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An investigation of shame and perceived family of origin health in a sample of adult children of alcoholics compared to a sample of adult children of nonalcoholics

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AN INVESTIGATION OF SHAME AND PERCEIVED FAMILY OF ORIGIN
HEALTH IN A SAMPLE OF ADULT CHILDREN OF ALCOHOLICS
COMPARED TO A SAMPLE OF ADULT CHILDREN
OF NONALCOHOLICS

by

Shirley A. Butler

A Dissertation Submitted to the Faculty of the Graduate
School of Loyola University in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

May

1993

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VITA

The author, Shirley Ann Butler was born October 16, 1950 in Columbus, Ohio. Ms. Butler entered Ohio State University in September, 1968 and graduated cum laude with a Bachelor of Science degree in Nursing in March, 1973. In 1972, while attending Ohio State University, she was inducted into two honorary nursing organizations, Torch Club and Sigma Theta Tau.

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CHAPTER I
INTRODUCTION

Alcoholism (problem drinking) is a widespread biophysiological and psychosocial problem that affects not only the alcoholic (problem drinker) but others in his or her environment. Until recently, treatment of a drinking problem has focused primarily on the alcoholic. However, in the past several years it has become apparent that alcoholism takes a very large toll on the entire family of the alcoholic. The latest focus of attention is on the offspring of alcoholics and how having grown up with an alcoholic parent affects their childhood as well as their adult lives. There are estimated to be some 28 to 34 million people in the United States who are the grown offspring (age 18 or older) of parents who have had alcohol problems (Russell, Henderson, & Blume, 1985). Black (1981) estimated that one in six American families is affected by alcoholism. In recent years, adult children of alcoholics are going into psychotherapy treatment, having recognized as adults, that they are now facing interpersonal and emotional problems that they partly attributed to the consequences of having grown up in an alcoholic family (Vannicelli, 1989).

Important developments have also occurred with

increasing numbers of adult children of alcoholics finding their way to treatment. First, there has been a significant increase in the body of clinical literature that addresses itself to the consequences in adulthood of having been raised by an alcoholic parent (Brown, 1988; Brown & Beletsis, 1986; Cermak & Brown, 1982; Gravitz & Bowden, 1984; Kern, 1985; Macdonald & Blume, 1986; Seixas & Levitan, 1984; Vannicelli, 1988, 1989; Wood, 1987). Secondly, research findings are beginning to document the effects of alcoholism on the entire family system not just the addicted family member (Davis, Berenson, Steinglass, & Davis, 1974; Steinglass, 1979; Steinglass, Davis, & Berenson, 1977; Vannicelli, 1989; Wolin, Steinglass, Sendroff, Davis, & Berenson, 1975). These earlier studies (Fox, 1962) suggested that "every member in an alcoholic family is affected by it--emotionally, spiritually and in most cases economically, socially and often physically" (p. 72).

Purpose of the Study

The overall purpose of the study was to test for differences in internalized shame (ISS) and perceived family of origin health (FOS) between a sample of adult children of alcoholics (ACA) compared to a sample of adult children of nonalcoholics (ACNA). Such comparative data are necessary to determine if the long-term psychological effects of being reared in an alcoholic home differ significantly from those of individuals who grew up in nonalcoholic family

environments.

The following research questions were addressed:

1. Do internalized shame scores (ISS) of adult children of alcoholics differ significantly from adult children of nonalcoholics?
2. Do perceived levels of family of origin health of adult children of alcoholics differ significantly from adult children of nonalcoholics?
3. Are there significant interrelationships among the subjects' internalized shame scores and perceived level of family of origin health?

Theoretical Rationale

The hypotheses tested in this research project were crafted to assess the accuracy of some of the recent clinical descriptions of adult children of alcoholics. Family systems and shame theories provide a framework for understanding adult children of alcoholics.

The family can be defined as a group of individuals with a shared past and future (Haley, 1963; Lantz, 1978). A functional family is one in which the needs of various family members are met. The family is a relationship system in which each family member has influence upon all other members and in which each individual member is influenced by all other family members. The family shapes and continues to determine the course and outcome of human lives.

According to Carter and McGoldrick (1976), family

relationships tend to be highly reciprocal, repetitive, and patterned and have circular rather than linear motion. Maintenance of the system's functioning is based upon a process of feedback. The family system operates by means of a feedback loop that maintains an internal balance in family interactions. This internal balance is termed homeostasis.

Jackson (1968) wrote that family homeostasis "... implies the relative constance of the internal environment, a constance; however, which is maintained by a continuous interplay of dynamic forces." The constance of family homeostasis does not imply an entity that is unchanging, but rather that the interplay of forces serves to limit and direct behavior change. Family systems theorists view all behavior as purposeful in maintaining the family system. Therefore, dysfunctional behavior also serves a function in maintaining family homeostasis. Haley (1962) described symptomatic behavior as follows:

Psychopathology in the individual is a product of the way he deals with his intimate relations, the way they deal with him, and the way other family members involve him in their relations with each other. Further, the appearance of symptomatic behavior in the individual is necessary for the continued functioning of a particular family system. Therefore, changes in the individual can occur only if the family system changes, and resistance to change in the individual centers on the influence of the family as a group (p. 70).

Family and systems theorists (Bowen, 1974; Watzlawick, Weakland & Fisch, 1974; Satir, 1964) conceptualize the alcoholic family as a maladaptive or dysfunctional system which is organized around one member's alcoholism (Black,

1981; Bowen, 1974; Wegscheider, 1981). Patterns of relating stem from strategies to deal with the impact of alcoholism. In turn, patterns of interacting within the relationship circularly set up new patterns until the system becomes unrewarding and dysfunctional. Essentially, individual family members are damaged by the effects of alcoholism upon the system.

The alcoholic family environment is often characterized as one of chaos, inconsistency, unpredictability, unclear roles, arbitrariness, changing limits, repetitious and illogical thinking, and possibly abusive (physical, sexual, emotional) (Beletsis & Brown, 1981; Black, 1981; Cork, 1969; Seixas, 1979). This environment does not allow for continued growth of individuals; therefore, the level of health (healthy functioning) decreases. Unhealthy guilt and shaming experiences proliferate the alcoholic family environment (Evans, 1987). Negative affirmations in dysfunctional families outweigh the positive ones (Jacob, 1987).

Kaufman (1989) hypothesized that high levels of internalized shame lead to the development of a "shame-based identity." He suggested that the need to belong or identification with others and shame are two principal sources of identity. Kaufman also views shame as the source of "depression, alienation, self-doubt, loneliness, paranoid and schizoid phenomena, compulsive disorders, splitting of

the self, perfectionism, inferiority, inadequacy, failure, borderline conditions, and narcissism" (Kaufman, 1985, p. viii).

Shame is associated with social relationships and is often triggered with regard to social situations where there is a breaking off of the connection between individuals where one is seeking to establish or maintain that connection. Kaufman (1989) has referred to this as the breaking of the "interpersonal bridge."

Alcoholic family members often break or damage the interpersonal bridge. Therefore, the family system inhibits the development of healthy relationships and thus perpetuates high levels of shame in family members.

A major premise of the literature on alcoholic families is that these families are dysfunctional or unhealthy. Hopefully, the objectives of this research project will help to clarify the notion that the entire family system adjusts in some dysfunctional way to alcoholism (problem drinking) and deprives the family's ability to address the psychological needs of the family members. Given what is reported above, the research objectives of this study were focused on a nonclinical sample, and were directed at:

1. exploring the differences in internalized shame between adult children of alcoholics and adult children of nonalcoholics.
2. exploring the differences in perceived family of

origin health between adult children of nonalcoholics and adult children of alcoholics.

3. determining whether interrelationships exist among the adult children's levels of perceived family of origin health and internalized shame.

Significance of the Study

Alcoholism has long been recognized as a problem that affects the family system. Previous research has focused on the effect parental alcoholism has on children's psychological functioning. Over the past ten years, more empirical studies have explored the psychological effects of having had an alcoholic parent as a person approaches adulthood.

The significance of this study is that to date there has been no empirical research examining shame and perceived family of origin health in a nonclinical adult children of alcoholics population. However, the clinical literature strongly suggests that adult children of alcoholics have less favorable family health levels (more family dysfunction) and are more prone to shame-based identities than adult children of nonalcoholics. The vast majority of knowledge gained about adult children of alcoholics has been through clinical observation procedures. This study is meant to bridge the gap between practice and research.

