well-being of ACOAs.

Studies suggest that ACOAs may be at higher risk for experiencing generalized distress and maladjustment across symptom and personality dimensions than those with no history of parental psychopathology (Harter, 2000). Beesley and Stoltenberg (2002) reported that ACOAs may exhibit symptoms similar to individuals with post traumatic stress disorder, which may include: highly defensive, self-protective behaviors; difficulty coping with emotions; lack of trust; problems with intimacy; dependency on the approval of others, and an increased need to control others and one's environment. Research also indicates that ACOAs may report lower levels of self-esteem, and may be at increased risk for developing problems with anxiety, depression and substance abuse (Cuijpers, Langendoen & Bijl, 1999; Harter, 2000; Woititz, 1989).

Alcoholic Family Roles

In response to the instability within their environments, children in these systems often learn to monitor implicit and explicit rules and conditions within the family, and may engage in behaviors to minimize their feelings of turmoil (Beesley & Stoltenberg, 2002; Harter, 2000). In an effort to compensate, children may adopt a role, or distinct identity within the system, to help them cope.

> Family systems theory explains role identification as a function of a child's desire to create, contribute to, and maintain a family's homeostasis….Essentially, children learn to behave in accordance with the most salient needs of the family (Veronie & Fruehstorfer, 2001, p.56).

While the majority of the literature in this area has examined ACOAs as a single group, some authors suggest that this may be a heterogeneous group. Scharff, Broida, Conway and Yue (2003) argued that the identification and delineation of family roles in ACOA

research may be an important variable, providing information about variance within this group. Theorists have defined four roles children living in alcoholic family systems may develop: the Hero, the Scapegoat, the Lost Child, and the Mascot (Alford, 1998; Veronie & Fruehstorfer, 2001; Woititz, 1983).

The *Hero* role is characterized by a child who, "…attracts positive attention through achievement-related behaviors" (Williams & Potter, 1994, p. 418). In an attempt to feel some level of control, provide stability to the system, and draw negative attention away from issues related to the alcoholic parent, a child adapting using the Hero role may appear competent, overachieving and serious to others, while he/she may feel inadequate and guilty inside (Veronie & Fruestorfer, 2001; Williams & Potter, 1994). Children who assume the role of *Scapegoat* may illicit attention through negative, oppositional or defiant behaviors (Veronie & Fruehstorfer, 2001; Williams & Potter, 1994). In contrast, the purpose of the Scapegoat is to displace attention from the alcoholic parent's behavior, reinforcing the prevalent implicit rule of denying the parent's substance abuse (Veronie & Fruehstorfer, 2001). The child assuming the role of Scapegoat often shows a preference for non-family activities and may have the strongest need for peer involvement and influence (Veronie & Fruehstorfer, 2001). The *Lost Child* role is often characterized as a child who appears withdrawn, one who may not fully develop social skills and tends to compensate by engaging in an active fantasy life (Veronie & Fruehstorfer, 2001). Finally, the *Mascot* role is described as a child who relies upon humor when facing challenging thoughts, feelings, or situations (Veronie & Fruehstorfer, 2001, Scharff et. al., 2003). A child in this role may have exaggerated awareness of his/her influence on others and may believe that survival is dependent on giving others

what they want or expect, which in an alcoholic home is a sense of light hearted comic relief. However, this external focus often results in the child not developing an awareness of his/her own needs (Veronie & Fruehstorfer, 2001, Woititz, 1983). Authors suggest that while these roles may be adaptive for children living in alcoholic homes, they become progressively more harmful as ACOAs move into adulthood (Scharff et. al., 2003).

Studies have found support for the concept of family roles as well as the influence of ACOA family roles on outcome measures. Longitudinal data suggests that a child's family role is stable across time (Veronie & Fruehstorfer, 2001). Additionally, Scharff et. al. (2003) reported statistically significant outcome data in a sample of ACOAs when measuring psychological stress levels using childhood family roles as a grouping variable. Regarding outcome variables, clinical disorders including antisocial, passive aggressive and drug dependent disorders, were found only in the Scapegoat group (Scharff et. al., 2003). However, the least adaptive group across all four roles was the Lost Child group, reaching sub-clinical levels of several disorders, including the highest number of symptoms for anxiety disorders, somatoform disorders, alcohol dependency, drug dependency, passive aggression, self-defeating behavior and debasement (Scharff et. al., 2003). Additionally, this study reported that participants identifying most with the Hero role produced the lowest number of symptoms across all dependent variables.

Adult Children of Alcoholics Relationships and Attachment

According to the literature, ACOAs may be at an increased risk for experiencing a myriad of issues related to interpersonal relationships. However, a recent search of peer reviewed journals only produced nine citations related to the study of ACOAs and adult

attachment. Previous studies have linked adult attachment styles to early familial experiences (Lease, 2002). Jaeger, Hahn and Weinraub (2000) suggested that attachment theory may be a compelling paradigm for understanding adjustment in ACOAs for two reasons. Primarily, attachment offers a framework through which a child's early psychological organization and subsequent development, throughout adulthood, may be understood. In addition, attachment theory suggests that how a child develops these systems of psychological organization is directly related to the level of responsiveness and nurturance provided by the parent (Jaeger, et. al., 2000). Clinically, parenting in alcoholic family systems has been related to a lack of nurturance, the denial of children's feelings and needs, the reversal of parent-child roles and, in extreme cases, emotional and physical abuse (Jaeger, et. al., 2000). The authors report that these are the same parental characteristics associated with the development of insecure attachment in children.

As children within alcoholic family systems, ACOAs often experience disruptive relational patterns of instability, resulting in problems with intimacy and trust (Beesley & Stoltenberg, 2002). Harter (2000) noted that research has shown ACOAs may experience; lower levels of relationship satisfaction, increased marital conflict, decreased marital satisfaction, decreased social support, decreased family cohesion, increased parental role stress, increased chance of having a romantic partner with a substance abuse problem, as well as, more problematic parenting strategies than non-ACOA populations. Additionally, based on her clinical experience, Woititz (1989) suggested that many ACOAs may bring childhood coping strategies into adult relationships. For example, as a result of the instability they experience in their families of origin, ACOAs may continue to feel a need to control others in their adult relationships.

Interpersonal relationship difficulties in ACOAs appear to span relationship across age groups and different types of relationships. For example, Flora & Chassin (2005) also found that ACOAs are less likely to be married and benefit less from the positive and protective factors associated with being in a committed romantic relationship. Another study examining the intrapersonal and interpersonal functioning in middle-aged female ACOAs indicated that when compared to a sample of non-ACOAs they reported lower levels of perceived social support, family cohesion and marital satisfaction (Domenico & Windle, 1993). Further research has suggested that ACOAs experience less secure attachment styles in both romantic and general adult relationships (Kelley et. al., 2005). ACOAs also endorsed higher levels of parental role distress and perceiving themselves as more powerless to control their children's behavior than non-ACOAs, suggesting these interpersonal difficulties may stretch into parent-child relationships.

Beesley & Stoltenberg (2002) suggested that ACOAs may experience additional challenges to establishing and maintaining interpersonal relationships due to the higher potential for experiencing limited access to models for healthy relationships. Kelley and colleagues also noted that children of alcoholics often experience inadequate parenting and negative parent-child interaction patterns (Kelley, Nair, Rawlings, Cash, Steer & Fals-Stewart, 2005). Research has shown that couples in which at least one parent met criteria for alcohol dependence demonstrated lack of empathy for their children's needs, advocated physical punishment, and often created an environment that promoted role reversal between parent and child (Gallant, Gorey, Gallant, Perry & Ryan, 1998). This absence of appropriate relational modeling may decrease ACOAs understanding of the

behaviors and traits necessary for establishing and maintaining adaptive relationships, including, intimacy, vulnerability, trust, honesty and mutual sharing (Beesley & Stoltenberg, 2002). As a result, research suggests that ACOAs may experience less secure attachment styles when compared with non-ACOAs (Vungkhanching, Sher, Jackson & Parra, 2004). Kelley and colleagues reported that in a sample of college students, those classified as ACOA reported significantly more fearful general adult attachment and more avoidant attachment behaviors in romantic relationships (Kelley et. al, 2005; Kelley, Cash, Grant, Miles & Santos, 2004). While ACOAs may desire intimate relationships, because of their childhood experiences of alcoholic attachment figures, they may have increased difficulty trusting others and anticipate rejection (Kelley et. al., 2005).

Additional research has explored ACOA interpersonal relationships in the context of specific family process variables. Larson & Reedy (2004) examined the effects of parental alcoholism on young adult romantic relationship quality, including trust, intimacy, commitment, and satisfaction, in the context of family process, including, cohesion, conflict resolution and family competence. Results suggested that young adults from alcoholic families that experienced more positive family processes, reported more positive relationship outcomes.

Al-Anon and Attachment

As discussed above, the underlying principles and practice of Al-Anon Family groups emphasize the importance of taking care of oneself, while caring for others in a healthy and appropriate manner. Al-Anon may be beneficial for ACOAs, in part, because it advocates for self-care, healthy detachment from others and perhaps improves ACOA

self schemas (Al-Anon Family Groups, 1997; Humphreys & Kaskutas, 1995). As well, the community support and ideals of helping others in a healthy and appropriate manner may alter for the better, internal cognitive working models of others. As a result based on Griffin and Bartholomew's model of adult attachment ACOAs who attend Al-Anon meetings may have more secure attachment styles than those who are not ACOA members.

Chapter Three

Methodology

This chapter details the methodology used in this dissertation study. It consists of a description of data collection, procedures, sample, and instruments. Included in this section are research questions and proposed hypotheses.

Procedures

The principal investigator first sought permission from the Institutional Review Board (IRB) at the University of Texas at Austin to conduct this study. Approval was granted by the review board in January 2008. This study was conducted in accordance with the University of Texas and the American Psychological Association ethical standards to assure the ethical treatment of all participants. Once approval from the IRB was obtained, participant recruitment began.

All study documents were completed online. A web based data collection strategy was used for several reasons. Research has reported several advantages to this format, for example; speed of completion, higher rates of response, convenience for respondents and lower costs (Thatch, 1995). In addition, this data collection modality allows for individuals to respond to questions outside the laboratory setting, allowing for a more naturalistic setting, which may help participants feel more comfortable, provide a stronger sense of anonymity and may decrease the chances that responses will be influenced by social desirability factors (McKenna & Bargh, 2000; Nosek et al., 2002). In addition, researchers have also compared data collected through internet and traditional methods. Findings indicated no difference in the level of accuracy or the

respondents commitment to completing the survey between these two modalities (Gosling, Vazire, Srivastava & John, 2004).

Participants were asked to log onto a website, on which the first page was the informed consent form for this study. Participants were directed to read the informed consent form and were provided contact information for Meredith Draper, M.Ed. and Alissa Sherry, PhD, as supervisor, for any questions or concerns. Additionally, the first page included instructions on how to proceed, asking respondents to acknowledge or deny consent to participate in this study.

If a participant consented to complete the study, he/she was redirected to the Children's Role Inventory (CRI), the Relationship Scales Questionnaire (RSQ), the Family of Origin Scale (FOS), and finally a demographics questionnaire page. As several demographic questions pertained to aspects of growing up in an alcoholic family, these questions were left until the end of data collection so as not to influence participants' answers to scale questions. Each web page of the survey had an *Exit the Study* link which took respondents to a debriefing page. This allowed participants to easily exit the study at any time, while still receiving debriefing information. For those who chose to complete the study, when all questionnaires were completed, a debriefing and explanation of the study was visible to all participants. This statement included contact information for the study Principal Investigators, Al-Anon Family Groups, and other mental health resources. In addition, participants from the subject pool were given the option to provide their email addresses, which was logged separately from their responses to ensure confidentiality. Email addresses of participants who entered the

study through the university subject pool were used to distribute verification of extra credit points.

Participants

The inclusion criteria for this study were as follows: 1) Age 18 or older and 2) participants must have resided in the United States. Three hundred and seventy six adults were recruited to participate in this study. See Table 1 for a summary of demographic data. One source included the Educational Psychology subject pool where participation in a study is an EDP course requirement. Other sources included online list-serves, message boards and related websites. Participation in this study was voluntary. Participants who were recruited through the university subject pool were offered one extra credit point for completing the study, to be used towards his/her grade in an undergraduate class in the Educational Psychology department. All data was collected in a confidential, online format. For subject pool participants receiving course credit, they were asked to enter their email addresses and a university identification code, for those recruited online, no identifying information was collected.

Overall Sample Demographics

Demographic results indicated that 52.1% (n=188) of the overall sample were recruited from the EDP subject pool, while 47.9% (n=172) came from IRB approved online invitations to complete the study. Overall participant's ages ranged from 18 to 73, where 62.5% were between the ages of 18 to 25; 14.3% were between the ages of 25-34; 11.9% were between the ages of 35-45; 7.3% were between the ages of 45-55; and 4% were over the age of 55. The breakdown of sex in the overall sample was 69.7% women and 29.5% men.

When asked to indicate their race the overall sample identified with the following groups; 66.5% Caucasian; 14.9% Asian American; 5.1% Hispanic/Latino/a; 1.1% identified African American and 10.6% identified themselves as other. Participants were also asked about the geographic region of the United States in which they resided at the time of the study. The majority of respondents were from the southwest (52.7%); 8.8% from the northeast; 17.3% from the southeast; 8% from the central United States; 9.8% from the Midwest and 2.7% from the northwest.

Approximately 44% of participants indicated a yearly income of $75,000 or higher, 13.7% reported earning $50,000 to $69,999 annually; 19.8% earned $30,000 to $49,999; 13.7% reported $10,000 to $29,999; 9.1% earned less that $10,000. When asked about their highest level of education completed, participants in the overall sample reported: 60.4% indicated some college; 13.3% completed a graduate degree; 14.1% had a college degree; 2.1% had some graduate school; 7.7% had a high school degree or equivalent; and .8% had some high school.

Participants were asked to report their marital status and the majority of participants (66.2%) indicated they were single never married; 4.3 % reported being divorced single; 17.3 % stated that were currently married; and 7.2% reported they were partnered. Participants were also asked about the marital status of their parents during childhood. In the overall sample they indicated; 2.1% grew up in a single parent home with no contact with the other parent; 18% reported that their parents had divorced and 1.1% were separated during their childhood; 77.2% of participants parents were married; and 1.6% reported their parents were partnered or lived together but were not married. A breakdown of sample demographic groups is seen in Table 1.

Table 1. Demographic Information 360 Adults Participating in Study, by Group.