Definition of Terms

The following are definitions of terms used in this

study:

Adult child of an alcoholic (ACA) - is defined as a person who reports being raised by a parent who they perceived as experiencing a drinking problem while they were growing up. Operationally, a person who scored two or more on the Children's of Alcoholics Screening Test.

Adult child of a nonalcoholic (ACNA) - is defined as a person who reports being raised by a parent who they perceived as not having a drinking problem while they were growing up. Operationally, a person who scored one or less on the Children's of Alcoholics Screening Test.

Nonalcoholic parent - is defined as parent who is perceived by his or her offspring as not having a drinking problem.

Alcoholic parent - is defined as a parent who is perceived by his or her offspring as having a drinking problem that interfered with the parent's ability to function in any major area of life-social, emotional, legal, vocational, and spiritual.

Alcoholism - is defined as drinking that interferes with a person's ability to function in any major area of their life: social, emotional, legal, vocational, spiritual.

Family of origin health - is defined as the subject's perceived levels of autonomy and intimacy (level of health or healthy functioning) in his or her family of origin.

Operationally, level of family of origin health is measured by the person's score on Family of Origin Scale (FOS).

Shame - is defined as that deep sense of self worthlessness and self rejection which is rooted in shame affect. The shame affect has become internalized from many repeated rejections throughout childhood (Kaufman, 1985, 1989). Operationally, shame is measured by the person's score on the Internalized Shame Scale (ISS).

Summary

This chapter has introduced the research study on adult children of alcoholics. It has defined adult children of alcoholics as a significant population to examine. The chapter has focused on the lack of empirical research dealing with adult children of alcoholics' issues and the need to bridge the gap between clinical literature and empirical research. Additionally, this chapter presented the research questions, theoretical rationale, significance of study, and definition of terms.

The next chapter reviews clinical literature and empirical research. The chapter is divided into three sections: Alcoholic Families, Adult Children of Alcoholics, and Shame and Adult Children of Alcoholics.

CHAPTER II

REVIEW OF THE LITERATURE

The literature review presented here is based on clinical observation, and on empirical and theoretical work related to adult children of alcoholics. It is divided into three parts: (1) alcoholic families; (2) adult children of alcoholics; and (3) shame and adult children of alcoholics. Much of the literature is based on clinical observations. A major shortcoming of most of addictions' research is the lack of any theoretical foundation. Without a conceptual framework, data collection yields few applications for prevention and intervention situations (Nardi, 1981). Although much of the research on adult children of alcoholics continues without such frameworks, some researchers (Bowen, 1978; Brown, 1988; Hardwick, 1990; Kashubeck, 1989; Nardi, 1981; Post, 1991; Teece, 1990; Steinglass, 1980) have used existing theories (e.g., role, psychodynamic, family systems, cognitive social learning, stress and coping) to understand the dynamics of growing up in an alcoholic home.

General methodological problems (lack of randomization, lack of comparison groups, and small sample sizes) also exist in most of the research published to date. Barnes,

Benson and Wilsnack (1979) concluded from a review of the literature that because existing studies are so methodologically weak, it is very difficult to generalize findings to the greater population of adult children of alcoholics. Many studies do not have control groups, or neglect to match control subjects on important variables (Jacob, Favorini, Meisel & Anderson, 1978; Nardi, 1981; Wilson & Orford, 1978). Data collection techniques vary greatly with respect to the variables and format studied with no focused attention given to any single variable, thereby limiting the reliability of the findings (Nardi, 1981). Few studies considered the possible influence of such variables as ethnicity, religion, social class, sex roles, cross-cultural variations, family structure, and child's age at onset of parental alcoholism. According to Nardi (1981) the "impact of parental disturbance on children is often mediated by these social and cultural factors" (p. 238). This research project was designed in an effort to address some of these issues.

Alcoholic Families

Before 1960 little research directly investigated members from alcoholic families; however, a few studies on adult alcoholism did explore characteristics and issues of nonalcoholic family members. Generally only the male alcoholic was examined; some early studies referred to alcoholics as if all were males (Jones, 1968). Extensive

research was done in several areas--personality traits (Jones, 1968), the etiology of the disease (Lisansky, 1960), and methods of treatment (Catanazaro, 1968). In these research studies it was the alcoholic who received the central focus and almost exclusive attention.

At that time family theory as a functional system was in its beginning stages and psychodynamic notions dominated the alcoholism literature (Ackerman, 1966; Bowen, 1974; Guerin, 1976; Paolino & McCrady, 1979). Both the alcoholic, often theorized as a sociopath, and his spouse were labeled as mentally disordered personalities (Jones, 1968). Jackson (1954) and others (Fox, 1962; Futterman, 1953; Jacob, Favorini, Meisel, & Anderson, 1978; MacDonald, 1956) investigated personality traits and the role of the spouse. During this time, it was believed that wives played a major part in the initiation and continuation of her husband's abuse of alcohol. Jackson (1954) described stages in a developmental disease process of alcoholism for the spouse and family members.

After 1960, the concept of "alcoholic family" or "family disease" evolved with the focus of research on the interactions, adjustments, and development of the family with an alcoholic member. Jackson (1962) challenged the belief of inherent personality faults in alcoholic families. Jackson's research studies (1954, 1958, 1962, 1963) and those of Bailey, Haberman and Sheinberg (1965) supported the

concept that the stress of maintaining an alcoholic family with its decreasing economic, social, emotional and crisis-management resources, was responsible for distress among family members, rather than inherent pathology of individual members.

Since the climate was changing in the direction of family systems theories, Jackson's research prompted attention upon the "experience" of the wife and research focused on marital interactions (Paolino & McCrady, 1979). Few studies (Baker, 1945; Hunter, 1963) recognized the maladaptive and disorganized character of family structure or that examined the consequences for the children. Alcoholism was still considered a problem of men in lower socioeconomic groups. Little clinical attention was paid to children and many alcoholism treatment programs did not include family members. In psychological and psychiatric literature (Ackerman, 1966; Bowen, 1974; Cotton, 1979; Goodwin, 1979), the notion that alcoholism was a family disorder and that alcoholics often had offspring who also became alcoholic became firmly established. Research studies were done to examine environmental correlates and genetic patterns of alcoholism.

Genetic research had always been a central focus. Russell, Henderson, and Blume (1985) summarized in their review of the literature the genetic characteristics related to alcoholism. These included biological markers,

neurophysiological and biochemical factors. According to Brown (1988), the findings of these genetic studies reflected the possibility that there are "multiple alcoholisms" with different biochemical determinants, patterns of inheritance, and clinical manifestations. More recently studies reflect an awareness of the complexity of the alcoholism, and the occurrence of multiple causal factors, especially the interplay between genetics, environment, social, psychological, and cultural factors. Cloninger (1981, 1983) investigated the interaction between environment and genetics. Goodwin (1984) suggested that a new, individual category of "familial alcoholism" be used to reflect differences in development and symptomatology.

Some researchers (Aronson & Gilbert, 1963; Haberman, 1966; Nylander, 1960) hypothesized that a relationship existed between alcoholic fathers and serious problems in their offspring. These problems included hyperactivity (Cantwell, 1972), enuresis (Sloboda, 1974), fetal alcohol syndrome (Rosett, 1976), and child abuse (Ellwood, 1980; Hindman, 1976; Mayer & Black, 1977; Seixas, 1979). Depression, suicide, behavioral, and school problems were also associated to parental alcoholism (Wegscheider, 1978).

As the dynamics of family alcoholism were examined, more attention was given to the need for research on children in interaction with an alcoholic family, rather than research on specific behavioral problems.

Cork (1969) attempted to address these issues when she wrote an influential book, The Forgotten Children, about her research on the experience of children raised in an alcoholic family. She postulated that offspring of alcoholics had more difficulty making friends, exhibited dysfunctional parent-child relationships, and were mistrustful, hostile, and uncomfortable with the opposite sex. Cork's study was unique in its examination of the child's perceptions as a member of an alcoholic family, although Cork's research study was methodologically weak. The research conclusions were intuitively plausible, and it still has an impact upon clinicians. The book focused the attention on the need for consideration and treatment of children of alcoholics.

A few early studies did focus on family members, and one is significant because its findings were contrary to those of Cork. In 1945, Roe in her research of adult adjustment of children of alcoholics, concluded that there was no difference in adult adjustment between the adult children of alcoholics and the control group.

The early research emphasized the deviancy of the alcoholic family. Subjects were usually limited to males, lower socioeconomic groups, or delinquents. However, these studies focused upon the family system and the child of parental alcoholism was associated with negative consequences. These early studies led to later and more

definitive research which focused on the emotional and social effects of parental alcoholism on children rather upon behavior problems and deviancy (Bowen, 1974).

Today our knowledge of "alcoholic families" is still somewhat primitive, given the newness of interest in alcoholism by family researchers, as well as the newness of interest in whole families by addiction researchers. Increasingly, alcoholism is viewed as a system dysfunction, not reflecting individual pathology to which others respond, but a multifaceted problem in the family which affects every member and to which every member contributes. This notion of the systematic nature of alcoholism is reflected in the recent addiction clinical literature (e.g., Ackerman, 1983; Beardslee, Son & Vaillant, 1986; Bradshaw, 1988; Friel & Friel, 1988; Fossum & Mason, 1986; Jacob, Favorini, Meisel & Anderson, 1978; Lawson, Peterson & Lawson, 1983; Wegscheider & Wegscheider, 1978), the family therapy literature (e.g., Berenson, 1976; Bowen, 1974; Steinglass, 1976; Steinglass, Weiner & Mendelson, 1971), and in the increasing inclusion of the whole family system in the treatment process. Self-help groups for spouses and children of alcoholics (Al-Anon, Alateen, and Adult Children of Alcoholics) have been established to acknowledge the importance of treatment and recovery for all family members. Shulamith, Straussner, Weinstein and Hernandez (1979) found that nonalcoholic family members developed similar defenses and symptoms to

those of the alcoholic member, for example, denial. Recently terms like codependent, co-alcoholic, and para-alcoholic are being used to describe nonalcoholic family members (Beattie, 1987; Friel & Friel, 1988; Greenleaf, 1981; Subby & Friel, 1984) in the addiction clinical literature. Emphasis is being placed on the system's interdependent responsibility and recovery rather than the individual subsystem. A model for alcoholic families has been proposed by Steinglass and his colleagues which integrates family systems concepts (Davis, Berenson, Steinglass & Davis, 1974; Steinglass, Weiner & Mendelson, 1971). They define "alcoholic systems" as those whose central organizing principle is the issue of alcohol. In the alcoholic system, the presence or absence of alcohol is the key that determines the system's interaction. Therefore, the notion of circular causality helps to explain why no one part of the family system can be singled out and held responsible for the perpetuation of the alcoholic cycle.

Other systems concepts are helpful in viewing the alcoholic family system. The homeostatic quality of alcoholism for families has been addressed in the literature. Jackson (1957) was the first to discuss this homeostatic quality and by 1968, Ewing and Fox referred to homeostasis in alcoholic marriages, which were:

established... to resist change over long periods of time. The behavior of each spouse is rigidly

controlled by the other. As a result, an effort by one person to alter his typical role behavior threatens the family equilibrium and provokes renewed efforts by the spouse to maintain the status quo. (p. 87)

According to Steinglass (1976) alcohol may have stabilizing and adaptive consequences for many families. The alcohol abuse produces predictable and manageable sets of system's responses to external and internal stressors. Jacob, Dunn and Leonard (1983) found that high satisfaction and decreased symptomatology in the spouses of steady drinkers was correlated with high alcohol consumption. Davis and his colleagues theorized that alcohol abuse has specific adaptive outcomes that reinforce chronic alcohol abuse on several different levels for family members and the system. Boszormenyi-Nagy and Spark (1973) coined the phrase, "invisible loyalty" which applies to many alcoholic families. Since these families have a strong homeostatic force, the loyalty to the system may continue inspite of the negative outcomes. Bowen referred to this behavior as "undifferentiated." Later Steinglass (1980, 1981a, 1981b) and others (Wolin, Bennett, Noonan & Teitelbaum, 1980) investigated family homeostasis as a significant variable in understanding the impact of parental alcoholism, but also the differences between families with a drinking parent.

Some writers have focused on the homeostatic mechanism as one regulating the family system's intimacy. Nurse (1982) postulated that alcohol is triangulated with the marital dyad to reduce the tension in the relationship, and

that "fear of intimacy ... is primary" (p. 160). Coleman (1982) indicated that:

... chemical abuse become the coping mechanism for family intimacy dysfunction. This abuse pattern leads to further intimacy dysfunction in adolescence and adulthood, which is passed from generation to generation. (p. 155)

System related boundary issues are also relevant to a discussion of alcoholic families. Minuchin (1974) described three types of boundaries: clear, enmeshed and disengaged. Clear boundaries foster intimacy, flexibility, and individual identity (autonomy) and growth are present in most "healthy" family systems. Alcoholic family systems often have enmeshed and disengaged boundaries contingent upon the presence or absence of alcohol and the family's perception of its level of functioning (Killorin & Olson, 1984). Internally, subsystem boundaries are frequently and inappropriately crossed. Boundaries between parents and children are also confused. Family therapists attempt to delineate clearly the subsystems' boundaries or authority.

Bowen (1978) referred to families who have not successfully completed such a process as having "undifferentiated family ego mass." He postulated that the less differentiation is present between individuals in a family system, the more likely psychopathology exists.

Interactional patterns of alcoholic family systems were investigated by Steinglass (1981), Bowen (1974), and Hindman (1976). Johnson (1984) explored differences between

nonalcoholic parent-child and alcoholic parent-child interactions. Wilson and Orford (1978) and his colleagues (Gorad, 1971; Moos, Finney & Gamble, 1982; Orford, Oppenheimer, Egert, Hendsman & Guthrie, 1976) investigated the pattern of drinking and its impact on family process. Ackerman (1956, 1958) proposed a need for a "psychosocial diagnosis of the family." The sick behaviors of these family members are often closely woven and mutually reinforcing" (Ackerman, 1958).

From what is reported above, family and system theorists (Ackerman, 1958; Bowen, 1974; Satir, 1964; Steinglass, 1981a, 1981b; Watzlawick, Weakland & Fisch, 1974) appear to have laid the groundwork to gain a better understanding of the kinds of responses and interactional patterns family members develop to maintain the alcoholic family system.

Adult Children of Alcoholics

Clinical Literature on Adult Children of Alcoholics

Young children of alcoholics have been identified as a research and treatment population for approximately 30 years; however, the concept of adult children of alcoholics is more recent (Newsweek, 1979). Literature specific to the characteristics and the needs of adult children is more readily available. In a relatively brief period of time, recognition of adult children of alcoholics as a research and treatment group has evolved from an idea to a national

social movement. There is widespread consensus among clinicians that adults who are raised in alcoholic homes do suffer consequences and do have legitimate treatment needs of their own (Beletsis & Brown, 1981; Black, 1981; Cermak & Brown, 1982; Thanepohn, 1986).

Woititz (1983) postulated that adult children of alcoholics, at least internally, "... feel different from other people because to some degree they actually are" (p. 48). Seixas and Youcha (1985) suggested that this difference arises from the nature of alcoholic families, and that family members have had limited opportunities to share and compare their experiences with others.

Brown and Beletsis (1986) found that adult children of alcoholics in a long-term clinical research and treatment program reported serious psychological problems in their adult lives which they related to their childhood family environment and especially to the alcoholism of one or both parents. Cermak (1984) has compared the after effects of being reared by an alcoholic parent to post-traumatic stress disorder with chronic signs and symptoms of sleep disturbance, nightmares and anxiety similar to those experienced by war veterans (Wilson, 1985).

Based on clinical observation, Black (1981) theorized that having adjusted to their family of origin experiences as younger children in ways that helped them cope with the stress of family life, adult children of alcoholics often

start to have problems in their mid-twenties or later as these coping strategies are not well-suited to more "normal" adult social interactions. El-Guebaly and Orford (1977) postulated that "the offspring of alcoholics appear to be at increased risk for the serious psychological illness of adulthood" (p. 357). Wanck (1985) indicated that many adult children of alcoholics are adept at presenting the appearance of healthy functioning while experiencing emotional pain and turmoil.