	Overall Sample	ACOAs	Non-ACOAs
Recruitment Source			
Subject Pool	188 (52.1%)	7 (5.8%)	168 (70.3%)
Community	172 (47.9%)	114 (94.2%)	71 (29.7%)
Age			
18-25	225 (62.5%)	30 (24.8%)	187 (78.1%)
26-35	51 (14.3%)	27 (22.3%)	29 (12.2%)
36-45	43 (11.9%)	33 (27.3%)	11 (4.6%)
46-54	26 (7.3%)	21 (17.3%)	7 (3.0%)
55 and over	15 (4.0%)	10 (8.3%)	5 (2.1%)
Sex			
Female	251 (69.7%)	96 (79.3%)	160 (66.9%)
Male	109 (29.3%)	25 (20.7%)	79 (33.1%)
Marital Status			
Single	238 (66.2%)	50 (41.3%)	189 (77.4%)
Divorced (single)	15 (4.3%)	12 (9.9%)	6 (2.5%)
Married	62 (17.3%)	36 (29.8%)	29 (12.1%)
Partnered	26 (7.2%)	13 (10.7%)	14 (5.9%)
Widowed	19 (1.1%)	10 (2.5%)	1 (0.4%)
Highest Education			
Some high school	3 (0.8%)	2 (1.7%)	1 (0.4%)
High school degree	28 (7.7%)	10 (8.3%)	20 (8.4%)
Some college	217 (60.4%)	50 (40.5%)	162 (67.7%)
College degree	51 (14.1%)	33 (27.3%)	21 (8.8%)
Some graduate school	8 (2.1%)	1 (0.8%)	6 (2.5%)
Graduate degree	48 (13.3%)	25 (19.8%)	29 (12.1%)
Region			
Northeastern United States	32 (8.8%)	22 (18.2%)	14 (5.9%)
Southeastern United States	62 (17.3%)	28 (23.1%)	34 (14.2%)
Central United States	29 (8.0%)	1 (2.5%)	13 (10.5%)
Midwestern United States	35 (9.8%)	19 (15.7%)	15 (6.3%)
Northwestern United States	10 (2.7%)	10 (8.3%)	6 (2.5%)
Southwestern United States	190 (52.7%)	41 (32.2%)	157 (60.7%)
Annual Income			
Less than $10,000	33 (9.1%)	9 (7.4%)	22 (9.2%)
$10,000-$29,999	49 (13.7%)	26 (21.5%)	26 (10.9%)
$30,000-$49,999	71 (19.8%)	41 (33.9%)	29 (12.1%)
$50,000-$69,999	49 (13.7%)	19 (15.7%)	29 (12.1%)
$75,000 or higher	157 (43.7%)	26 (21.5%)	133 (55.6%)
Race			
Caucasian	239 (66.5%)	98 (81.0%)	147 (61.5%)
African American	4 (1.1%)	2 (1.7%)	2 (0.8%)
Asian American	54 (14.9%)	3 (2.5%)	52 (21.8%)
Hispanic	18 (5.1%)	5 (4.1%)	10 (4.2%)
Other	38 (10.6%)	13(7.4%)	28 (11.7%)
Caregiver Marital Status			
Single Parent	8 (2.1%)	5 (4.1%)	4 (1.7%)
Divorced	65 (18%)	40 (33.1%)	25 (10.5%)
Separated	4 (1.1%)	3 (2.5%)	1 (0.4%)

Married	278 (77.2%)	70 (57.9%)	207 (86.6%)
Partnered/Lived together	6 (1.6%)	3 (2.5%)	2 (0.8%)

Note: Sample size ACOA Group, n=121; sample size Non-ACOA Group, n=239.

ACOA Specific Demographics

Further demographic information was collected from individuals who self-identified as ACOAs, specifically pertaining to factors related to living with an alcoholic caregiver. These results are summarized in Table 4. Participants who self-identified as ACOAs were asked if they were members of Al-Anon Family groups. The majority of ACOA respondents indicated that they were not, 95.3%. For those who did endorse Al-Anon membership, they indicated attending an average of 11.2 meetings in the previous six months. ACOA participants were also asked to identify close relatives who they believed were alcoholics. Fathers, were the most identified group with 73.6% of ACOAs indicating their dads were alcoholics, as opposed to 26.4% who did not. Approximately 46% of ACOA respondents reported their mothers were alcoholics; 23.6% stated their grandfathers and 3.8% of their grandmothers were alcoholics. In addition, 8.5% of the ACOA group indicated that they had another close relative who they considered suffering from the disease of alcoholism.

ACOA group members were also asked about the other factors related to alcohol use in their homes growing up. When asked about their retrospective memory of the frequency of use by an alcoholic caregiver 70.8% of ACOAs recalled the family member drinking daily, 22.6% reported that person drinking three to five times per week and 6.3% noted use one to three times per week. In addition, ACOAs were asked to estimate the amount of alcohol their family member usually consumed at one sitting; 21.7% indicated 12 or more drinks; 41.5% estimated 6-12 drinks; 30.2% indicated 3-5 drinks

and 1.9% endorsed one to two drinks. Furthermore, 29.2% of ACOAs reported that other drugs were used in their home as children, in addition to alcohol. On average, ACOAs reported that their alcoholic caregiver drank for 16.35 years and the mean length of time ACOAs reported living with their alcoholic caregiver was 17.48 years during childhood. Finally, 37.1% of ACOAs indicated that their alcoholic caregiver had entered recovery at some point. The average age ACOAs reported experiencing a caregiver enter recovery from alcoholism was 22.8.

Table2 . Demographics Specific to ACOA Group.

Al-Anon Membership	116 (95.3%) 5 (4.7%)	Not a member Member
For Al-Anon Members Avg. # of meeting attended in the last 6 months	11.2	
Identified mother as an alcoholic	55 (45.7%) 66 (53.8%)	Yes No
Identified father as an alcoholic	89 (73.6%) 32 (26.4%)	Yes No
Identified grandmother as an alcoholic	5 (3.8%) 116 (95.3%)	Yes No
Identified grandfather as an alcoholic	29 (23.6%) 92 (75.5%)	Yes No
Identified other relative as an alcoholic	10 (8.5%) 111 (91.5%)	Yes No
Frequency of drinking by alcoholic caregiver	86 (70.8%) 27 (22.6%) 8 (6.3%)	Daily 3-5 times per week 1-3 times per week
Amount consumed at sitting by alcoholic caregiver	26 (21.7%) 50 (41.5%) 37 (30.2%) 8 (1.9%)	12 or more drinks 6-12 drinks 3-5 drinks 1-2 drinks
Other drugs used in the home	35 (35.8%)	Yes

	86 (64.2%)	No
Average # of years caregiver drank during ACOA childhood	16.35	
Average # of years ACOA lived with alcoholic caregiver	17.48	
Caregiver enter recovery	45 (37.1%)	Yes
	76 (62.9%)	No
Average age of ACOA if caregiver entered recovery	22.8	

Note: N=121

Measures

A summary of the instrumentation used in this study may be found in Table 4. Once participants have acknowledged consent to participate in this study, they will be asked to complete the following measures: (1) a sixty-item instrument that measures a respondent's retrospective report of his/her role as a child in his/her family of origin across four possible roles theory suggests are frequently found in alcoholic family systems (Potter & Williams, 1991); (2) a thirty-item questionnaire that measures adult attachment style across four dimensions (Griffin & Bartholomew, 1994a); and (3) a forty-item instrument that measures a respondent's retrospective account of the psychological health of his/her family of origin (Hovestadt et. al., 1985); (4) a six item instrument that will be used to determine ACOA/non-ACOA status (Hodgins, Maticka-Tyndale, El-Guebaly & West, 1993); (5) a set of demographic questions as seen in Appendix F;.

Table 3. Summary of Instruments

Instrument	Number of Items	Response Format	Possible Range of Scores
Children's Role Inventory	60	Likert (1-5)	4 Subscale Scores
Relationship Scales Questionnaire	30	Likert (1-5)	4 Subscale Scores
Family of Origin Scale	40	Likert (1-5)	40-200
CAST-6	6	Dichotomous Yes/No	1-6

The Children's Roles Inventory (See Appendix B): Based on the work of Black (1982) and Weigscheider (1981), the Children's Roles Inventory (CRI: Potter & Williams, 1991) was designed to assess the theoretical four roles children may internalize when raised in an alcoholic family system. Potter & Williams (1991) noted that at the time the scale was developed, clinical literature and theory had established the existence of four patterns of coping that children in alcoholic family systems may assume as an adaptive measure to cope with unhealthy family dynamics. However, very little research had been completed to validate the actual existence and/or impact of these roles. The authors indicated that this scale was developed to provide researchers and clinicians a paper and pencil instrument to measure these four roles (Potter & Williams, 1991). The four children's roles include: the Hero, who attracts positive attention through achievement related behaviors; the Mascot, who attempts to draw attention away from the family problems through clown-like behavior; the Lost Child, who may be described as a wallflower, quiet and withdrawn, and the Scapegoat, who attracts attention through acting out, or negative behaviors (Potter & Williams, 1994).

Scale development initially included 100 items that were sent to five psychologists specializing in the treatment of alcoholic family systems (Potter &

Williamson, 1991). These experts were asked to identify the statements with one of the four children's roles (i.e. Hero, Mascot, Lost Child and Scapegoat) to determine items that would fit into four distinct categories. Further analysis lead to the deletion of 40 items, yielding 60 items that were shown to delineate between the four roles (Potter & Williams, 1991; Williams & Potter, 1994). The final version of the CRI included 60-items divided across four subscales (Potter & Williams, 1991; Williams & Potter, 1994). Participants are asked to rate on a 5-point Likert-type scale, to what extent each statement describes them as children. Reliability for each subscale has been reported as: Hero .93, Mascot .90, Lost Child .95 and the Scapegoat .95 (Potter & Williams, 1991).

Table 4. Children's Role Inventory

Subscale	Number of Items	Response Format	Possible Range of Scores
Hero	15	Likert (1-5)	15-75
Mascot	15	Likert (1-5)	15-75
Lost Child	15	Likert (1-5)	15-75
Scapegoat	15	Likert (1-5)	15-75

Relationship Scales Questionnaire (See Appendix C): Adult attachment will be measured using the Relationship Scales Questionnaire (RSQ: Griffin & Bartholomew, 1994a). The RSQ is a 30-item scale influenced by the Adult Attachment Scale (Collins & Read, 1990), the Relationship Questionnaire (Bartholomew & Horowitz, 1991), and Hazan and Shaver's (1987) attachment instrument. Seventeen of the thirty items on the RSQ make up the subscales for the four category attachment model.

The RSQ was developed as a continuous measure to create an attachment profile consistent with Griffin and Bartholomew's (1994) four-dimension model of adult attachment. Based on Bowlby's attachment theory, which argued that based on interactions with primary caregivers, infants develop internal positive and negative

working models of self and others, Griffin and Bartholomew (1994) argue that adult attachment should be conceptualized on a similar intersecting continuum. As a result, respondents' scores create an attachment profile, where each respondent has a score on each dimension, rather than assignment to a specific attachment type.

Respondents are asked to rate, on a 5-point Likert scale, the extent to which each statement matches their experiences in close interpersonal relationships. The scale produces a mean score for each of the four dimensions of adult attachment. Internal consistency has been shown to range from alpha = .41 for the secure group to alpha = .70 for the dismissing group. Griffin & Bartholomew (1994b) reported that internal consistencies for the RSQ are variable and can be low because two orthogonal dimensions (self-model and other-model) are being combined. The RSQ has been shown to have excellent convergent validity with interview prototype ratings with direct self-report and indirect self-report ratings of the Relationship Questionnaire and the RSQ (Griffin & Bartholomew, 1994b; Kelley et. al., 2005).

Table 5. Relationship Scales Questionnaire

Subscale	Number of Items	Response Format	Possible Range of Scores
Secure	5	Likert (1-5)	5-25
Preoccupied	4	Likert (1-5)	4-20
Fearful	4	Likert (1-5)	4-20
Dismissing	5	Likert (1-5)	5-25

The Family-of-Origin Scale (See Appendix D): The Family-of-Origin Scale is a 40 item self report instrument designed to measure a respondent's retrospective perceptions regarding the health of his/her family of origin (Hovestadt et. al. 1985). The FOS is based on the family systems theoretical perspective that differentiation as supported by one's family of origin is an important factor in a person's ability to develop

autonomy, a sense of self separate from one's family of origin, while being able to maintain intimacy, a sense of connection with others. The FOS assesses information from respondents across two main domains, autonomy and intimacy.

The FOS also includes 10 subscales, five under each of the two main domains. The autonomy domain subscales were developed to capture data to indicate the level at which a family of origin emphasized the following five constructs: clarity of expression, responsibility, respect for others, openness to others and acceptance of separation and loss. Additionally the intimacy subscales attempt to describe the extent to which a family of origin supported; expression of a range of feelings, the creation of a warm home environment, coping with conflict without undue stress, promoting a sensitivity/empathy towards others and the development of trust in others (Hovestadt et. al., 1985). The scale may produce an overall score to indicate global family of origin health, as well as 10 subscale scores. Reliability of the overall family of origin scale score has been reported in a test-retest coefficient of .97, across a two week period (Hovestadt et. al, 1985; Corcoran & Fischer, 2000; Campbell, Masters & Johnson, 1998). Test-retest reliability for the autonomy subscales ranged from .39 to .88, with a median of .77. Additionally, test-retest reliability for the intimacy subscales were reported ranging from .46 to .87 with a median of .73 (Corcoran & Fischer, 2000). The FOS has been shown to discriminate between clinical and non-clinical populations (Lee, Gordon & O'Dell, 1989; Neidermeier, Searright, Handal, Manley & Brown, 1995). Some debate exists in the literature regarding construct validity and the number of distinct factors present in the FOS exists, with some authors suggesting the FOS measures a unidimensional or bidimensional construct (Lee et. al., 1989, Kline & Newman, 1994). However, more

recent research argued that this is an oversimplification of the scale's utilization and supported the original structure of the scale (Schouten, 1996).

For the purposes of this study, the FOS 10 subscales will be used in analysis of all data. As research conducted by Schouten (1996) and Hovestadt and his colleagues suggested and theory supports, the psychological health of a family is likely due to multiple factors. As such, use of the ten subscales may provide more detailed information regarding what factors within an ACOA's family of origin affect what children's role, as measured by the CRI, they adopt. Additionally, use of the ten subscales may help create more a more detailed conceptualization of family factors that influence heterogeneity in ACOAs.

Table 6. Family of Origin Scale

Subscale	Number of Items	Response Format	Possible Range of Scores
Autonomy			
• Clarity of Expression	4	Likert (1-5)	4-20
• Personal Responsibility	4	Likert (1-5)	4-20
• Respect for Others	4	Likert (1-5)	4-20
• Openness to Others in the Family	4	Likert (1-5)	4-20
• Acceptance of Separation and Loss	4	Likert (1-5)	4-20
Intimacy			
• Expression of a Range of Feelings	4	Likert (1-5)	4-20
• Mood and Tone of Home	4	Likert (1-5)	4-20
• Dealing with Conflict Resolution	4	Likert (1-5)	4-20
• Promoting Sensitivity or Empathy	4	Likert (1-5)	4-20
• Developing Trust	4	Likert (1-5)	4-20

The Children of Alcoholics Short Form (See Appendix E): The Children of Alcoholics Short-Form (CAST-6) was derived from the original 30 item form developed by Pilat and Jones (1984). Noting the importance of identification of children of

alcoholics within clinical settings to provide early intervention for children and adults potentially at risk of developing negative symptoms associated with growing up with an alcoholic caregiver, Pilat & Jones (1984) developed the full CAST. The original CAST is a 30 item inventory designed to measure respondents' feelings, attitudes, perceptions and experiences related to their parents' drinking behavior. Several studies across a variety of settings and populations have judged the full CAST to be a reliable and valid measure (Pilat & Jones, 1984; Staley & el-Guebaly, 1991; Charland & Cote, 1998; Sheridan, 1994). However, Hodgins and colleagues (1993) noted that, while clinically useful, the large number of items in the full CAST was unnecessary for ACOA identification purposes in research settings. As such, the CAST-6 was developed as a 6 item measure meant for use to differentiate children of alcoholics from those who did not grow up in a home with an alcoholic caregiver.

Initial development of the CAST-6 included study from three distinct populations (Hodgins, et. al., 1993). Authors reported the first group was recruited from individuals seeking outpatient psychotherapy within a hospital based program. The second group included individuals seeking psychotherapy within a substance abuse program in a community based mental health clinic. The third group was recruited from a sample of medical student participating in a larger study of attitudes towards substance abuse. Hodgins and his colleagues utilized principle components factor analysis to assist in identifying items from the full CAST that would discriminate between ACOA and non-ACOA's within all three samples. Researchers reported that simple structure was maximized using varimax rotation. Results yielded six items from the full CAST that successfully differentiated ACOA from non-ACOA participants across all groups.

Internal consistency of the six items was assessed comparing item-total correlations for this and the full 30 item scale. In addition, Hodgins and his colleagues reported Chronbach's alpha. Item-total correlations for the CAST-6 was reported as ranging from .62-.89 across the three groups of respondents and correlations between the CAST-6 and the full form ranges from .92-.94, suggesting strong internal consistency in the short form. Furthermore, analysis suggested that a cutoff score of 3 or higher was sufficient to differentiate ACOA from non-ACOA's within their sample.

Table 7. Children of Alcoholic Screening Test – Short Form (CAST-6)

	Number of Items	Response Format	Possible Range of Scores
CAST – 6	6	Dichotomous (Yes/No)	1- 6 with a cutoff of 3 or higher for ACOA status

Reliability of Measures in Current Study

Scores on all measures used were examined for internal consistency (reliability) and distributional normality. Scales were analyzed for distributional normality utilizing a measure of skewness. All scale scores met the normality assumption. A summary of internal consistency data is seen in Table 13. As is evident from the table, internal consistency for all measures ranged from alpha=0.39 to 0.98, with the majority falling above 0.80. Results from Chronbach's Alpha indicated moderate to strong reliability of all measures, with the exception of the Preoccupied Scale (alpha=0.39) of the Relationship Questionnaire (RSQ). These results are consistent with Griffin & Bartholomew's (1994b) reports that internal consistencies for the RSQ are variable and can be low because two orthogonal dimensions (self-model and other-model) are being combined.

Table 8. Summary of Internal Consistency of Instruments.

Instrument	**Chronbach's Alpha**
Children's Role Inventory (CRI) [a]	
Hero Subscale	0.90
Scapegoat Subscale	0.92
Mascot Subscale	0.91
Lost Child Subscale	0.92
The Relationship Questionnaire (RSQ) [b]	
Secure Subscale	0.50
Fearful Subscale	0.83
Preoccupied Subscale	0.39
Dismissing Subscale	0.58
Family of Origin Scale (FOS) [c]	
Clarity of Expression Subscale (CE)	0.72
Responsibility Subscale (R)	0.85
Respect for Others Subscale (RO)	0.86
Openness to Others Subscale (O)	0.87
Acceptance of Separation and Loss Subscale (A)	0.90
AUTONOMY (conglomerate of 5 subscales)	0.95
Expression of a Range of Feelings Subscale (RF)	0.86
Mood and Tone of Home Subscale (MT)	0.92
Dealing with Conflict Resolution Subscale (C)	0.90
Promoting Sensitivity or Empathy Subscale (E)	0.88
Developing Trust Subscale (T)	0.81
INTIMACY (conglomerate of 5 subscales)	0.94
FOS TOTAL	0.98
Children of Alcoholics Screening Test (CAST-6) [d]	0.94

Note. N= 360.

Research Hypotheses

Part 1 – Examination of within group heterogeneity of adult children of alcoholics (ACOA) sample

Research Question 1: Do ACOAs who endorse membership to Al-Anon family groups differ in attachment style (RSQ), family of origin psychological health (FOS) and children's role (CRI) than non-Al-Anon ACOAs?

As relatively few studies have been conducted comparing ACOAs that attend Al-Anon meetings and non-Al-Anon ACOAS, a preliminary analysis was proposed to determine whether statistically significant differences exist between these two groups. If the two groups were similar, they would be pooled for the remaining analysis. However, if statistically significant differences are detected further analyses will be completed separately.

As discussed above, the underlying principles and practice of Al-Anon Family groups may be beneficial for ACOAs, in part, because they advocate for self-care, health detachment from other and perhaps improve ACOA self schemas (Al-Anon Family Groups, 1997; Humphreys & Kaskutas, 1995). As well, the community support and ideals of helping others in a healthy and appropriate manner may alter for the better, internal cognitive working models of others. As a result, ACOAs who attend Al-Anon meetings may have more secure attachment styles than those who are not ACOA members. In addition, individuals who seek out Al-Anon membership may be different than those who chose not to seek out such help, prior to group membership. Further differences may be seen in ACOAs who are Al-Anon members in the areas of family of origin psychological health and adopted family roles. ACOAs whose families

engendered more trust in others and a greater sense of empathy for others may be more comfortable seeking assistance from others. Additionally, ACOAs who adopted the hero and mascot role may also be more likely to seek outside help because they are more likely to have had positive experiences of others, unlike ACOAs who adopted the lost child or scapegoat roles.

Hypothesis 1: ACOAs Al-Anon membership will be related to more secure attachment styles (RSQ), higher levels of family of origin health (FOS) and higher scores on the Hero and Mascot role subscales (CRI).

Hypothesis 2: ACOA non-Al-Anon membership will be associated with less secure attachment styles (RSQ), lower levels of family of origin psychological health (FOS) and higher scores on the Lost Child and Scapegoat subscales (CRI).

Differentiation of ACOA Children's Roles

Research Question: Do scores on the four attachment dimensions (RSQ) and the Family of Origin Scale (FOS) describe separation between the four family role groups (CRI)?

Debate exists in the literature regarding the etiology of heterogeneity within ACOAs as a group. As suggested by Scharff et. al. (2004), one explanation for the variance within this population may be the role a child takes on within his/her family of origin (i.e. Hero, Mascot, Lost Child or Scapegoat). Research using these children's roles as a grouping variable has reported some significant differences in psychological health measures in ACOAs, supporting the assertion that a child's role within an alcoholic family of origin may differentiate the children of alcoholics as adults (Alford, 1998; Scharff et. al., 2004).

Previous research has also found that one main area of difficulty for ACOAs is experiencing and maintaining satisfying interpersonal relationships (Harter, 2000; Woititz, 1983; Jacob et. al, 1999). As one's adult attachment style may influence the quality of such relationships, adult attachment style may be a relevant variable to explore potential differences within ACOAs based on their respective children's role. Additionally, as one's attachment style is developed early in childhood and is thought to be primarily based on a child's experience of his/her primary caregivers, this study will also explore to what extent the psychological health of respondents' families of origin, as measured by the Family of Origin Scale, may discriminate between children's roles (i.e. Hero, Mascot, Lost Child and Scapegoat).

Hypothesis 3: ACOAs in the Hero role will be related to secure attachment to a greater extent than the other three family roles. Additionally, participants in the Hero group will report higher levels of responsibility, respect for others and a family which engendered trust in others to a great extent that the three other groups.

Hypothesis 4: ACOAs in the Mascot role will be related to preoccupied attachment to a greater extent than the other three family roles. Furthermore, respondents in this group will report lower levels of acceptance of separation and loss than the other three groups and high levels of ability to deal with conflict within their families of origin than those in the Scapegoat or Lost Child groups.

Hypothesis 5: ACOAs in the Lost Child role will be related to fearful attachment to a greater extent than the other three family roles. Additionally, participants in this group will report family of origin functioning that included a lower quality of mood and

tone, lower levels of engendering trust in others and lower levels of respect for others in their families of origin, than the other three groups.

Hypothesis 6: ACOAs in the Scapegoat role will be related to dismissing attachment to a greater extent than the other three family roles. Individuals responding in this group will also report lower levels of promotion of empathy/sensitivity and lower levels of engendering trust in others within their families of origin than the Hero or Mascot groups. Additionally, this group will report lower levels of respect for others and responsibility within their families of origin that any other the other groups.

Hypothesis 7: Participants whose responses on the CRI indicate more identification with the Hero role will be predicted by families of origin in which there were higher levels of responsibility and respect for others reported and who also report a more secure attachment style.

Hypothesis 8: Participants whose responses on the CRI indicate greater identification with the Lost Child role will be predicted by families of origin in which there were less positive mood and tones, lower levels of development of trust in others, lower levels of separation and loss and lower levels of respect for others in their families of origin, and respondents that report a more fearful attachment style.

Hypothesis 9: Participants whose responses on the CRI indicate greater identification with the Mascot role will be predicted by families of origin in which there were lower levels of positive conflict resolution and respondents that report a more preoccupied attachment style.

Hypothesis 10: Participants whose responses on the CRI indicate greater

identification with the Scapegoat role will be predicted by families of origin in which there were lower levels of respect for others, clarity of expression, development of trustworthiness in others and promoting empathy and respondents that report a more dismissing attachment style.

Part 2 – Examination of between group differences of adult children of alcoholics (ACOAs) and non-adult children of alcoholic (Non-ACOAs) samples

Research Question: To what extent do significant differences exist between adult children of alcoholics and adults who do not endorse growing up with an alcoholic caregiver, on dimensions of adult attachment style (RSQ)?

According to the literature, ACOAs may be at an increased risk for experiencing a myriad of issues related to interpersonal relationships. Interpersonal relationship difficulties in ACOAs appear to span relationships across age groups and different types of relationships. For example, Flora & Chassin (2005) also found that ACOAs are less likely to be married and benefit less from the positive and protective factors associated with being in a committed romantic relationship. Another study examining the intrapersonal and interpersonal functioning in middle-aged female ACOAs indicated that when compared to a sample of non-ACOAs they reported lower levels of perceived social support, family cohesion and marital satisfaction (Domenico & Windle, 1993). Further research has suggested that ACOAs experience less secure attachment styles in both romantic and general adult relationships (Kelley et. al., 2005). ACOAs also endorsed higher levels of parental role distress and perceiving themselves as more powerless to control their children's behavior than non-ACOAs, suggesting these interpersonal difficulties may stretch into parent-child relationships.

Beesley & Stoltenberg (2002) suggested that ACOAs may experience additional challenges to establishing and maintaining interpersonal relationships due to the higher potential for experiencing limited access to models for healthy relationships. Kelley and colleagues also noted that children of alcoholics often experience inadequate parenting and negative parent-child interaction patterns (Kelley, Nair, Rawlings, Cash, Steer & Fals-Stewart, 2005). Research has shown that couples in which at least one parent met criteria for alcohol dependence demonstrated lack of empathy for their children's needs, advocated physical punishment, and often created an environment that promoted role reversal between parent and child (Gallant, Gorey, Gallant, Perry & Ryan, 1998). This absence of appropriate relational modeling may decrease ACOAs understanding of the behaviors and traits necessary for establishing and maintaining adaptive relationships, including, intimacy, vulnerability, trust, honesty and mutual sharing (Beesley & Stoltenberg, 2002). As a result, research suggests that ACOAs may experience less secure attachment styles when compared with non-ACOAs (Vungkhanching, Sher, Jackson & Parra, 2004). Kelley and colleagues reported that in a sample of college students, those classified as ACOA reported significantly more fearful general adult attachment and more avoidant attachment behaviors in romantic relationships (Kelley et. al, 2005; Kelley, Cash, Grant, Miles & Santos, 2004). While ACOAs may desire intimate relationships, because of their childhood experiences of alcoholic attachment figures, they may have increased difficulty trusting others and anticipate rejection (Kelley et. al., 2005).

Additional research has explored ACOA interpersonal relationships in the context of specific family process variables. Larson & Reedy (2004) examined the effects of

parental alcoholism on young adult romantic relationship quality, including trust, intimacy, commitment, and satisfaction, in the context of family process, including, cohesion, conflict resolution and family competence. Results suggested that young adults from alcoholic families that experienced more positive family processes, reported more positive relationship outcomes.

Hypothesis 1: Adults who are identified as adult children of alcoholics (ACOAs) will endorse significantly less secure attachment styles (RSQ) when compared with adults who reportedly did not grow up with an alcoholic caregiver.

Chapter four will address statistical analyses and results related to each research question and hypothesis.

Chapter Four

Results

The first goal of this study was to explore the potential influence of Al-Anon membership on adult attachment style within adult children of alcoholics (ACOAs). The second goal of this study was to explore whether the roles ACOAs adopted in their family of origin (i.e. Hero, Scapegoat, Mascot or Lost Child) could be utilized to explain heterogeneity of this population, using adult attachment style (RSQ) and retrospective family of origin health (FOS) as outcome variables. Finally, this study aimed to explore potential differences in the adult attachment styles of ACOAs and respondents who did not grow up in a home with an alcoholic caregiver. This chapter presents the results of the study and its goals.