Many authors (Beletsis & Brown, 1981; Black, 1981; Cermak & Brown, 1982; Gravitz & Bowden, 1984; Seixas, 1982; Wegscheider-Cruse, 1985; Woititz, 1983, 1985) have attempted to describe personality traits of "typical" patterns of dysfunction characteristic of adult children of alcoholics. Empirical studies (Alterman, Searles & Hall, 1989; Barnard & Spoentgen, 1986; Calder & Kostyniuk, 1989; Goodman, 1987; Seefeldt & Lyon, 1991; Venugopal, 1985) have not supported a "core constellation" of the adult-child syndrome; however, clinical evidence for such a profile is substantial.

According to Vannicelli (1989), the most commonly identified problems/issues in the clinical literature include: (1) difficulty with intimate relationships (Ackerman, 1987; Black, 1981; Cermak & Brown, 1982; Gravitz & Bowden, 1984; Wegscheider-Cruse, 1985; Woititz, 1983); (2) lack of trust in others (Black, 1981; Cermak & Brown, 1982; Gravitz & Bowden, 1984; Greenleaf, 1981; Seixas, 1982;

Wegscheider-Cruse, 1985); (3) fear of loss of control (Black, 1981; Cermak & Brown, 1982; Gravitz & Bowden, 1984); (4) conflicts over personal responsibility, characterized by super-responsible and/or super-irresponsible behavior (Ackerman, 1987; Black, 1981; Cermak & Brown, 1982; Gravitz & Bowden, 1984; Greenleaf, 1981; Wegscheider-Cruse, 1985; Woititz, 1983); (5) denial of feelings and of reality (Ackerman, 1987; Black, 1981; Seixas, 1982; Wegscheider-Cruse, 1985); (6) proclivity toward uncompromising self-criticism (Ackerman, 1987; Black, 1981; Cermak, 1985; Woititz, 1983); and (7) problems with self-esteem (Black, 1981; Cermak, 1985; Gravitz & Bowden, 1984; Greenleaf, 1981; Wegscheider-Cruse, 1985; Woititz, 1983).

Several writers (Black, 1981; Wegscheider, 1981) have developed classification systems describing coping styles in alcoholic families. Black identified three key roles and their behavioral presentations--the responsible child, the placater, and the adjuster. Wegscheider described four--the family hero, the scapegoat, the mascot and the lost child. Wegscheider (1981) had focused on maladaptive role patterns but Nardi (1981) and El-Guebaly and Orford (1979) also recognized the importance of the "competent" child who, rather than developing psychopathology as a result of the chaotic environment, demonstrated characteristics of a "model" child. Niven (1984) called this group the "invulnerables." Invulnerables are unlikely to enter the

mental health systems and therefore will not be identified as having difficulties related to parental alcoholism until adulthood, if at all (Brown, 1988).

Empirical Literature on Adult Children of Alcoholics

Empirical research studies may be organized into two groups: those that address the physiological or genetic component of being the offspring of an alcoholic, and those studies that investigate various psychological and/or environmental correlates of being raised in an alcoholic family environment. The physiological/genetic studies have focused on areas such as predisposition to the development of alcoholism in offspring (Cotton, 1979; Jones, 1972; Parker & Harford, 1988; Rogosch, Chassin & Sher, 1990; Schuckit, Goodwin & Winokur, 1972; Svanum & McAdoo, 1991), and neurophysiological deficits (Kaplan, Hesselbrock, O'Connor & Depalma, 1988; Tarter, Hegedus, Goldstein, Shelly, & Alterman, 1984).

Since the late 1980's studies of the psychological/environment correlates of this population have focused on a wide variety of areas, including: (a) physical problems, such as an increased occurrence of illness and accidents (Chafetz, Blane & Hill, 1971; Miller, Finn, Ditto & Pihl, 1989), physical and sexual abuse (Black, Buckey & Wilder-Padilla, 1986; Coleman, 1982); (b) psychopathology for example, anxiety disorders (Kushner, Sher, & Beitman, 1990; Merikangas, Leckman, Prusoff, Pauls & Weisman, 1985; Munjack

& Moss, 1981; Noyes, Crowe, Harris, Hamra, McChesney & Chaudhry, 1986), affective disorders (Black, Buckey & Wilder-Padilla, 1986; Clair & Genest, 1987; Cloninger, Reich & Wetzell, 1979; Cole, 1988; Glenn & Parsons, 1989; Goodwin, Schulsinger, Knop, Mednick & Guze, 1977; Guerra, 1991; Hesselbrock, Hesselbrock, Syzmanski & Weidenman, 1988; Jarmas, 1988; Merikangas et al., 1985; Parker & Harford, 1988; Sloboda, 1974; Wilson, 1988), and personality disorders (Earls, Reich, Jung, & Cloninger, 1988; Gagnon, 1991; Hoover, 1990; Reich, 1988; Russell, Henderson & Blume, 1985). Some research studies have also focused on interpersonal problems of adult children of alcoholics (Black, Buckey & Wilder-Padilla, 1986; West & Prinz, 1987).

Empirical Studies on Psychopathology in Adult Children of Alcoholics. A summary of the results of empirical research in psychopathology reveals evidence to support more psychopathology in adult children of alcoholics compared to controls (Benson & Heller, 1987; Cole, 1988; Franks & Thacker, 1979; Ginchereau, 1989; Knowles & Schroeder, 1990; McKenna & Pickens, 1983; Miller & Jang, 1977). Equally valid studies reveal evidence not supporting more psychopathology in this population (Barnard & Spoentgen, 1986; Beardslee, Son & Vaillant, 1986; Gerner, 1989; Kashubeck, 1989).

Empirical Studies on Personality Characteristics of Adult Children of Alcoholics. Since the late 80's a vast

number of empirical studies have examined the personality characteristics of adult children of alcoholics (Bachner-Schnorr, 1987; Berkowitz & Perkins, 1988; Carder, 1991; Carroll, 1991; Cole, 1988; Eve, 1987; Fidelibus, 1988; Goglia, 1986; Jackson, 1985; Moore, 1987; Moroney, 1991; Sharma, 1990; Stevens, 1980; Thomson, 1989; Van-Vranken, 1990; Walitzer, 1991). In a review of literature, Kenneth Sher (1991) surveyed three broad domains of personality: (1) behavioral under control (impulsivity, aggression) (Alterman, Bridges & Tarter, 1987; Alterman, Searles & Hall, 1989; Berkowitz & Perkins, 1988; Goglia, 1986; Knop, Teasdale, Schulsinger, & Goodwin, 1985; Mann, Chassin & Sher, 1987; Molina, Chassin, Sher, Crews, & Hepworth, 1990; Nathan, 1988; Saunders & Schuckit, 1981; Schulsinger, Knop, Goodwin, Teasdale, & Nikkelson, 1986; Sher, 1985; Sher, Walitzer, Wood, & Brent, in press; Werner, 1986; Windle, 1990), (2) emotionality (tendency to experience negative affective states, neuroticism) (Benson & Heller, 1987; Berkowitz & Perkins, 1988; Finn & Pihl, 1987; Schuckit, 1983), and (3) sociability (Berkowitz & Perkins, 1988; Finn & Pihl, 1987; Schuckit, 1983; Tarter, 1988). Several additional traits (activity level, self-esteem, locus of control, Type A behavior pattern, alexithymia, cognitive style, hyperactivity) have also been investigated. In general, empirical evidence has been inconclusive.

Researchers have used a variety of personality tests

and/or inventories (e.g., Minnesota Multiphasic Personality Inventory (MMPI), Edwards Personal Preference Schedule (EPPS), Personality Research Form (PRF), Jackson Personality Inventory (JPI), California Psychological Inventory (CPI), Sixteen Personality Factor Questionnaire (16 PF), Myers-Briggs Type Indicator (MBTI), Guilford-Zimmerman Temperament Survey, Million Clinical Multi-axial Inventory (MCMI) to measure personality characteristics/traits. As mentioned earlier, clinicians (Black, 1979; Woititz, 1983) have described a "typical profile" of adult children of alcoholics. These descriptions were based on summaries of clinical impressions made during treatment. Empirical studies have not supported a "typical profile."

A recent study done by Seefeldt and Lyon (1992) attempted to confirm the characteristics of adult children of alcoholics (ACOAs) as presented by Woititz (1983). The characteristics are the following:

1. ACOAs guess at what normal behavior is.
2. ACOAs have difficulty following a project through from beginning to end.
3. ACOAs lie when it would be just as easy to tell the truth.
4. ACOAs judge themselves without mercy.
5. ACOAs have difficulty having fun.
6. ACOAs take themselves very seriously.
7. ACOAs have difficulty with intimate relationships.