Prior to discussing the main goals of this study, descriptive information regarding the current study's sample is provided. As described earlier in the methods chapter, results are delineated by the primary grouping variable identifying ACOAs from non-ACOAs. ACOA group status was given to respondents who both self-identified as ACOAs and also endorsed items yielding a score of three or higher on the Child of Alcoholics Screening Test, Short Form (CAST-6). Demographics of the ACOA group indicated that respondents in the sample were predominantly Caucasian (81%), female (79.3%), many with some college or higher in education level (88.4%) and their ages ranged from 18 to 73. The majority of participants in the ACOA group endorsed being single or divorced (51.2%) and approximately 40% of the sample endorsed growing up in a single parent household, either as a result of divorce or no contact with the second

parent. ACOA respondents endorsed geographic locations across the United States, with the largest percentage (32.2%) living in the southwestern part of the country.

The non-ACOA group was also comprised of predominantly Caucasian (61.5%) females (66.9%). This group was also relatively well educated, with the majority of the sample (91.1%) endorsing completing some college or higher. The non-ACOA group was also predominantly single (79.9%); however, in contrast to the ACOA group, the majority of non-ACOA's (87.4%) endorsed growing up in intact homes with their parents either married or living together. Non-ACOA respondents also endorsed geographic locations across the United States, with the largest percentage (60.7%) living in the southwestern part of the country.

A summary of responses from the both groups of the main measures utilized in the study appears in Tables 9 through 12. Responses to the single item question of self-identification as an ACOA for the entire sample are summarized in Table 13.

Table 9. Summary of subscale means and standard deviations for ACOA and Non-ACOA Group scores on Children's Role Inventory.

	ACOA GROUP			NON ACOA GROUP		
Instrument	N	M	SD	N	M	SD
Children's Role Inventory (CRI) [a]						
Hero Subscale	121	54.22	11.29	239	58.55	7.89
Scapegoat Subscale	121	36.52	13.02	239	32.05	9.44
Mascot Subscale	121	47.37	9.67	239	49.35	8.40
Lost Child Subscale	121	44.91	12.53	239	38.57	11.41

Note. N=360 *a*. Responses ranged from 1 (strongly disagree) to 5 (strongly agree).

Table 10. Summary of subscale means and standard deviations for ACOA and Non-ACOA Group scores on The Relationship Questionnaire.

	ACOA GROUP			NON ACOA GROUP		
Instrument	N	M	SD	N	M	SD
The Relationship Questionnaire (RSQ) [a]						
Secure Subscale	121	14.52	3.37	239	16.57	3.26
Fearful Subscale	121	14.48	3.75	239	10.58	3.56
Preoccupied Subscale	121	11.68	3.24	239	10.93	2.73
Dismissing Subscale	121	17.67	2.62	239	16.22	2.61

Note. N=360 *a*. Responses ranged from 1 (not at all like me) to 5 (very much like me).

Table 11. Summary of Item means and standard deviations for ACOA and Non-ACOA Group scores on The Family of Origin Scale.

	ACOA GROUP			NON ACOA GROUP		
	N	**M**	**SD**	**N**	**M**	**SD**
Instrument						
Family of Origin Scale (FOS) [c]						
Clarity of Expression Subscale (CE)	121	10.35	2.49	239	14.00	3.29
Responsibility Subscale (R)	121	6.40	2.59	239	10.30	2.49
Respect for Others Subscale (RO)	121	10.22	3.84	239	14.02	3.93
Openness to Others Subscale (O)	121	9.62	3.69	239	13.94	3.69
Acceptance of Separation and Loss Subscale (A)	121	9.53	3.95	239	14.10	3.76
AUTONOMY (conglomerate of 5 subscales)	121	46.14	13.57	239	66.38	15.28
Expression of a Range of Feelings Subscale (RF)	121	9.92	3.84	239	16.02	3.47
Mood and Tone of Home Subscale (MT)	121	10.56	1.83	239	13.66	2.50
Dealing with Conflict Resolution Subscale (C)	121	7.75	2.79	239	13.41	3.93
Promoting Sensitivity or Empathy Subscale (E)	121	9.32	3.31	239	14.54	3.65
Developing Trust Subscale (T)	121	10.59	3.58	239	14.59	3.22
INTIMACY (conglomerate of 5 subscales)	121	48.15	13.47	239	72.23	14.78
FOS TOTAL	121	94.30	26.02	239	138.61	29.45

Note. N=360. Higher scores are indicative of reporting more positive family health. *a*. Responses ranged from 1 (Strongly disagree) to 5 (strongly agree).

Table 12. Summary of Item means and standard deviations for ACOA and Non-ACOA Group scores on The Child of Alcoholic Screening Test-Short Form..

	ACOA GROUP			NON ACOA GROUP		
	N	**M**	**SD**	**N**	**M**	**SD**
Instrument						
Children of Alcoholics Screening Test (CAST-6) [d]	121	5.30	0.88	239	0.24	0.60

Note. N=360. *a*. Response options were yes/no.

Table 13. Summary of Single Item Question Used in Analyses.

Question	Yes	No
Do you self-identify as adult child of an alcoholic? [a]	31.5%	68.5%

Note. N= 360. *a*. Responses ranged from 1(Yes) to 2 (No).

As demonstrated in the tables above, there were some similarities and notable differences in mean scores between the ACOA and non-ACOA groups. Table nine indicates that ACOA and non-ACOA group mean scores on subscales from the Children's Role Inventory (CRI) were similar. However, a cursory review of mean scores on the Relationship Questionnaire (RSQ) and the Family of Origin Scale (FOS) indicate some differences between the groups which will be addressed in further analyses later in this chapter.

Part I – Examination of Within Group Heterogeneity of Adult Children of Alcoholics (ACOA) Sample

This section presents statistical analyses regarding within group differences, in relation to childhood role, family of origin health and adult attachment, within the ACOA sample.

Research Question One: Do ACOAs who endorse membership to Al-Anon family groups differ in attachment style (RSQ), family of origin psychological health (FOS) and children's role (CRI) from non-Al-Anon ACOAs?

The initial proposal of this study included exploratory analysis for within group differences between ACOAs who attend Al-Anon and those who did not endorse Al-Anon membership. However, these analyses could not be completed as out of the entire ACOA sample (n=121), only five participants endorsed Al-Anon membership. Several

Al-Anon groups and listservs were contacted for recruitment in this study; however, these requests were turned down. Contacts cited Tradition 12 in the Al-Anon literature which states, "Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles above personalities." (Al-Anon Family Groups, 1997, p.132). As such, this prevented direct recruitment of Al-Anon members. Research has cited this issue in the past in relation to collecting data from 12-step group members and it has been noted that most research with this population has been completed with inpatient preexisting groups or clinical trials in which an "Al-Anon based" group experience is created (Humphreys & Kaskutas, 1995; Room & Greenfield, 1993; Miller, et. al., 1999). As such, this study adds evidence that it remains difficult to capture data from this population and as such, ACOA exploratory analyses for within group differences (i.e. Al-Anon members vs. non-Al-Anon members) were not completed.

Research Question Two: Do scores on the four attachment dimensions (RSQ) and the Family of Origin Scale (FOS) describe separation between the four family role groups (CRI)?

Hypotheses purported that less secure attachment styles (RSQ) will be associated with group membership to the Lost Child and Scapegoat, whereas, more secure attachment styles will be predictive of the Hero and Mascot groups (CRI). In addition, it was hypothesized that certain aspects of retrospective family of origin health (FOS) will be predictive of each group. Initially the ACOA sample was separated into four groups representing the role they endorsed taking as a child in their family of origin. These groups were based on participants' responses on the Children's Role Inventory (i.e. Hero, Mascot, Lost Child and Scapegoat). Additionally descriptive discriminant analysis

(DDA) was conducted to evaluate the extent to which ACOAs adult attachment style and reports of health in their family of origin, would predict group membership into one of the four childhood roles.

ACOA Group Membership Based on Children's Role Inventory (CRI)

While all respondents, ACOA and non-ACOA completed the Children's Role Inventory (CRI), scores from this measure were ``only used as the primary grouping variable for within group analyses of the ACOA sample. As discussed in chapter three, the CRI yields four subscale scores for each respondent. Each of the four subscales measures attributes associated with one of the four family roles research suggests children may adopt within alcoholic family systems: the Hero, the Mascot, the Scapegoat and the Lost Child. A participant's group assignment was determined by a clear two point difference in subscale scores across the four roles. Data from participants whose CRI scores did not meet these criteria were not included in the data analysis. Results of the CRI grouping are detailed in Table 14.

Table 14. Summary of family role grouping based on CRI scores in ACOA sample.

Assigned Family Role	Percentage	N
Hero	52.1%	63
Mascot	17.4%	21
Scapegoat	9.1%	11
Lost Child	21.5%	26

Note. N= 121

As is evident from Table 14, the distribution of ACOA participants between the four groups based on the CRI was somewhat skewed. Results indicated over half of all ACOA respondents identifying with the Hero role, followed by the Lost Child (21.5%) and Mascot (17.4%) roles; and finally the Scapegoat group (9.1%). The distribution of

participants in each group is consistent with attributes and research regarding the four family roles.

Research suggests that individuals who identify with the Hero group endorse items associated with over-performance and may have learned to "…attract positive attention through achievement-related behaviors" (Williams & Potter, 1994, p. 418). As such, due to demand characteristics associated with research respondents, this group may be more likely volunteer to complete surveys in an online setting. In addition, almost half (47.9%) of ACOA respondents reported having a college or graduate degree. Completing these levels of education is also consistent with a larger proportion of individuals identifying with the Hero role, as the attributes of being achievement oriented associated with this role may assist these individuals in academic settings. Additionally, research suggests that children of alcoholics that identify with the Scapegoat role often exhibit oppositional and defiant behaviors. Theory suggests that this may be a result of learning to cope with the family environment by acting out in an attempt to displace attention from the alcoholic parent's behavior (Veronie & Fruehstorfer, 2001; Williams & Potter, 1994). As such, individuals who identify with this role may be less likely to volunteer to complete a research study and may also be more likely to complete a lower level of education.

The percentage of ACOA participants identifying with the Lost Child and Mascot roles is also consistent with theoretical and research based descriptions of these roles. As ACOAs were recruited through online message boards and listservs related to addiction, it may be that the social withdrawal associated with the Lost Child role leads individuals who identify with the role more comfortable looking for support and expressing

themselves in an online, anonymous format. This may have increased their likelihood of participating. In addition, as the Mascot role is associated with individuals who may have an overdeveloped sense of others needs. As such, respondents identifying with this group may have been more likely to respond to a request to complete a survey for a graduate student asking for volunteers.

Descriptive Discriminant Analysis (DDA) was used to provide a more detailed description of the ACOA sample. Sherry (2006) indicated that DDA was an alternate multivariate choice to Multivariate Analysis of Variance (MANOVA) and may be preferable under some circumstances. First, while MANOVA is able to detect the existence of overall group differences using multiple dependent variables, if significant, it requires the use of follow up testing to determine where and to what extent these differences existed among the dependent variables. Use of follow up testing may increase the Type I error rate. However, DDA is able to detect both existence of group differences as well as where the differences lie with one statistical procedure, therefore avoiding a potential increase in the Type I error rate through the use of follow up testing. DDA provides an additional advantage for this analysis over MANOVA, as it considers all factors simultaneously, while taking into account relationships between dependent variables.

Initially it was proposed that a DDA would be run including fourteen variables of adult attachment (RSQ) and family of origin (FOS) subscales to describe potential differences between the group membership of a prescribed child role (CRI) (i.e. Hero, Scapegoat, Mascot or Lost Child). In other words, examining how the four child roles may be different in terms of attachment and family of origin. However, one assumption

of DDA is that the number of variables being compared does not exceed the number of participants in any group (Sherry, 2006). As the Scapegoat group was only comprised of eleven participants, the proposed analysis had to be amended. As such, the Scapegoat group was dropped from this analysis and only the Hero, Mascot and Lost Child groups were used. As the Hero group was approximately three times the size of the Mascot and Lost Child groups, twenty-eight cases were randomly selected from the Hero group using SPSS version 15.0, to level out the distribution. The breakdown of the three groups is summarized in Table 15.

Table 15. Summary of family role grouping for three groups based on CRI scores in ACOA sample.

Assigned Family Role	Percentage	N
Hero	37.3%	28
Mascot	28.0%	21
Lost Child	34.6%	26

Note. N= 75

Results from SPSS version 15.0 indicated that that the sample means met the assumption of multivariate normality. The principal investigator reviewed and evaluated scattergram plots of the Mahalanobis distances and paired chi-square values. As the plots yielded a straight, diagonal line, this indicated that the data met the assumption of multivariate normality. Review of the Box's M statistic indicated a significant result - $F(105, 8324.66) = 1.361$, $p = 0.009$, indicating that the homogeneity of variance assumption was not met.

Table 16. Means and Standard Deviations on the Measures for Three ACOA Groups.

Instrument	HERO GROUP N	M	SD	MASCOT GROUP N	M	SD	LOST CHILD GROUP N	M	SD
The Relationship Questionnaire (RSQ)									
Secure Subscale	28	15.43	3.01	21	14.57	4.53	26	13.08	3.20
Fearful Subscale	28	14.43	3.76	21	14.33	4.58	26	15.31	3.39
Preoccupied Subscale	28	11.48	3.07	21	11.71	3.00	26	12.08	3.51
Dismissing Subscale	28	17.93	2.05	21	17.24	2.57	26	18.00	2.84
Family of Origin Scale (FOS) [a]									
Clarity of Expression Subscale (CE)	28	10.29	2.62	21	9.67	2.85	26	10.23	2.34
Responsibility Subscale (R)	28	6.36	2.48	21	6.33	2.94	26	5.92	2.50
Respect for Others Subscale (RO)	28	10.86	3.71	21	10.95	3.80	26	8.69	4.09
Openness to Others Subscale (O)	28	10.82	3.30	21	10.10	3.97	26	7.77	3.05
Acceptance of Separation and Loss Subscale (A)	28	10.54	4.15	21	10.00	3.90	26	7.58	3.85
Expression of a Range of Feelings Subscale (RF)	28	10.07	3.80	21	9.52	4.32	26	8.62	3.38
Mood and Tone of Home Subscale (MT)	28	10.61	1.89	21	11.00	2.12	26	10.12	1.58
Dealing with Conflict Resolution Subscale (C)	28	8.25	2.86	21	7.86	2.92	26	6.96	2.48
Promoting Sensitivity or Empathy Subscale (E)	28	9.96	3.14	21	9.38	3.50	26	7.85	3.16
Developing Trust Subscale (T)	28	11.43	3.40	21	10.86	3.68	26	9.04	3.33

Note. *a*. Higher scores on FOS subscales indicate greater endorsement of health in that domain.

Examination of the canonical correlation, did not yield a statistically significant result. In other words, in this ACOA sample the four dimensions and adult attachment and the ten aspects of family of origin health did not describe group differences between the three family role groups compared (i.e. Hero, Mascot and Lost Child). As such, no further analysis was interpreted. Results are summarized in Table 17.