8. ACOAs overreact to changes over which they have no control.

9. ACOAs constantly seek approval and affirmation.

10. ACOAs usually feel they are different from other people.

11. ACOAs are super responsible or super irresponsible.

12. ACOAs are extremely loyal, even in the face of evidence that loyalty is undeserved.

13. ACOAs are impulsive (Woititz, 1983, p. 4).

Three groups of college students (adult children of alcoholics, non adult children of alcoholics and participants in an adult children of alcoholics treatment group) were compared on 12 of Woititz's 13 characteristics using objective personality measures (Personality Research Form, Jackson Personality Inventory and Impostor Phenomenon Scale). Seefeldt and Lyon reported no significant differences among the three groups on any of the characteristics measured. Based on these findings, they question the validity of Woititz's descriptions of adult children of alcoholics. "Our results support the findings of previous researchers who have found the ACOA group to be heterogeneous" (Seefeldt & Lyon, 1992, p. 592). To date the evidence from empirical research on adult children of alcoholics personality characteristics/traits failed to substantiate adult children of alcoholics as a homogeneous

group.

Empirical Studies Supporting Family of Origin Dysfunction in Adult Children of Alcoholics. Research studies have compared levels of health or dysfunction in the family of origin to current personality characteristics/traits in adult children of alcoholics and adult children of nonalcoholics. Andrasi (1987) examined self-esteem in adult children of alcoholics and controls. There was a significant between-group difference ($p < .001$) in the Family of Origin Scale ratings (Hovestadt et al., 1985), suggesting that adult children of alcoholics experience their families of origin as less facilitative in feeling expression, autonomy and promoting trust than controls. The relationship between family of origin ratings and self-esteem was measured using a Pearson product-moment correlation which proved significant for both adult children of alcoholics ($p < .01$) and controls ($p < .001$).

Three studies explored the relationships between family functioning and perceived intimacy. Using the Family Environment Scale (Moos & Moos, 1981) to evaluate cohesion and expressiveness in the family of origin, Durlak (1988) investigated the relationships between current perceived intimacy and family of origin relationships in adult children of alcoholics and controls. Results indicated that cohesion in the family of origin was a significant predictor of higher perceived emotional and social intimacy for adult

children of alcoholics compared to controls while conflict in the family of origin was a significant predictor for higher perceived sexual intimacy for adult children of alcoholics than controls.

Carey (1986) studied intimacy and family of origin relationships in female adult children of alcoholics and controls. Adult children of alcoholics measured higher levels of dysfunctional family of origin relationships than controls. Adult children of alcoholics with two alcoholic parents reported even higher levels of dysfunction in family of origin relationships. For both groups (ACAs, controls) significant weak correlations existed between intimacy and perception of family of origin relationships.

In 1988 Latham investigated the relationship between intimacy and autonomy in adult children of alcoholics. He used the Waring Intimacy Questionnaire (Waring, 1984) and the Family of Origin Scale (Hovestadt et al., 1985) to explore the family of origin experience in adult children of alcoholics compared to controls. Adult children of alcoholics scored significantly lower (more dysfunction) on the overall score ($p < .025$) as well as all subscales of the Family of Origin Scale and significantly higher (more pathology) on the Parentification Scale ($p < .01$). Affection and autonomy were found to be correlated with the family of origin experience.

Sollars (1989) found a significant relationship in

adult children of alcoholics and controls between current symptomatology and levels of family of origin dysfunction. He used the Family Adaptability and Cohesion Evaluation Scale III (Olson, Portner & Lavee, 1985) to group adult children of alcoholics and adult children of non-alcoholics into family of origin dysfunction levels and the Symptom Check List (SCL-90-F: Derogatis, 1976) to establish symptomatology.

Transeau (1988) investigated family of origin relationships, pathology and individuation in adult children of alcoholics. Using the Symptom Checklist-90-Revised (Derogatis, 1976) he found significant negative correlations between psychopathology and three areas of healthy family functioning: low intimidation by parents, low triangulation with parents and adequate individuation from parents.

Gold (1989) studied aspects of family of origin dysfunction, impairment in object relations and reality testing in adult children of alcoholics and controls. Using FACES III and the Bell Object Relations and Reality Testing Inventory (Alper, 1991; Bell, Billington, & Becker, 1986), significant correlations were found. Gold also indicated that after controlling for familial alcoholism, extent of family of origin dysfunction "made a significant contribution to impairment of object relations ... across both ACA and non-ACA groups" (p. 10).

Results of other empirical studies (Brower, 1987;

Pierucci, 1990; Soukup, 1990) also provide significant support for the relationship between family of origin dysfunction and dysfunctional adult children of alcoholics personality traits/characteristics.

Empirical Studies Not Supporting Family of Origin Dysfunction in Adult Children of Alcoholics. Two studies done by Tolton (1988) and Kunstenaar (1991) found no relationships between family of origin dysfunction and personality variables. Tolton (1988) investigated the perception of family of origin relationships using the Family Relations Index (Wilson & Mulhall, 1983) in a study measuring depression in family adult children of alcoholics and controls. No differences were found between the two groups.

Using the Bell Object Relations Inventory, the Fundamental Interpersonal Relations Orientation-Behavior and the Family Environment Scale, Kunstenaar (1991) assessed parental alcoholism, family dysfunction and later personal and interpersonal dysfunction. The sample was divided into four groups: subjects who were raised by one or more alcoholic but non-abusive parents; abusive but nonalcoholic parents; parents who were both alcoholic and abusive; and controls. Results indicated that parental alcoholism is not associated with adult intimacy dysfunction nor with family of origin dysfunction. Parental abuse in early life is associated with both adult family of origin dysfunction and

adult intimacy dysfunction, regardless of parental alcoholism.

To date, no empirical research has compared the differences between perceived family of origin dysfunction and shame in adult children of alcoholics and adult children of non-alcoholics with a nonclinical population. The next section will review clinical literature and empirical research dealing with shame and adult children of alcoholics.

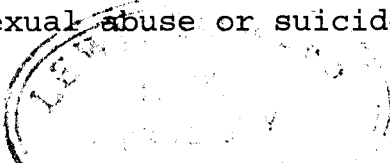
Shame and Adult Children of Alcoholics

Over the past five years clinical literature has focused on the concept of shame and the alcoholic family system. Growing up in a dysfunctional or alcoholic family is frequently associated with shame and low self-esteem in members of that family (Whitfield, 1989).

Fossum and Mason (1986), family therapists, defined shame in experiential terms:

Shame is an inner sense of being completely diminished or insufficient as a person. It is the self judging the self. A moment of shame may be humiliation so painful or an indignity so profound that one feels one has been robbed of her or his dignity or exposed as basically inadequate, bad, or worthy of rejection. A pervasive sense of shame is the ongoing premise that one is fundamentally bad, inadequate, defective, unworthy, or not fully valid as a human being. (p. 5)

Fossum and Mason also described certain families as "shame-bound"; these are frequently families with a history of physical abuse, addiction problems or with a family secret such as sexual abuse or suicide.



According to Fossum and Mason a shame-bound family is:

A family with a self-sustaining, multigenerational system of interaction with a cast of characters who are (or were in their lifetime) loyal to a set of rules and injunctions demanding control, perfectionism, blame and denial. The pattern inhibits or defeats the development of authentic intimate relationships, promotes secrets and vague personal boundaries, unconsciously instills shame in the family members, as well as chaos in their lives and binds them to perpetuate the same in themselves and their kin. (p. 8)

Later they recognized that this shaming pattern was also present in families where there was no addiction to alcohol. Fossum and Mason (1986) associated shame with other compulsive behaviors (e.g., eating disorders).

Fossum and Mason (1986) identified three stages of shame: external, inherited generational, and maintained. External shame is the "event, often traumatic, that risks the family's public expose and humiliation." Inherited generational shame is a result of the family's secret protection of external shame. Maintained shame is the ongoing shame-bound dynamic that sustains the shame in the family and in its members' pattern of interactions.