Table 17. Wilks's Lambda and Canonical Correlation for Three Groups.

Function	Wilks's Lambda	X^2	*df*	*p*	*Rc*	Rc^2
1 through 2	.548	39.356	28	.075	.601	36.1%
2	.858	10.041	13	.691	.377	14.2%

Part II – ACOA and Non-ACOA Between Group Analyses

This section presents statistical analyses regarding between group differences, in relation to childhood role and adult attachment, in the ACOA and non-ACOA samples.

Research Question: To what extent do significant differences exist between adult children of alcoholics and adults who do not endorse growing up with an alcoholic caregiver, on dimensions of adult attachment style (RSQ)?

Hypotheses suggested that differences between the adult attachment styles of ACOA and non-ACOAs would be detected. More specifically, it was hypothesized that ACOAs would endorse less secure attachment styles than non-ACOAs. Again descriptive discriminant analysis (DDA) was utilized to determine if the four dimensions of adult attachment (RSQ – secure, dismissing, preoccupied and fearful) described group differences between ACOAs and non-ACOAs. Details of the mean scores on the RSQ for these two groups were summarized earlier in this chapter in Table 10.

Data was again analyzed using SPSS version 15.0, and results indicated that the sample means met the assumption of multivariate normality. The principal investigator again reviewed and evaluated scattergram plots of the Mahalanobis distances and paired chi-square values. These plots also yielded a straight, diagonal line, which indicated that the data met the assumption of multivariate normality. Review of the Box's M statistic indicated a significant result - $F(10, 282766.10) = 2.921$, $p = 0.001$, indicating that the homogeneity of variance assumption was not met. Sherry (2006) however suggested that Box's M is an overly sensitive test of nonnormality, particularly when sample sizes are large. This sample was large, including three hundred and sixty participants. As such, further results were reviewed, but should be interpreted with caution.

Examination of the canonical discriminant function, yielded a canonical correlation on Function 1 (.271), with an effect size of R_c^2 =21.3%. The full model test of Function 1 was statistically significant at the p<.001. Table 18 reports these findings.

Table 18. Wilks's Lambda and Canonical Correlation for Two Groups.

Function	Wilks's Lambda	X^2	*df*	*p*	*Rc*	Rc^2
1	.787	83.906	4	.000	.462	21.3%

To determine what variables contributed to group differences, standardized discriminant function coefficients and structure coefficients were examined. Table 19 summarizes coefficients examined. For Function 1, Fearful, Secure and Dismissing adult attachment styles were primary involved in group describing group differences. Fearful and Dismissing adult attachment styles were positively correlated, while the Secure

attachment style was negatively related to both. However, out of the three, Fearful attachment should be highlighted as it was the most highly responsible for group differences.

Table 19. Standardized Discriminant Function and Structure Coefficients for the Two Groups.

	Function 1		
Scale	*Coefficient*	*rs*	rs^2(%)
Secure	-.53	-.**566**	32.03%
Fearful	.900	.**984**	96.80%
Preoccupied	.115	.219	4.80%
Dismissing	.119	.**498**	24.80%

Note. N = 360. Coeff. = standardized canonical function coefficients; r_s = structured coefficient; r_s^2 = squared structured coefficient or variance explained; structured coefficient r_s greater than |.45| are in bold type.

Group centroids evaluated in this analysis are listed in Table 20. Results indicate that participants in the ACOA group endorsed higher levels of Fearful and Dismissing and lower levels of Secure adult attachment styles than the Non-ACOA group. As such, the group differences noted in Function 1 pertaining to Fearful, Dismissing and Secure adult attachment styles may be attributed to those identified as ACOA. In other words, members of the ACOA group experienced more Fearful and Dismissing and less secure attachment styles than participants in the non-ACOA group.

Table 20. Group Centroids.

Group	*Function 1*
Non-ACOA	-0.374
ACOA	0.720

Post-Hoc Analyses of Between Group Differences

Initial research questions and hypotheses did not include between group comparisons on measures of family of origin, review of the mean scores from the FOS scale prompted further investigation.

Post Hoc Research Question: Do ACOAs and non-ACOAs report significant differences in their retrospective family of origin health?

While research and clinical literature support the instance of potentially harmful family dynamics specific to homes with substance abusing caregivers, there is debate as to whether family factors within alcoholic homes differ significantly from families with other dysfunction. In their review of the literature on ACOAs in 1990, Giglio and Kaufman expressed, "much of the appeal of the ACA [ACOA] movement is in the applicability of its issues to children from any dysfunctional family. The definitive question of the uniqueness and specificity of the problems of being the adult child of an alcoholic is still unanswered." (Giglio & Kaufman, 1990, p. 286).

In a more recent review of the ACOA literature, Harter revisited the question regarding the "…specificity of the psychosocial problems attributed to a history of parental alcoholism…" (Harter, 2000, p. 311). Based on her review of controlled studies of the psychosocial adjustment of ACOAs published from 1988-2000, she concluded that while ACOAs are at an increased risk of a myriad of negative outcomes, including substance abuse, low self-esteem and difficulty in interpersonal relationships, "there is no evidence for a specific 'ACOA syndrome' uniformly characterizing ACOAs or

distinguishing them from other high-risk populations." (Harter, 2000, p.332). However, as described in Chapter Two, both clinical and research literature supports the notion that there may be a specific pattern of dysfunction common within alcoholic family systems. As this debate is ongoing, it was determined that additional post-hoc analyses would be conducted to determine if dimensions of retrospective family of origin health (FOS) describe group differences between ACOAs and non-ACOAs in this sample. A review of mean scores on all subscales of the Family of Origin Scale (FOS) was summarized previously in Table 11.

Post-hoc analyses were also completed using SPSS version 15.0, and results again indicated that the sample means met the assumption of multivariate normality. As in earlier analysis, the principal investigator reviewed and evaluated scattergram plots of the Mahalanobis distances and paired chi-square values. These plots indicated that the data met the assumption of multivariate normality. Review of the Box's M statistic indicated a significant result - $F(55, 200116.3) = 2.626$, $p < 0.001$, indicating that the homogeneity of variance assumption was not met. As was discussed earlier in this chapter, Sherry (2006) however suggested that Box's M is an overly sensitive test of nonnormality, particularly when sample sizes are large. This sample was large, including three hundred and sixty participants. As such, further results were reviewed, but should be interpreted with caution.

Examination of the canonical discriminant function, yielded a canonical correlation on Function 1 (.564), with an effect size of R_c^2 =43.6%. The full model test of Function 1 was statistically significant at the p<.001. Table 21 reports these findings.

Table 21. Wilks's Lambda and Canonical Correlation for Two Groups.

Function	Wilks's Lambda	X^2	*df*	*p*	*Rc*	Rc^2
1	.564	201.923	10	.000	.660	43.6%

To determine what variables contributed to group differences, standardized discriminant function coefficients and structure coefficients were examined. Table 23 summarizes coefficients examined. For Function 1, expression of range of feeling, dealing with conflict and responsibility subscales were involved in group describing group differences. They were all positively correlated. Expression of range of feelings was noted as having the highest responsibility for describing group differences.

Table 22. Standardized Discriminant Function and Structure Coefficients for the Two Groups.

	Function 1		
Scale	*Coefficient*	*rs*	rs^2(%)
Clarity of Expression	-.039	**.912**	83.17%
Responsibility	.341	**.848**	71.91%
Respect for Others	-.284	**.833**	69.39%
Openness to Others	-.290	**.794**	63.04%
Acceptance of Separation/Loss	.103	**.726**	52.71%
Expression of Range of Feelings	.605	**.645**	41.60%
Mood & Tone of Home	-.078	**.644**	41.47%
Dealing with Conflict	.478	**.643**	41.34%
Promoting Empathy	.007	**.629**	39.56%
Developing Trust	.155	**.525**	27.56%

Note. N = 360. Coeff. = standardized canonical function coefficients; r_s = structured coefficient; r_s^2 = s squared structured coefficient or variance explained; structured coefficient r_s greater than |.45| are in bold type.

Group centroids evaluated in this analysis are listed in Table 23. Results indicate that participants in the ACOA group endorsed significantly lower levels of family of origin health in the areas of expression of a range of emotions, coping with conflict and personal responsibility than the Non-ACOA group. As such, the group differences noted in Function 1 pertaining to expression of range of feelings, dealing with conflict and responsibility may be associated with the Non-ACOA group. In other words, members of the Non-ACOA group endorsed more healthy expression of emotions, coping with conflict and responsibility in their families of origin than participants in the ACOA group.

Table 23. Group Centroids.

Group	*Function 1*
Non-ACOA	0.623
ACOA	-1.231

A discussion of all results reported in this chapter will be completed in Chapter Five.

Chapter Five

Discussion

This chapter presents a summary of findings in this study, as well as implications this research may have for working with the adult children of alcoholic population. A review and further discussion of post-hoc analyses are also included. As well, a discussion of the limitations of this study and areas for future research are addressed.

Overview of the Study's Goals and Primary Findings

It has been estimated that over 17 million adults in the United States meets criteria for alcohol use or dependence, based on criteria in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (American Psychiatric Association, 2000: National Institute of Health, 2004). In addition, research suggests that over 20 million individuals in this country meet criteria for substance abuse or dependence (Substance Abuse and Mental Health Services Administration, 2004). In actuality, alcoholism currently impacts an estimated 30 million additional individuals in the United States, including approximately 6.6 million children living within alcoholic family systems (Gordis, 1990; Woodside, 1988). Research reports that an estimated 43 percent of adults, or 76 million people, in the United States have relatives who are alcoholics, and that one is eight individuals, or an estimated 30 million adults, have an alcoholic parent (Hall & Webster, 2002; Domenico & Windle, 1993).

Alcoholism has long been conceptualized as a family disease, referring to the systemic impact on those close to an alcoholic. Literature from both clinical and research settings have examined the impact of growing up with an alcoholic caregiver. The

ACOA literature has suggested that adult children of alcoholics are at an increased risk for a range of negative outcomes including; depression, anxiety disorders, substance abuse/dependence themselves, interpersonal problems, as well as, martial and parenting stress (Harter, 2000). However, debate exists in the literature as to whether a true "ACOA syndrome" exists, and several studies and meta-analyses have suggested that this is a heterogeneous population (Harter, 2000; Giglio & Kaufman, 1990). Recent studies have begun to explore the potential etiology of the heterogeneity within the ACOA population.

Previous research has identified an increased risk of difficulties within interpersonal relationships as one of the most prevalent negative outcomes experienced by ACOAs (Jaeger, et. al, 2000; Beesley & Stoltenberg, 2002; Kelley et. al., 2005). Study of attachment theory has indicated that more secure adult attachment styles have been related to more positive relationship outcomes; whereas identification with less secure patterns is associated with more negative interpersonal dynamics (Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994a). Several studies suggest that ACOAs report significantly less secure attachment styles than non-ACOAs (Beesley & Stoltenberg, 2002; Wungkhanching, et. al., 2004). For example, Kelley and colleagues reported that in a study of college age men and women, participants who identified growing up with an alcoholic caregiver endorsed significantly greater avoidance of romantic relationships and more fearful attachment styles than those who did not endorse growing up in an alcoholic family system (Kelley, et. al., 2004). In a similar study by the same researchers, these findings were replicated. However, in addition, retrospective

reports of parenting behavior in respondents' families of origin were shown to predict anxious behavior in romantic relationships, while ACOA status combined with parenting behavior predicted both more fearful attachment styles and avoidant behavior in romantic relationships, suggesting that factors from the family of origin may play a significant role in relationship outcomes (Kelley, et. al., 2005).

The first goal of this study was to explore one area of potential heterogeneity within the ACOA population, by comparing individuals who endorsed membership in Al-Anon Family Groups and ACOAs who did not. As discussed in previous chapters, Al-Anon Family Groups are a community based, peer-lead, 12-Step organization which provides support to ACOAs and other individuals affected by a close friend or relative's alcoholism (Al-Anon Family Groups, 1997). Assistance is provided through methods such as, 12-Step meetings, sponsorship by more senior members and the reading of Al-Anon approved literature. One of the central themes discussed in Al-Anon literature relates to a concept they label "detachment," or in other words the empowerment of members to continue to love the alcoholic in their life, while not taking responsibility for his/her actions or the consequences of his/her disease (Al-Anon Family Groups, 1982). Many of the principles woven into the culture of Al-Anon appear consistent with attributes associated with secure attachment including the supporting of self-care, developing a more positive sense of self and the ability tolerate both pleasure and pain within close relationships (Ainsworth et. al., 1978; Bartholomew and Horowitz, 1991). As such, it was hypothesized that ACOAs who endorsed Al-Anon membership would

also report more secure adult attachment styles than those who were not Al-Anon members.

The second goal of this study was to add a dimension to the current debate regarding the heterogeneity within the ACOA population, pulling from existing research that suggests there are four common roles that children assume in alcoholic family systems, the Hero, Mascot, Lost Child and Scapegoat (Williams & Potter, 1994). Each role may be explained as a group of internalized coping mechanisms, adopted by children to address the stress of growing up in an alcoholic family system (Alford, 1998; Veronie & Fruehstorfer, 2001; Woititz, 1983). This study's second hypothesis was that the role an ACOA identified with as a child, as measured by the Children's Role Inventory, would help describe one aspect of the heterogeneity within this group, using their current adult attachment style (RSQ) as a primary outcome measure. Additionally, to further describe group separation, it was hypothesized that certain aspects of participants' perceptions of health in their families of origin (FOS), would also be associated with each childhood role.

Post-Hoc Analyses: Following the collection and review of data, it became clear that one additional area of study would be useful to explore, in keeping with one of the main goals of the study. Inherent in the second goal of this study was the assertion that alcoholic family systems create a specific pattern of dysfunction as a result of the common attributes and disease characteristics of the family disease of addiction (Woitiz, 1983). As such, following a review of the data, an additional between groups analysis was conducted to explore the potential differences in retrospective perceptions of family

of origin health, as measure by the Family of Origin Scale (FOS). These results will also be discussed in this chapter.

Part I: Discussion of Heterogeneity within the ACOA Population

Within Groups Comparison Regarding Al-Anon Group Membership

In regards to this study's first goal, providing additional data to describe the heterogeneity within the ACOA population, some unanticipated challenges arose. Participants were recruited through the EDP subject pool at the University of Texas and through online community resources, many of which targeted individuals with some interest in addiction or recovery. The principal investigator contacted Al-Anon Family Groups and several local and online meetings however, permission to perform direct recruitment of Al-Anon members was denied. Al-Anon and several online forum and chat administrators cited Tradition 12 in the Al-Anon literature which states, "Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles above personalities." (Al-Anon Family Groups, 1997, p.132). Research has cited this issue in the past in relation to collecting data from 12-step group members. It has been noted that most research with this population has been completed with groups in inpatient settings or through clinical trials in which an "Al-Anon based" group experience is created (Humphreys & Kaskutas, 1995; Room & Greenfield, 1993; Miller, et.al., 1999). As a result, Al-Anon members were not targeted for recruitment and only five out of one-hundred and twenty-one ACOA participants endorsed membership. Because there was such a large disparity in group sizes, no comparison based on this grouping variable was completed.