According to Fossum and Mason (1986), the shame-bound cycle (control, release, shame, control, etc.) is a way of conceptualizing the self-sustaining process in the family system. This cycle is readily observable in alcoholics who get drunk (release) and shame themselves and their families. Alcoholics attempt to control their drinking pattern but are often unsuccessful; then comes the release stage where they get drunk (release) again. After losing control and

drinking, alcoholics experience shame once more and the cycle starts over with a new attempt to control the drinking pattern.

The term "invisible dragon" was used by Mason and Fossum (1986) to describe shame. In therapy a conscious effort is made to make shame visible, by encouraging shame-bound family members to discuss openly the secrets. The goal of treatment is to interrupt the shame-bound cycle and move the family from shame to respect.

Harper and Hoopes (1990) also explored the impact of shame on individuals as well as family systems. Persons with "shame prone identities" interpret situations as verification of how worthless they are, how bad they are and how undesirable they are (Harper & Hoopes, 1990). According to Harper and Hoopes (1990, p. 72). They also identified some common characteristics that families with shame prone identities have:

- . They are pathological.
- . Coping strategies and conflict resolution skills are inadequate (Lavee, McCubbin, & Olson, 1987).
- . Some or all family members have unhealthy personalities.
- . Intimacy, dependency, and other needs are usually not met, with negative affirmations dominant (Carnes, 1989).
- . The quality of the marital/parental relationship, parent-child relationships, sibling relationships, and extended family relationships influence negative affirmation of identities as members experience shame and guilt.

. Such family systems are either caustically or rigidly disengaged. The use of space, time, and energy is such that family members are always distancing from each other (Olson, Sprinkle, & Russell, 1979).

. One or more adults bring to the nuclear family unresolved issues from their family of origin, e.g., unresolved emotional illness of their parents, incest, addictions, codependency, cult practices, parentification (Kerr & Bowen, 1988).

. Chronic illness and/or disability, e.g., cancer, AIDS, multiple sclerosis, amputations, strokes, alcoholics, may be present.

. Uncontrollable trauma, e.g., rape, murder, loss of home by fire or flood, stock market collapse, has been experienced (Potter & Ronald, 1987) (p. 73).

Harper and Hoopes (1990) described how addictive family systems develop shame-prone identities. "If parents do not meet their children's dependency, intimacy and accountability needs, or fail to meet them in some critical situation, children develop beliefs that shaped their lives as adults. Many of them are shame-prone" (Harper & Hoopes, 1990, p. 92).

John Bradshaw (1988) was one of the first clinicians in the addictions field to discuss the role of shame in both adult children of alcoholics and alcoholics. Using Gershen Kaufman's definition of shame,

... a sickness of the soul. It is the most poignant experience of the self by the self, whether felt in humiliation or cowardice, or in a sense of failure to cope successfully with challenge. Shame is a wound felt from the inside, dividing us both from ourselves and from one another (1985, p. viii).

Bradshaw applied Kaufman's concepts to his work with alcoholic families. Bradshaw theorized that shame is the

key to much of human suffering. He identified two forms of shame: nourishing/healthy shame and toxic/life-destroying shame. Healthy shame is an emotion which allows us to know our limits. "It tells us that to be human is to be limited" (Bradshaw, 1988). Bradshaw described toxic shame as "the shame that binds you." It is experienced as a pervasive sense of being flawed and defective as a human being. Toxic shame is a state of being rather than an emotion that signals our limits (Bradshaw, 1988). Bradshaw also theorized that toxic shame occurs in an interpersonal context. It begins in the family of origin. Families are where we first learn about ourselves. "Our core identity comes from the mirroring eyes of our primary-caregiver" (Bradshaw, 1988, p. 29). Bradshaw identified the characteristics of "shame based families" which are similar to Harper and Hoopes.

Whitfield (1989) in Healing the Child Within describes and develops the concept of adult children of troubled or dysfunctional families in general, rather than concentrating only on the alcoholic family. Whitfield (1989) postulated that being raised in a troubled or dysfunctional family is generally associated with shame and low self-esteem in members of the family. According to Whitfield, shame or low self-esteem play a significant role in stifling our child within. He writes, "shame is both a feeling or emotion, and an experience that happens to the total self, which is our

true self or child within" (Fisher, 1985; Kaufman, 1985; Kurtz, 1981; Whitfield, 1989).

Whitfield attributes the source of shame to rules from parents and authority figures and negative messages. He listed typical negative rules and typical negative messages commonly found in alcoholic families. In shame-based families, he identified two major ingredients, secrets and inappropriate boundaries.

Potter-Efron and Potter-Efron (1988), addictive therapists, explored the nature of shame (a painful belief in one's basic defectiveness as a human being). They described five different sources of shame:

- . genetic and biochemical makeup
- . American culture
- . families of culture
- . current shaming relationships, and
- . self-shaming thoughts and behaviors (p. 2).

Potter-Efron and Potter-Efron also differentiate the effects of normal shame from that of excessive shame and a deficiency of shame.

In Shame and Guilt: Masters of Disguise, Jane Middleton-Moz (1990), hypothesized that debilitating shame and guilt are at the root of all dysfunctions in families. She described how debilitating shame is developed and fostered in early childhood and how it exerts itself in adulthood and in intimate relationships. Middleton-Moz used

to make shame a more recognizable clinical entity and to formulate a language to describe it. Empirical research on shame and adult children of alcoholics has lagged behind clinical literature; more research needs to be done to narrow the gap.

In summary, earlier empirical studies primarily focused on clinical populations. This study examined nonclinical adult children of alcoholics. In the 1980's there was trend to overgeneralize the characteristics of adult children of alcoholics. The clinical literature and the media seemed to suggest that adult children of alcoholics exhibit many commonalities. Empirical investigation can help to clarify differences and similarities in the adult children of alcoholics population.

CHAPTER III

METHOD

This research was designed to study empirically nonclinical adult children of alcoholics. A comparison group of adult children who were not raised in alcoholic families was also utilized. This chapter presents the hypotheses, sample, the procedure and measurements.

Hypotheses

The following null hypotheses were tested:

1. There will be no difference in the internalized shame scale (ISS) scores across groups (ACNA and ACA groups).
2. There will be no difference in the family of origin scale (FOS) scores across groups (ACNA and ACA groups).
3. There will be no significant interrelationships among the subjects' FOS and ISS subtest scores.

Sample

A nonprobability sample (N = 162) of graduate psychology students enrolled in a private midwestern university participated in the study. The sample was divided into two groups, ACA (adult children of alcoholics) and ACNA (adult children of nonalcoholics) based on their scores on the Children of Alcoholics Screening Test (CAST).

Subjects who scored 2 or more on the CAST were placed in the adult children of alcoholics group [(n = 60) (37%)]. Those subjects receiving a CAST score of one or less were placed in the adult children of nonalcoholics group [(n = 102) (63%)]. It should be noted that the percentage of adult children of alcoholics (37%) in this sample was higher than the national average (11%).

Sample Characteristics

Demographic characteristics of the sample reflected both the subjects' current life [sex, age, marital status, religion, ethnic background and type of counseling/therapy, (e.g., individual, family, group)], and family of origin information (birth order, socioeconomic level, presence of physical, sexual or emotional abuse, history of parental alcoholism/or other diseases, and the incidence of intergenerational drinking problems. Chi-square statistical analyses were performed to determine if the groups differed with respect to these demographic variables (see Tables 2 and 3). The age range for ACAs was 22-59 (M = 32.27); the age range for ACNAs was 22-58 (M = 32.93). In general, the two groups (ACA, ACNA) were equivalent (see Table 1). However, the ACA group differed from the ACNA group in two areas (frequency of grandparent drinking and the incidence of emotional abuse).