Adult Attachment, Family of Origin Health and Children's Role Comparison

The first goal of this study was also related to identifying factors that may explain further the heterogeneity within the ACOA population. However, similar issues with sample size limited the scope of this analysis. One hundred and twenty-one ACOA participants were identified from the overall sample and each respondent was grouped based on their score on the Children's Role Inventory (CRI). ACOAs were identified as falling into the Hero, Mascot, Lost Child or Scapegoat group. Results however indicated that there was not even distribution across the four groups within the sample. The majority of respondents identified with the Hero role (n=63, 52.1%); whereas, only 9.1% (n=11) endorsed items consistent with the Scapegoat group. Dispersion between the Mascot and Lost Child groups were similar, 17.4% and 21.5% respectively. As was discussed in Chapter Four, this distribution of roles may be seen as consistent with the attributes and traits associated with each of the children's role.

As there was such a significant disparity between group sizes, the analysis was amended by dropping the Scapegoat group and using a smaller random sample from the Hero group. However, analysis using three groups did not yield any statistically significant results. In other words, within this sample there was no evidence that adult attachment styles and respondents' perceptions of the health of their family of origin, described group differences between the four family roles. Results may have been influenced by the small group sample sizes. In addition, the development of attachment style may be more similar within children in these families based on the power of the shared experience of parental unavailability within an alcoholic family system. While the

identification of a particular children's role may act as a coping mechanism to stressors within the family, perhaps it does not mediate the parenting deficits often characterized in alcoholic homes. However, it is possible, that children's roles may help explain heterogeneity within the ACOA population in other domains such as; the development of psychopathology or stress and coping. These results suggest that in this study, childhood family roles (i.e. Hero, Mascot, Lost Child, Scapegoat) may not be helpful in explaining the heterogeneity in within the population using adult attachment and family of origin health as primary outcome measures.

Part II – ACOA and Non-ACOA Between Groups Comparisons

Between Groups Comparison Descriptive Statistics

Prior to completing the second goal of this study, a review of descriptive statistics pertaining to the ACOA and Non-ACOA groups was conducted. A few differences between the groups were noted. A review of the recruitment source data indicated that the majority of ACOA participants identified with the community sample (94.2%); whereas the Non-ACOA group was primarily comprised of individuals recruited from the EDP subject pool (70.3%). Some differences in age and marital status also reported, the Non-ACOA group was primarily comprised of younger adults, with 78.1% age 18 to 25, while this age group made up 24.8% of the ACOAs. In addition, a higher proportion of the Non-ACOA group indicated their marital/partnered status as single (77.4%); whereas, 41.3% of the ACOA group endorsed the same. These differences are most likely attributable to sampling differences between the sources of the two groups. College students tend to be younger, and as such, a higher proportion may not be in a partnered

romantic relationship or marriage. While both groups were predominantly Caucasian, females, who had completed some college or a higher level of education, there was also a notable difference in reports about caregiver marital status. The Non-ACOA group reported that 86.6% had grown up in an intact home, in which their parents were married. However, only 57.9% of the ACOA group reported that their parents were married during their childhood. In contrast, 39.7% of the ACOA sample reported that their parents were divorced or otherwise separated; whereas, only 12.6% of the Non-ACOA group reported the same. While the specific conditions of divorce and separation may impact the outcome on the child, it may be plausible to suggest that these differences may be consistent with ACOAs experiencing less parental marital stability within their families of origin than Non-ACOAs in this sample.

Between Groups Comparison of Adult Attachment Styles

The second goal of this study was to explore the potential differences between ACOAs and non-ACOAs reports of adult attachment styles. It was hypothesized that based on previous research related to interpersonal relationships and adults who grew up with an alcoholic caregiver, ACOAs would endorse less secure attachment styles than Non-ACOAs. Analyses indicated that within this sample, ACOAs reported significantly more Fearful and Dismissing, and significantly less Secure attachment styles than the Non-ACOA group. There was no significant difference in the level of Preoccupied attachment styles between the groups. However, these results should be being evaluated with caution, as multicolinearity within this data may have impacted the significant outcome. These findings are consistent with earlier research on ACOA attachment styles

and provide additional support to previous research that ACOAs may experience more difficulties within interpersonal relationships than adults who do not endorse growing up with an alcoholic caregiver (Kelley, et. al., 2004; Kelley, et. al., 2005).

Recall that adult attachment, as measured in this model, is comprised of two intersecting continuums in which individuals develop a cognitive working model related to their feelings about themselves and others. The continuum describe a range of positive to negative views about self and other, and the internal schema based on these two views describes the adult attachment style (Griffin & Bartholomew, 1994a). As was discussed in earlier chapters, the Fearful attachment style is characterized by individuals who have internalized a negative schema about both themselves and others. As such, this attachment style is associated with feeling highly dependent on external sources of validation, but because of their negative expectations of others, individuals with Fearful attachment styles may avoid intimacy in fear of anticipated loss and rejection (Griffin & Bartholomew, 1994a).

It may be argued that the development of the Fearful attachment style is consistent with the environment and relationship dynamics common within alcoholic family systems. As was discussed in Chapter Two, alcoholic family systems are often described as chaotic, due to the unpredictability of the alcoholic's behavior (Beesley & Stoltenberg, 2002). The family often organizes around managing this behavior and preventing the potential negative consequences. As such, children often experience unavailability of one or both parents, and frequently receive inconsistent feedback about their own worth and performance (Harter, 2000; Woititz, 1983).

For example, a child could come home from school with three A's and B on his/her report card. In one instance, the alcoholic parent may be available to support the child and recognize the child's positive performance and good grades, giving positive feedback and expressing pride in the child. However, on another day, which might not be predicted by the child, he/she could come home with the same report card, but the alcoholic caregiver at that time might be intoxicated or frustrated because he/she got in trouble for being late to work as the result of a hangover. It is likely in this scenario, that the child would receive inconsistent feedback from the parent, perhaps in which he/she yells at the child for getting a B grade.

In another scenario, a teenager might come home after a night out with friends. Perhaps she had a fight with a friend and is left feeling betrayed and not sure what how to process these feelings. When she arrives at home upset, she finds her mother despondent because her father, who is an alcoholic, has gone out again to a bar and not come home on time. Again, it is possible to imagine that in such a situation, the teen's mother might not be available to discuss the incident with her daughter and as such, the teen receives the message that her mother is unable to meet her needs to make sense of an upsetting interpersonal exchange with her friend.

In either of these cases, a child may develop a negative cognitive working model about others, based on the unavailability or unpredictability of the parents meeting his/her needs. As alcoholism is conceptualized as a family disease, this experience may be with the alcoholic caregiver or other parent/caregiver in the child's life. In addition, without

the benefit of consistent positive feedback and support from a parent, the child might also develop a negative sense of self or schema.

Results also indicated that a Dismissing attachment style described group differences between ACOAs and non-ACOAs. ACOAs were shown to have more Dismissing attachment styles than non-ACOAs. Again, referring back to Chapter Two, the Dismissing style is defined by a positive internalized cognitive working model of the self, and a negative schema around views of others (Griffin & Bartholomew, 1994a). Similar to the Fearful attachment style, individuals with a greater tendency towards Dismissing attachment styles may avoid close relationships because of their negative associations about other people. However, individuals with this style of attachment have a higher sense of self worth than those associated with the Fearful attachment style, and as such may justify their distance from others by defensively denying the importance of close relationships and placing greater value on independence.

Within the paradigm of family systems theory, the Dismissing attachment style may also be consistent with the dynamics within an alcoholic family system. For similar reasons to those with more Fearful attachment styles, children who develop Dismissing attachment styles may develop a negative view towards others as a results of the unavailability of one or more caregivers in the home. However, it is plausible to imagine a child receiving positive attention outside the family of origin, from teachers or extended family, in which he/she could develop a positive sense of self. However, without the consistent support from his/her primary caregivers, this same child would likely learn to

mistrust others and value independence as a safer option than risking repeated disappointment in relationship with someone else.

Consistent with the first two findings under this goal, this study also found that ACOAs reported significantly less Secure attachment styles than non-ACOAs. The Secure attachment style is described as a positive internal cognitive working model of both the self and others (Griffin & Bartholomew, 1994a). Attachment research suggests that to develop this style of attachment, a child needs to experience consistent positive feedback and availability from his/her caretakers, so as to internalize ideals that people are generally good, safe and will meet our needs. As a result, an individual with a more Secure attachment style generally accepts others as positive and has a greater tolerance for weathering difficulties within close interpersonal relationships. The alcoholic family system dynamics cited above which may support the development of the more insecure attachments styles, Fearful and Dismissing, may also work against the development of more Secure styles in ACOAs.

Post-Hoc Analysis of Between Groups Comparison of Perceived Family of Origin Health

As discussed earlier in this chapter, review of data from this sample indicated that addition analyses might be helpful in addressing the second goal of this study, exploring differences between ACOA and Non-ACOA groups. Consistently throughout the ACOA literature, particularly in meta-analytic studies, there is debate about the heterogeneity of the ACOA population. While initial research and clinical writing on this topic supported the idea of a consistent subset of negative outcomes for which all ACOAs were at risk, meta-analyses reported no evidence for an "ACOA syndrome" with a consistent pattern

of negative outcomes for all members of this population. Some researchers have hypothesized that children growing up in alcoholic family systems do not differ from those who experience dysfunction for other reasons in their families of origin, for example divorce, domestic violence or maladaptive interpersonal patterns (Harter, 2000; Giglio & Kaufman, 1990). However, the literature also supports the notion that a pattern of dysfunction exists within alcoholic family systems as a consequence of relational issues specific to living with the disease of alcoholism (Woititz, 1983; Harter, 2000; Al-Anon Family Groups, 1997; Bowen, 1991). To further address this question, between groups analysis on the ten subscales of the Family of Origin Scale (FOS) was conducted.

As discussed in Chapter Three, the ten subscales of the FOS are designed to measure two broad constructs, the respondent's perceptions about development of intimacy and autonomy within his/her family of origin. When compared with the Non-ACOA group, ACOAs were found to have perceived that their families fostered significantly less personal responsibility. In addition, ACOA respondents perceived less support for the expression of emotions, positive or negative, and a family environment that did not promote the development of conflict resolution without undue stress than Non-ACOAs.

These findings appear consistent with the assessment of alcoholic families from a systems perspective. One aspect of the disease of alcoholism is the difficulty the alcoholic experiences in taking responsibility for his/her actions (O'Farrell & Fals-Stewart, 2003). Research and clinical literature suggests that this dynamic often leads the family to organize around enabling the individual's maladaptive behavior or preventing

the alcoholic from facing the natural consequences of his/her choices (Beesley & Stoltenberg, 2002). As such, it is reasonable to imagine that a child growing up in such a family system would perceive this dynamic. From the theoretical underpinnings of the FOS, personal responsibility is seen as a component used in developing autonomy.

The FOS constructs of learning to express a range of feelings and dealing with conflict without undue stress are related conceptually to the family's support for the development of intimacy in members of the system. The healthy development of both constructs could be seen as arrested by aspects of the family disease of alcoholism. Research suggests that part of the disease process of addiction, is the alcoholic's intolerance of negative feelings and the use of avoidance strategies, such as drinking, to prevent experiencing them (O'Farrel & Fals-Stewart, 2003; Bowen, 1991). As was discussed in Chapter Two, this avoidance may lead to tenuous and unpredictable environment, in which family members deny the existence of negative occurrences and feelings. In addition, these systems have implicit rules to not directly address conflict, as family members quietly contain the consequences of the alcoholic's behaviors, or at other times the level of conflict may be quite high as members of the system fight to change the alcoholics drinking (Al-Anon, 1997; O'Farrel & Fals-Stewart; Beesley & Stoltenberg, 2002). As such, children within these systems may not learn to cope with conflict in a constructive and safe manner.

Consideration of Adult Attachment and Family of Origin Differences

When examined together, the between groups analyses of adult attachment style and family of origin factors may be complimentary in providing further explanation

regarding the experience and negative outcomes associated with ACOAs. Results from this study support the theory that there may be a predictable pattern of family dysfunction within alcoholic family systems that specific to the disease of addition. As discussed previously, ACOAs in this study endorsed family of origin environments which provided less support for the development of personal responsibility, expression of a range of emotions and constructive conflict resolution than Non-ACOAs. While each of these areas of dysfunction may be seen in other families, when combined in the context of the disease of addiction, they are consistent with a systems approach to describing many common processes within an alcoholic family. Previous research has also suggested that ACOAs report less secure attachment styles than individuals who do not endorse growing up with an alcoholic caregiver (Kelley, et. al., 2004; Kelley, et. al., 2005). This may in part be the result of growing up in an environment that does not foster aspects of autonomy and intimacy which would support the development of more secure attachment styles.

In summary, this study faced several challenges in meeting its first goal of adding to the body of ACOA literature attempting to explain the heterogeneity reported in outcome studies of this population. However, in contrast the second goal appears to have replicated previous studies that suggest ACOAs do endorse less secure attachment styles than Non-ACOAs (Kelley, et. al., 2004; Kelley, et. al., 2005). In addition, results support the notion that there may be a specific pattern of dysfunction within alcoholic family systems, which may differ from Non-ACOAs. Furthermore, the pattern of family dysfunction found in this study is consistent with previous literature regarding the

dynamics within these families and may help to better explain the development of less secure attachment styles in this population.

Implications for Counseling Psychology

The stated purpose of this study was to add to the clinical and research literature currently available to help inform the conceptualization and treatment of ACOAs. While results were not able to add to the literature explaining the heterogeneity of this population, attachment style and family of origin functioning were identified as potentially important factors. These areas may be salient in consideration of treatment selection, case conceptualization and focus of interventions when working with this population.

Research suggests that adult attachment style may influence choice of psychotherapy modality and treatment outcomes. Daniel (2006) cited several studies that noted that both patient and therapist attachment styles may impact; in-treatment behavior, the quality and development of the treatment alliance, as well as the overall outcome of treatment. McBride, Atkinson, Quilty and Bagby (2006) conducted a study in which adult attachment style in participants with depression was measured, prior to being randomized to either cognitive behavioral therapy (CBT) or interpersonal psychotherapy (IPT). They reported that participants with more avoidant attachment styles experienced greater reduction in illness severity and a higher likelihood of remission when engaged in CBT interventions than IPT. Authors noted the importance of considering the interaction between attachment style and modality of treatment.

Studies have also reported that psychoanalytic therapy increases participants' likelihood of developing more secure attachment styles, both in long term and time limited courses of treatment (Daniel, 2006; Travis, Bliss, Binger & Horne Moyer, 2001). However, studies have also suggested that individuals with less secure attachment styles may not benefit as much from psychotherapy as those with more secure styles. Horowitz and colleagues reported that individuals who endorsed a more dismissing attachment style in a study of brief psychodynamic therapy had the poorest outcome, when compared to individuals with other attachment styles (Horowitz, Rosenberg & Bartholomew, 1993). However, it is important to note that there are limitations to this body of research. Primarily, there is not a consensus in measurement techniques for adult attachment in the literature and studies have used a range of structured interviews and self-report measures to identify attachment styles in participants. As such, some variance in outcome studies may be impacted by the variability in measures used (Daniel, 2006).

While there is still debate for clinicians about a cohesive "ACOA Syndrome," when working with this population the literature and results of this study support the importance of considering both attachment style and perceived family of origin health in case conceptualization and treatment planning. This might include asking more detailed questions about parental drinking habits on intake forms or asking clients to complete attachment assessments upon entering treatment. In addition, clinicians may consider approaching therapy with this population from an attachment perspective to address the higher likelihood of insecure attachment styles. In addition, given the evidence that ACOAs appear to be at higher risk for Fearful attachment styles, clinicians should be

aware of that issues related to, being late, canceling appointments and other daily office interactions may hold deeper significance for this population, as they hold negative expectations of others. It may also be helpful to consider attachment style when responding to a break in treatment alliance or client attrition from this population.

Previous research and this study also support the notion that when working with the ACOA population, the patterns of dysfunction often described in alcoholic family systems should be considered when conceptualizing current issues. This study highlights the potential importance of three areas, coping with conflict, expressing a range of emotions and addressing potential issues related to personal responsibility. Although many of these issues are common in psychotherapy clients, clinicians may want to consider them within the context of the family disease of alcoholism and it may be helpful to assist the client into developing further insight into the potential etiology of these symptoms.

Limitations of the Current Study

While the present study adds to the body of literature regarding ACOAs, several limitations should be considered. Two main concerns relate to the sampling of participants within this study. Approximately half of the sample was recruited through the EDP subject pool at the University of Texas at Austin and this sample comprised the majority of the non-ACOA group. As the community sample was recruited through online formats, there were some differences noted between the groups. First, the distribution of ages in university based sample was predominantly younger than the community sample. In addition, there were some differences in marital/partner status between these two samples. Second, it should be noted that because study participants were recruited through web based formats and data was collected online, this may have skewed the population towards participants with higher socio-economic status and higher levels of education (McKenna & Bargh, 2000). Another area of limitation of this study related to using only self-report measures. Research suggests that this increases the probability of bias in response. In addition, two of the primary measures, the CRI and FOS, asked participants to answer questions based on their memories of childhood. As such, their answers may have been influenced by a number of factors since that time.

Limitations related to geographic location of the sample were also noted. The majority of this sample included participants from the Southwest. In addition, this sample was comprised of predominantly Caucasian women, limiting the generalizability of results to other racial/ethnic groups, as well as, men.

There were additional limitations related to the sample used in this study. The sample included just over one-hundred ACOA participants, and when grouped by childhood role the distribution of respondents was skewed. A larger sample of ACOAs may have resulted in more even groups and enough participants across the childhood roles with which to run analyses. Furthermore, this study was unable to complete analysis utilizing Al-Anon membership for comparison. As such, one goal of the study remains unmet.

In addition, another limitation may be that several demographic questions pertaining to the use of alcohol in participants' families of origin were created by the principal investigator. Unfortunately the way the survey was constructed, respondents who endorsed multiple family members with alcoholism, could only report recalled frequency and amounts of consumption on one person. Finally, as between groups analyses of ACOA and Non-ACOA perceptions of family of origin health were completed post-hoc there were additional limitations. This study did not address any potential covariates, such as parental marital/partner status, number of alcoholics in the family, or information on the level of conflict within the home, when comparing these two groups.

Directions for Future Research

There are several areas of future research that may create further understanding of the heterogeneity of ACOAs, in relation to both adult attachment styles and childhood roles, as well as the between groups comparisons of family dynamics with non-ACOAs. Some areas may focus on expanding our knowledge of the experience of ACOAs, incorporating other family members, as well as exploration of the dynamics of Al-Anon and its impact on attachment.

In regards to childhood roles, future research may work to achieve a larger sample of ACOAs, with stronger representation of each role type (i.e. Hero, Mascot, Lost Child and Scapegoat). With larger samples and more equal group sizes, it may be possible to better evaluate if childhood roles are a viable method of explaining heterogeneity within this group. In addition, studies might examine treatment outcomes across different roles, or study of any difference in treatment seeking between the different roles.

Several studies have suggested that ACOAs report less secure attachment styles than non-ACOAs and future research in this area may be helpful. Further studies might include the use of covariate family and current relationship variables, such as current marital/partner status, Al-Anon membership, as well as previous psychotherapy treatment. Psychotherapy outcome studies specific to ACOAs in which attachment style is assessed in a pre/post design might also provide additional information about the best modalities for working with this population.

Additional research may also be relevant in providing additional data about the dynamics within alcoholic family systems, continuing to assess their similarities and

differences from other types of family dysfunction. Further studies may include consideration of variables specific to the alcoholic, severity of the addiction and resulting behaviors, level of conflict in the family of origin, amount of time spent with the alcoholic during childhood, marital status of the ACOAs parents and other factors associate with family dysfunction. Such study may also include the investigation of protective factors within the family or individual, which may also influence the heterogeneity of this population. In addition, as family systems theory suggests that relational dynamics are often repeated across generations, further research may measure current family functioning in ACOAs in comparison to Non-ACOAs.

Conclusion

This study of 360 adults was designed to add to the body of knowledge explaining the experiences and heterogeneity within the adult children of alcoholics population. Results of this study are consistent with previous research that ACOAs are more likely to develop less secure attachment styles and as such, may experience more difficulties in interpersonal relationships. In addition, this study provides some data to support the theoretical notion that alcoholic family systems create a specific pattern of dysfunction that may be clinically relevant to case conceptualization, treatment recommendations and modalities when working with this population. Additional research should focus on creating a better understanding of the implications of ACOA adult attachment style and how this may be related to predictable dynamics within these families of origin. In addition, future study should also address what variables add to the heterogeneity of this

population. Finally, further exploration of variables associated with family dysfunction should be studied to further explain those patterns specific to the disease of addiction.

Appendices

Appendix A

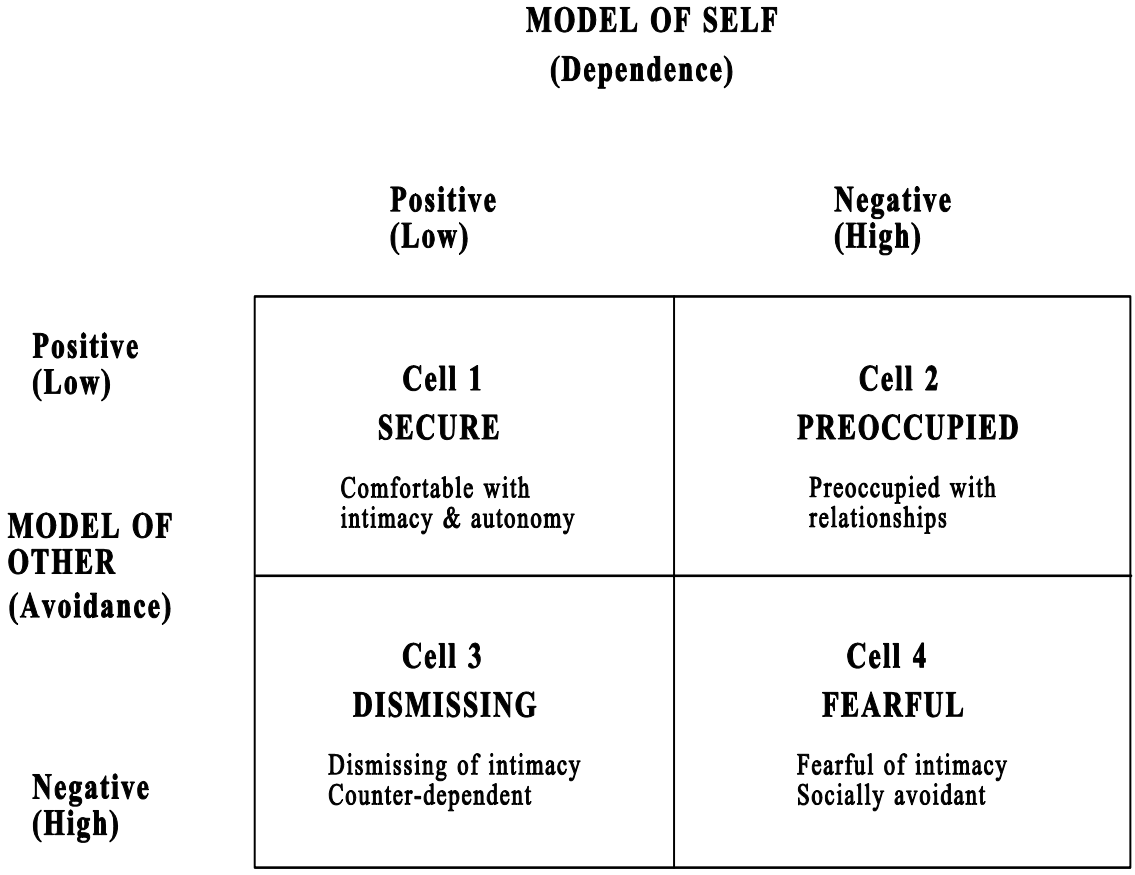

Figure 1.

Bartholomew's Model of Adult Attachment (Griffin and Bartholomew, 1994).

Appendix B

Community Recruitment E-mail

Hello,

My name is Meredith Draper and I am a doctoral student working on my dissertation in the Counseling Psychology Program at the University of Texas. I am currently collecting data for a study that involves examining how factors from our families of origin impact how we approach relationships as adults. Please consider participating in this dissertation study - **An Exploration of Adult Heterogeneity Utilizing Childhood Family Roles, Family of Origin Health and Adult Attachment Style**. It is my hope that this research will assist in understanding how the roles we adopt in our families as children impact how we experience relationships as adults.

Eligibility requirements are:
1) At least 18 years old of age.
2) Live in the United States

The survey takes about 45 minutes to complete. Participation is completely confidential. There are no foreseeable risks associated with this study and you may withdraw from the survey at any point.

For more information or to participate in this research opportunity, please click on the following link:

https://www.surveymonkey.com/s.aspx?sm=UIwVEqcrCGBI8BR071p1Ag_3d_3d

Thank you,

Meredith Draper, M.Ed.
Doctoral Candidate
Counseling Psychology Program
Department of Educational Psychology
1 University Station
University of Texas at Austin
Austin, TX 78712

Supervisor:
Alissa Sherry, Ph.D.

EDP Subject Pool Recruitment E-mail

Hello,

My name is Meredith Draper and I am a doctoral student working on my dissertation in the Counseling Psychology Program at the University of Texas. I am currently collecting data for a study that involves examining how factors from our families of origin impact how we approach relationships as adults. Please consider participating in this dissertation study - **An Exploration of Adult Heterogeneity Utilizing Childhood Family Roles, Family of Origin Health and Adult Attachment Style**. It is my hope that this research will assist in understanding how the roles we adopt in our families as children impact how we experience relationships as adults.

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The survey takes about 45 minutes to complete. Participation is completely confidential. There are no foreseeable risks associated with this study and you may withdraw from the survey at any point.

For more information or to participate in this research opportunity, please click on the following link:

https://www.surveymonkey.com/s.aspx?sm=kmCjwLuOFgCdnxFZkmzM_2bg_3d_3d

Thank you,

Meredith Draper, M.Ed.
Doctoral Candidate
Counseling Psychology Program
Department of Educational Psychology
1 University Station
University of Texas at Austin
Austin, TX 78712

Supervisor:
Alissa Sherry, Ph.D.

Appendix C

Informed Consent to Participate in Research

You are invited to participate in a survey, entitled "An Exploration of Adult Heterogeneity Utilizing Childhood Family Roles, Family of Origin Health and Adult Attachment Style." The study is being conducted by Meredith Draper, M.Ed. and Alissa Sherry, PhD, Department of Educational Psychology of The University of Texas at Austin, College of Education, 1 University Station D5800, Austin, TX 78712**,** (512) 656-2090 or (512) 471-0372,email address: meredithd@mail.utexas.edu or alissa.sherry@mail.utexas.edu.

The purpose of this study is to examine is to recruit 400 participants to explore how your perceptions about your family of origin and your childhood role in your family of origin might impact how you approach interpersonal relationships as an adult. Your participation in the survey will contribute to a better understanding of how our experiences in our families as children, affects our relationships when we grow up. We estimate that it will take about 45 minutes of your time to complete the questionnaire. You are free to contact the investigator at the above address and phone number to discuss the survey.

Risks to participants are considered minimal. There will be no costs for participating, nor will you benefit from participating. Identification numbers associated with email addresses will be kept during the data collection phase for tracking purposes only. A limited number of research team members will have access to the data during data collection. This information will be stripped from the final dataset.

Your participation in this survey is voluntary. You may decline to answer any question and you have the right to withdraw from participation at any time without penalty. If you wish to withdraw from the study or have any questions, contact the investigator listed above.

If you have any questions or would like us to email another person for your institution or update your email address, please call Meredith Draper, M.Ed. at (512) 656-2090 or send an email to meredithd@mail.utexas.edu. You may also request a hard copy of the survey from the contact information above.

To complete the survey, click on the link below:
https://www.surveymonkey.com/s.aspx?sm=UIwVEqcrCGBI8BR071p1Ag_3d_3d
The password for the survey is UT13579.

If you do not want to receive any more reminders, you may email us at meredithd@mail.utexas.edu.

This study has been reviewed and approved by The University of Texas at Austin Institutional Review Board. If you have questions about your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact - anonymously, if you wish - the Institutional Review Board by phone at (512) 471-8871 or email at orsc@uts.cc.utexas.edu.

IRB Approval Number: 2007120058

If you agree to participate please press the arrow button at the bottom right of the screen otherwise use the X at the upper right corner to close this window and disconnect.

Thank you.