Table 1

Demographic Data by Group

	ACA		ACNA	
	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
<u>Gender</u>				
Female	53	88.3	77	75.5
Male	6	10.0	25	24.5
Missing data	<u>1</u>	<u>1.7</u>	<u>--</u>	<u>--</u>
Total	60	100.0	102	100.0
<u>Marital Status</u>				
Single	28	47.5	44	43.1
Married	24	40.7	48	47.1
Divorced, single	1	1.7	4	3.9
Divorced, remarried	2	3.4	0	0
Separated	1	1.7	0	0
Widowed	0	0	1	1.0
Cohabiting	<u>3</u>	<u>5.1</u>	<u>5</u>	<u>4.9</u>
Total	59	100.0	102	100.0
<u>Religion</u>				
Catholic	28	47	46	45.1
Jewish	6	10	11	10.8
Protestant	13	22	30	29.4
No religious affiliation	8	14	10	9.8
Other	<u>4</u>	<u>7</u>	<u>5</u>	<u>4.9</u>
Total	59	100	102	100.0
<u>Religious Practice</u>				
Very religious	12	20.3	25	24.5
Somewhat religious	25	42.4	39	38.2
Not too religious	14	23.7	26	25.5
Not at all religious	<u>8</u>	<u>13.6</u>	<u>12</u>	<u>11.8</u>
Total	59	100.0	102	100.0
<u>Race</u>				
African American	4	7	6	5.9
Hispanic	2	3	3	2.9
Asian	1	2	3	2.9
Caucasian	49	83	90	88.2
Other	<u>3</u>	<u>5</u>	<u>0</u>	<u>0</u>
Total	59	100	102	100.0

Table 1 (continued)

	ACA		ACNA	
	<u>n</u>	%	<u>n</u>	%
<u>Socioeconomic Level</u>				
Upper	6	10.3	9	8.8
Middle	44	75.9	76	74.5
Lower	8	13.8	14	13.7
Missing data	<u>2</u>	<u>Missing</u>	<u>3</u>	<u>2.9</u>
Total	60	100.0	102	100.0
<u>Birth Order</u>				
First born	24	41.4	43	43
Second born	15	26.0	24	24
Third born	10	17.2	22	22
Fourth born	5	8.6	2	2
Fifth born	2	3.4	3	3
Sixth born	2	3.4	4	4
Seventh born	<u>0</u>	<u>0.0</u>	<u>2</u>	<u>2</u>
Total	58	100.0	100	100
<u>Parent Type</u>				
Biological	51	86.4	93	91.2
Adoptive	2	3.4	1	1.0
Biological mother and stepfather	1	1.7	1	1.0
Mother alone	1	1.7	5	4.9
Father alone	0	0	1	1.0
Missing Data	1	Missing	1	1.0
Other	<u>4</u>	<u>6.8</u>	<u>1</u>	<u>1.0</u>
Total	60	100.0	102	100.0
<u>Father Drinker</u>				
Very true	23	38.3	0	
Mostly true	15	25.0	0	
Mostly untrue	9	15.0	3	2.9
Very untrue	13	21.7	98	96.1
Do not know	<u>0</u>	<u>0</u>	<u>1</u>	<u>1.0</u>
Total	60	100.0	102	100.0
<u>Mother Drinker</u>				
Very true	5	8.3	0	
Mostly true	8	13.3	0	
Mostly untrue	15	25.0	0	
Very untrue	32	53.3	102	100
Do not know	<u>0</u>	<u>0</u>	<u>0</u>	<u>1.0</u>
Total	60	100.0	102	100.0

Table 1 (continued)

	ACA		ACNA	
	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
<u>Father Died</u>				
Yes	2	3.3	4	3.9
No	<u>58</u>	<u>96.7</u>	<u>98</u>	<u>96.1</u>
Total	60	100	102	100.0
<u>Mother Died</u>				
Yes	2	3.3	5	4.9
No	<u>58</u>	<u>96.7</u>	<u>97</u>	<u>95.1</u>
Total	60	100	102	100
<u>Parents Divorced</u>				
Yes	9	15.0	11	10.8
No	<u>51</u>	<u>85.0</u>	<u>91</u>	<u>89.2</u>
Total	60	100	102	100.0
<u>Frequency of Parents with Health Problems</u>				
<u>Emotional/Psychological</u>				
Yes	9	15.5	13	13.1
No	<u>49</u>	<u>84.5</u>	<u>86</u>	<u>86.9</u>
Total	58	100.0	99	100.0
<u>Physical</u>				
Yes	36	61.0	47	48.0
No	<u>23</u>	<u>39.0</u>	<u>51</u>	<u>52.0</u>
Total	59	100.0	98	100.0
<u>Frequency of Abuse</u>				
<u>Physical</u>				
Yes	13	22.4	13	13.1
No	44	75.9	86	86.9
Uncertain	<u>1</u>	<u>1.7</u>	<u>0</u>	<u>0.0</u>
Total	58	100.0	99	100.0
<u>Sexual</u>				
Yes	13	22.0	9	9.1
No	42	71.2	84	84.8
Uncertain	<u>4</u>	<u>6.8</u>	<u>6</u>	<u>6.1</u>
Total	59	100.0	99	100.0

Table 1 (continued)

	ACA		ACNA	
	<u>n</u>	%	<u>n</u>	%
<u>Self-Help Groups</u>				
Yes	15	25.4	11	11.2
No	<u>44</u>	<u>74.6</u>	<u>87</u>	<u>88.8</u>
Total	59	100.0	98	100.0
<u>Counseling/Therapy</u>				
Yes	44	74.6	55	56.1
No	<u>15</u>	<u>25.4</u>	<u>43</u>	<u>43.9</u>
Total	59	100.0	98	100.0

In the ACA group, there was a significant difference between the groups with respect to the number of grandparents with drinking problems (see Table 2). In general, the ACA group had a greater frequency of alcoholic grandparents than did the ACNA group. The percent of ACAs who reported no grandparent drinking problems was 43%; the percent of ACNAs who reported no grandparent drinking problems was 79%. Also, emotional abuse was more prevalent in the ACA group (46%) than in the ACNA group (29%).

Additionally, in the ACA group more fathers (63%) than mothers (22%) were reported to have drinking problems, but this difference in frequency was not found to be statistically significant. Generally, over half of the parental drinking started when the ACA was between 0-12 years old and stopped when the ACA was an adolescent or an adult (see Table 4).

Table 2

Frequency of Grandparent Drinking Problems by Group

	ACA		ACNA	
	<u>n</u>	%	<u>n</u>	%
Maternal father	7	11	11	11
Maternal mother	1	2	1	1
Paternal mother	6	10	2	2
Paternal father	7	11	3	3
Both maternal parents	1	2	0	0
Both paternal parents	1	2	0	0
Both grandfathers	4	7	3	3
Other combinations of grandparents	4	7	1	1
Do not know	3	5	0	0
None	<u>26</u>	<u>43</u>	<u>79</u>	<u>79</u>
Totals	60	100	100	100

$\chi^2 (9, N = 160) = 30.06, p = .00043.$

Table 3

Frequency of Emotional Abuse

	ACA		ACNA	
	<u>n</u>	%	<u>n</u>	%
Yes	27	45.8	29	29.3
No	24	40.7	60	60.6
Uncertain	<u>8</u>	<u>13.5</u>	<u>10</u>	<u>10.1</u>
Totals	59	100.0	99	100.0

$\chi^2 (2, N = 158) = 5.98, p = .05.$

Table 4

Developmental Stage of ACA When Parent Started Drinking

	<u>n</u>	<u>%</u>
Preschool (0-5 years)	21	39
School age (6-12 years)	9	17
Adolescence (13-17 years)	13	24
Adulthood (18-over)	8	14
Do not know	3	6
Totals	<u>54</u>	<u>100</u>

Table 5

Developmental Stage of ACA When Parent Stopped Drinking

	<u>n</u>	<u>%</u>
Preschool (0-5 years)	2	4
School age (6-12 years)	7	13
Adolescence (13-17 years)	21	40
Adulthood (18-over)	22	42
Parent is still drinking	1	1
Totals	<u>53</u>	<u>100</u>

Procedure

The questionnaire, What Was Your Experience (see Appendix A), consisted of a simple demographic and family

information questionnaire and three self-report standardized instruments (Internalized Shame Scale, Children of Alcoholics Screening Test, and Family of Origin Scale. All instruments were mailed to potential respondents. A pre-addressed, pre-stamped return mailing envelope, postcard and cover letter (see Appendix A) were also included in the packet. The questionnaire was not coded in an effort to maintain anonymity and confidentiality of the respondent's responses. Consent to participate in the study was indicated by returned materials. A follow-up letter (see Appendix F) was sent to potential respondents after a two-week period.

A total of 260 questionnaires were mailed to potential respondents. The study yielded a return rate of 65% (n = 168). Of the returned questionnaires, six were excluded in the data analysis due to incomplete or missing data.