Appendix D

Debriefing Statement

Thank you for participating in this research study. The purpose of this statement is to provide additional information regarding the questions this research is seeking examine.

As you stated in the introductory page prior to the questionnaires, this study is interested in examining if the role we assume as children in our families of origin impacts how we approach relationships as adults. In addition, research suggests that adults who have grown up in homes with an alcoholic parent or caregiver may experience problems later in life with relationships with others. However, recent research suggests that not all children who grow up with an alcoholic caregiver experience this difficulty. This study is interested in answering the question, if you grew up in a home with a caretaker with alcoholism, did the role you took on in your family affect the way you relate to others as an adult? This study is also exploring whether the overall health of one's family of origin might play a role in mediating the potentially negative effects of growing up with an alcoholic caregiver. We also hope to investigate if there are differences in the way adult children of alcoholics and those who did not grow up with an alcoholic caregiver approach relationships.

If you have any further questions about this study, please contact the principal investigator, Meredith Draper, M.Ed. at meredithd@mail.utexas.edu or via phone at 512-656-2090.

Available Resources:
If any of the information discussed in this study, or in the questionnaires, has caused you any level of emotional stress or discomfort the following resources are available:

For students at the University of Texas at Austin:

- UT Telephone Counseling Hotline (471-CALL)
- UT Counseling and Mental Health Center (471-3515)

For Austin residents who are not students at the University of Texas:

- Capital Area Mental Health Center (512) 302-1000
- Travis County MHMR (512) 472-4357

National Organizations:

- Al-Anon Family Groups http://www.al-anon.alateen.org/
- Adult Children of Alcoholics World Service http://www.adultchildren.org/

For specific referrals for mental health services in the Central Texas area, please contact the principal investigator, Meredith Draper, M.Ed. at 512-656-2090 or meredithd@mail.utexas.edu.

Appendix E

Children's Role Inventory

The following word or phrases describe behaviors and characteristics of children. Indicate the number that best describes how you were or how you acted **during your high school years.**

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

1. When I was a child I was an achiever.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

2. When I was a child I was aggravating.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

3. When I was a child I was aggressive.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

4. When I was a child I was animated.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

5. When I was a child I was annoying.

1	2	3	4	5
Strongly Disagree or	Disagree or	Undecided	Agree or	Strongly Agree or

Very Unlike Me Unlike Me Like Me Very Like Me

6. When I was a child I was belligerent.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

7. When I was a child I was capable.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

8. When I was a child I was the center of attention.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

9. When I was a child I was charming.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

10. When I was a child I was cheerful.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

11. When I was a child I was comical.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

12. When I was a child I was deceitful.

1 2 3 4 5

Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

13. When I was a child I was defiant.

1 Strongly Disagree or Very Unlike Me	2 Disagree or Unlike Me	3 Undecided	4 Agree or Like Me	5 Strongly Agree or Very Like Me

14. When I was a child I was delinquent.

1 Strongly Disagree or Very Unlike Me	2 Disagree or Unlike Me	3 Undecided	4 Agree or Like Me	5 Strongly Agree or Very Like Me

15. When I was a child I was dependable.

1 Strongly Disagree or Very Unlike Me	2 Disagree or Unlike Me	3 Undecided	4 Agree or Like Me	5 Strongly Agree or Very Like Me

16. When I was a child I was depressed.

1 Strongly Disagree or Very Unlike Me	2 Disagree or Unlike Me	3 Undecided	4 Agree or Like Me	5 Strongly Agree or Very Like Me

17. When I was a child I was disobedient.

1 Strongly Disagree or Very Unlike Me	2 Disagree or Unlike Me	3 Undecided	4 Agree or Like Me	5 Strongly Agree or Very Like Me

18. When I was a child I was disruptive.

1 Strongly Disagree or Very Unlike Me	2 Disagree or Unlike Me	3 Undecided	4 Agree or Like Me	5 Strongly Agree or Very Like Me

19. When I was a child I was dutiful.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

20. When I was a child I was entertaining.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

21. When I was a child I was excitable.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

22. When I was a child I was friendly.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

23. When I was a child I was funny.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

24. When I was a child I was helpful.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

25. When I was a child I was hostile.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

26. When I was a child I was humorous.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

27. When I was a child I was hyperactive.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

28. When I was a child I was ill-mannered.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

29. When I was a child I was introverted.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

30. When I was a child I was irritating.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

31. When I was a child I was level-headed.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

32. When I was a child I was lonely.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

33. When I was a child I was a loner.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

34. When I was a child I was mature.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

35. When I was a child I misbehaved.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

36. When I was a child I was orderly.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

37. When I was a child I was organized.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

38. When I was a child I was outgoing.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

39. When I was a child I was passive.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

40. When I was a child I performed well.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

41. When I was a child I played alone.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

42. When I was a child I was playful.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

43. When I was a child I was quiet.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

44. When I was a child I was rebellious.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

45. When I was a child I was reserved.

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

or Very Unlike Me	or Unlike Me		or Like Me	or Very Like Me

46. When I was a child I was sensible.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

47. When I was a child I was shy.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

48. When I was a child I was social.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

49. When I was a child I was solemn.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

50. When I was a child I was solitary.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

51. When I was a child I was submissive.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

52. When I was a child I was super-responsible.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

53. When I was a child I was successful.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

54. When I was a child I was timid.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

55. When I was a child I was thorough.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

56. When I was a child I was a trouble maker.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

57. When I was a child I was trustworthy.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

58. When I was a child I was unsocial.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

59. When I was a child I was withdrawn.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

60. When I was a child I was witty.

1	2	3	4	5
Strongly Disagree or Very Unlike Me	Disagree or Unlike Me	Undecided	Agree or Like Me	Strongly Agree or Very Like Me

Subscale Items:

Hero: 1, 7, 15, 19, 24, 31, 34, 36, 37, 40, 46, 52, 53, 55, 57
Scapegoat: 2, 3, 5, 6, 12, 13, 14, 17, 18, 25, 28, 30, 35, 44, 56
Mascot: 4, 8, 9, 10, 11, 20, 21, 22, 23, 26, 27, 38, 42, 48, 60
Lost Child: 16, 29, 32, 33, 39, 41, 43, 45, 47, 49, 50, 51, 54, 58, 59

Appendix F

THE RELATIONSHIP QUESTIONNAIRE (RSQ)

Please read each of the following statements and rate the extent to which you believe each statement best describes your feelings about **close relationships.**

		Not at all like me		**Some-what like me**		**Very much like me**
1.	I find it difficult to depend on other people.	1	2	3	4	5
2.	It is very important to me to feel independent.	1	2	3	4	5
3.	I find it easy to get emotionally close to others.	1	2	3	4	5
4.	I want to merge completely with another person.	1	2	3	4	5
5.	I worry that I will be hurt if I allow myself to become too close to others.	1	2	3	4	5
6.	I am comfortable without close emotional relationships.	1	2	3	4	5
7.	I am not sure that I can always depend on others to be there when I need them.	1	2	3	4	5

8.	I want to be completely emotionally intimate with others.	1	2	3	4	5
9.	I worry about being alone.	1	2	3	4	5
10.	I am comfortable depending on other people.	1	2	3	4	5
11.	I often worry that romantic partners don't really love me.	1	2	3	4	5
12.	I find it difficult to trust others completely.	1	2	3	4	5
13.	I worry about others getting too close to me.	1	2	3	4	5
14.	I want emotionally close relationships.	1	2	3	4	5
15.	I am comfortable having other people depend on me.	1	2	3	4	5
16.	I worry that others don't value me as much as I value them.	1	2	3	4	5
17.	People are never there when you need them.	1	2	3	4	5

18.	My desire to merge completely sometimes scares people away.	1	2	3	4	5
19.	It is very important to me to feel self-sufficient.	1	2	3	4	5
20.	I am nervous when anyone gets too close to me.	1	2	3	4	5
21.	I often worry that romantic partners won't want to stay with me.	1	2	3	4	5
22.	I prefer not to have other people depend on me.	1	2	3	4	5
23.	I worry about being abandoned.	1	2	3	4	5
24.	I am somewhat uncomfortable being close to others.	1	2	3	4	5
25.	I find that others are reluctant to get as close as I would like.	1	2	3	4	5
26.	I prefer not to depend on others.	1	2	3	4	5
27.	I know that others will be there when I need them.	1	2	3	4	5
28.	I worry about having others not accept me.	1	2	3	4	5

29.	Romantic partners often want me to be closer than I feel comfortable being.	1	2	3	4	5
30.	I find it relatively easy to get close to others.	1	2	3	4	5

Subscales for the attachment patterns defined by the four-category model:
Secure Items: 3, 9(Reverse), 10, 15, 28(Reverse).
Fearful Items: 1, 5, 12, 24.
Preoccupied Items: 6(Reverse), 8, 16, 25.
Dismissing Items: 2, 6, 19, 22, 26.

Appendix G

Family-of-Origin Scale

In reading the following statements, apply them to your family-of-origin, as *you remember it.* Using the following scale, circle the appropriate number. Please respond to each statement.

5(SA) = Strongly agree that it describes my family of origin.
4(A) = Agree that 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 and how they felt.
10. We talked about our sadness when a relative or family friend died.
11. My parents openly admitted it when they were wrong.
12. In my family, I expressed just about any feeling I had.
13. Resolving conflicts in my family was a very stressful experience.
14. My family was receptive to the different ways various family members viewed life.
15. My parents encouraged me to express my view openly.
16. I often had to guess at what other family members thought or how they felt.
17. My attitudes and my feelings frequently were ignored or criticized in my family.
18. My family members rarely expressed responsibility for their actions.
19. In my family, I felt free to express my own opinions.
20. We never talked about our grief when a relative or family member died.
21. Sometimes in my family, I did not have t say anything, but I felt understood.
22. The atmosphere in my family was cold and negative.
23. The members of my family were not very receptive to one another's views.
24. I found it easy to understand what other family members said and how they felt.
25. If a family friend moved away, we never discussed our feelings of sadness.
26. In my family, I learned to be suspicious of others.
27. In my family, I felt that I could talk things out and settle conflicts.
28. I found it difficulty to express my own opinions in my family.

29. Mealtimes in my home usually were friendly.
30. In my family, no one cared about the feelings of other family members.
31. We usually were able to work out conflicts in my family.
32. In my family, certain feelings were not allowed to be expressed.
33. My family believed that people usually took advantage of you.
34. I found it easy in my family to express what I thought and how I felt.
35. My family members usually were sensitive to one another's feelings.
36. When someone important to us moved away, our family discussed our feelings of loss.
37. My parents discouraged us from expressing different views from theirs.
38. In my family, people too responsibility for what they did.
39. My family had an unwritten rule: Don't express your feelings.
40. I remember my family as being warm and supportive.

Subscales for the autonomy and intimacy subscales:

Autonomy:

- Clarity of Expression (CE): positive items 24, 34 and negative items 9, 16
- Responsibility (R): positive items 11, 38 and negative items 5, 18
- Respect for Others (RO): positive items 15, 19 and negative items 4, 28
- Openness to Others (O): positive items 6, 14 and negative items 23, 37
- Acceptance of Separation and Loss (A): positive items 10, 36 and negative items 20, 25

Intimacy:

- Expression of a Range of Feelings (RF): positive items 1, 12 and negative items 32, 39
- Mood and Tone of Home (MT): positive items 29, 40 and negative items 2, 22
- Dealing with Conflict Resolution (C): positive items 27, 31 and negative items 7, 13
- Promoting Sensitivity or Empathy (E): positive items 21, 35 and negative items 17, 30
- Developing Trust (T): positive items 2, 8 and negative items 26, 33

Note: Higher scores indicate a higher degree of health on each dimension.

Appendix H

Children of Alcoholics Screening Test – Short Form (CAST-6)

Please circle the answer that best describes your feelings, behavior, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 6 questions.

1. Have you ever thought that one of your parents had a drinking problem?
   YES NO

2. Did you ever encourage one of your parents to quit drinking?
   YES NO

3. Did you ever argue or fight with a parent when one of them was drunk?
   YES NO

4. Have you ever heard your parents fight when one of them was drunk?
   YES NO

5. Did you ever feel like hiding or emptying a parent's bottle of liquor?
   YES NO

6. Did you ever wish that a parent would stop drinking?
   YES NO

Appendix I

Demographics Questionnaire

Subject ID#_____

1. What is your sex?
   - ☐ Female
   - ☐ Male

2. What is your age? _____

3. What is your marital status?
   - ☐ Single (never married)
   - ☐ Divorced (single)
   - ☐ Married
   - ☐ Partnered
   - ☐ Widowed
   - ☐ Other:_____

4. What is the highest level of education you have completed?
   - ☐ Some high school
   - ☐ High School degree or equivalent
   - ☐ Some college
   - ☐ College Degree
   - ☐ Some graduate school
   - ☐ Graduate degree (e.g., M.A., Ph.D., J.D., M.D)

5. What is your yearly income (if you are a student, indicate your family's income)?
   - ☐ Less than $10,000
   - ☐ $10,000-$29,999
   - ☐ $30,000-$49,999
   - ☐ $50,000-$60,999
   - ☐ $70,000- or higher

6. In terms of race, I consider myself to be:_____.

7. In terms of ethnic group, I consider myself to be:_____.

8. In your family while you were growing up, were your parents/caregivers:
   - ☐ Married
   - ☐ Partnered
   - ☐ Divorced
   - ☐ Separated
   - ☐ Never married but living together
   - ☐ Single parent/caregiver (for example you had no contact with one parent)

9. Do you self-identify as an adult child of an alcoholic? Y N

10. Are you a member of Al-Anon Family Groups? Y N
    If so, how many meetings have you attended in the last 6 months?_____

11. If you self-identify as an adult child of an alcoholic, which of your parents/caregivers were alcoholic (Please check all that apply)?

    Mother Father Grandmother Grandfather
    Other(please specifiy):_____

12. How frequently did he/she drink?
    - ☐ Daily
    - ☐ 3-5 times per week
    - ☐ 1-3 times per week
    - ☐ Every 1-2 weeks
    - ☐ Once a month or less

13. On average, what quantity of alcohol did he/she drink in one sitting?
    - ☐ 1-2 drinks
    - ☐ 3-5 drinks
    - ☐ 6-11 drinks
    - ☐ 12 or more drinks

14. Did your parent/caregiver use any other drugs?
    - ☐ Yes
    - ☐ No

    If yes, what other drugs did he/she/they use?

15. How many years during your childhood did you live with this/these parents/caregivers?

16. How much of the time you were living with this caregiver/parent(s) was he/she/they actively drinking?

17. Did your parent/caregiver(s) successfully enter into recovery from alcoholism? If so, how old were you when this happened?

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