Instrumentation

Internalized Shame Scale (ISS)

The ISS (Cook, 1989) is the result of a sustained and extensive effort to develop a measure of shame. The items were developed specifically to measure enduring, chronic shame that has become an internalized part of one's identity. The Internalized Shame Scale (ISS) consists of 30 Likert-scaled items that yield two basic scale scores. The two scales include a 24-item shame scale and a 6-item self-esteem scale. The 24-item shame scale includes two

subscales, an inferiority scale (15 items) and an alienation scale (9 items).

Scores for the Shame total range from 0-96, for Self-Esteem from 0-24, for Inferiority from 0-60, and for Alienation from 0-36. Norms are provided on the total Shame score (see Appendix C). The following interpretive guidelines are recommended for the other subscales: Self-Esteem scores of 18 or higher would indicate positive self-esteem and scores below 18 would be weak or negative self-esteem; Inferiority scores from 30-38 are moderately high, 39-45 are high, and above 45 are very high; Alienation scores from 18-23 are moderately high, 24-27 are high, and above 27 are very high.

The construction of the ISS started in 1984. The initial set of items was designed so that respondents could rate the frequency (never to almost always) with which they experienced the affect described by each item. The original pool of 90 items was decreased to 48 after a group of alcoholics hypothesized to have high levels of internalized shame sorted the items into those they experienced frequently and those not experienced at all. The ISS scale has been administered to over 3,000 subjects, both nonclinical and clinical (Cook, 1990). A number of reliability and validity research studies have resulted in four revisions of the scale.

Alpha reliability coefficients range from .95 for the

shame scale and .90 for the self-esteem scale, and test-retest reliability coefficients range from .71 to .84. These reliabilities have been consistently reproduced with large (N = 1000) and smaller samples, including both clinical and nonclinical samples.

A number of validity studies have been done. According to Cook (1991), these studies have focused on concurrent correlations with related variables and differences between clinical and non-clinical samples. The ISS correlates with measures of self-esteem such as the Tennessee Self-Concept Test (-.66) for 118 college subjects. Other shorter self-esteem measures produced correlations with the ISS ranging from .52 to .79. In addition, measures of depression have been found to correlate with the ISS. A non-clinical sample (N = 193) produced a correlation of .75 with the Multiscore Depression Inventory. On studies with the Beck Depression Inventory, the ISS correlated .72 for 300 college subjects and .75 for a clinical sample of 185 psychiatric patients.

The clinical subjects scored significantly higher than non-clinical subjects on the ISS. ISS means for the different groups were as follows: alcohol/drug patients (N = 247), 49.34; affective disorders (N = 84), 48.51; other psychiatric disorders (N = 36), 48.75; post traumatic stress patients (N = 47), 58.59; eating disordered women (N = 25), 68.92; non-clinical (N = 514), 33.98 (one way ANOVA, $F = 54.31$, $p = .0000$). The non-clinical group was found to be

significantly different from all clinical groups on the post-hoc test.

Another investigation (Cook, 1991) provided evidence for the shame and family of origin connection among alcoholic women. Women (N = 92) admitted to an inpatient alcohol treatment program completed the ISS and a childhood sexual abuse survey. The mean of the combined groups of abused women (N = 40), 57.6, was significantly different from the mean of the not-abused women (N = 52), 45.1 ($F = 11.6, p = < .001$). When the severely abused women were compared with the moderately abused and not abused women, the mean ISS score for the severely abused women (N = 19), 66.0, was significantly higher than both the moderately abused women (N = 21), 50.0, and the not-abused group (45.1). The moderately and not-abused groups did not differ from each other. According to Cook (1991) even within a group of alcoholic women where levels of shame would be expected to be high, these data suggest that severe sexual abuse in childhood leads to significantly higher levels of internalized shame. Taken as a whole, these research findings provide significant support for considering the ISS as a valid and reliable measure of that deep sense of self-worthlessness and self-rejection that is reportedly rooted in shame affect and has become internalized from repeated childhood rejections.

Children of Alcoholics Screening Test (CAST)

The CAST is a 30-item inventory that was designed to measure offspring feelings, attitudes, perceptions and experiences relating to parental drinking behavior. The inventory was based on the experiences of children of clinically diagnosed alcoholics. The CAST measures:

- (a) psychological distress associated with a parent's drinking;
- (b) perceptions of drinking-related marital discord between their parents;
- (c) attempts to control a parent's drinking;
- (d) efforts to escape from alcoholism;
- (e) exposure to drinking related violence;
- (f) tendencies to perceive their parents as being alcoholic;
- and (g) desire for professional counseling (Jones, 1982, p. 5).

A CAST score of 0 to one indicates that these individuals most likely have nonalcoholic parents. A CAST score of two to five indicates that parents are likely problem drinkers. Adult offspring who score in these ranges have probably experienced problems from parental drinking behavior. A CAST score of six or more indicates that a parent is likely alcoholic.

A Spearman-Brown split half (odd v. even) reliability coefficient of .98 was computed on two samples, one consisting of 82 latency age (ages 5-6) and adolescent children and 133 latency age and adolescent children attending Chicago schools. A Spearman-Brown split-half (odd

vs. even) reliability coefficient equal to .98 was reported on a sample of 81 randomly sampled adults in the Chicago area (Jones, 1982).

Two validity studies have been conducted with the CAST. In the first study, Jones (1982) administered the CAST to 82 children of clinically-diagnosed alcoholics, 15 self-reported children of alcoholics, and 118 randomly selected control group children. Results indicated that the clinically diagnosed children and the self-reported children of alcoholics scored significantly higher on the CAST compared to the controls ($p < .0001$).

In another study, Jones (1983b) administered CAST to 81 adults. Jones found significant positive correlations between the subject's total CAST scores and the total number of cans of beer, glasses of wine, and shots of whiskey that both of their parents were observed consuming in a typical week of drinking ($r (.79) = .63, p < .01$). Additionally, a significant positive correlation was found between the subjects' total CAST scores and the total number of days that both parents were observed consuming alcohol in an average week. These studies (Jones, 1982; Jones, 1983b) support the validity of the CAST as a screening tool for adult children of alcoholics.

The Family of Origin Scale (FOS)

The FOS was designed by Hovestadt, Anderson, Piercy, Cochran, and Fine (1985) to measure perceived levels of

autonomy and intimacy in the subject's family of origin, and infer a level of "health" (or healthy functioning) in that family. The 40-item test covers ten constructs--five under each of the two major concepts of autonomy and intimacy. The constructs related to intimacy are: range of feelings, mood and tone, conflict resolution, empathy, and trust. Those related to autonomy are: clarity of expression, responsibility, respect for others, openness to others, acceptance of separation and loss. (Refer to Appendix C for Paradigm for the Family of Origin Scale.)

The items for FOS were generated based on the constructs of family health proposed by Lewis (1976). Originally, 89 items were written by faculty and graduate students in a university family therapy program. After rating by a panel of six nationally recognized authorities in family therapy, the two positive and two negative items having the highest ratings were used in the final scale. They are scored on a 5-point Likert-type scale: 5 being the most "healthy" response and 1 being the least "healthy" response. The range of possible scores is from 40 to 200; a total score is assigned to one's perception of the overall level of health in the family of origin.

Normative samples (278 undergraduate and graduate students) found that scores between 63-134 correspond with a low level of perceived health; scores between 135-159 correspond with a moderate level of perceived health; and

scores between 160 and 198 correspond with a high level of perceived health. Several studies have been done which indicated that FOS did discriminate between subjects.

A test-retest reliability coefficient of .97 ($p < .001$) was obtained over an interval of two weeks on 41 graduate psychology students. Test-retest coefficients for the 20 items of the intimacy concept ranged from .46 to .87 with a median of .73; test-retest coefficients for the 20 items of the autonomy concept ranged from .39 to .88 with a median of .77. A Cronbach's (1951) alpha of .75 and a Standardized Item alpha of .97 were obtained in an independent study of undergraduate students ($N = 116$). Validity studies of FOS have been done. Fine (1982) administered the FOS, a semantic differential perception of marriage scale and the Rational Behavior Inventory (Shorkey & Whiteman, 1977) to 184 single university students (freshmen and sophomores). He found subjects having high, medium and low FOS scores had significantly different, $F(2, 181) = 14.056$, $p < .01$, perceptions of marriage. According to Fine, these data suggest that individuals who had a more positive perception of marriage perceived their families of origin as being higher in health than did those who perceived their families of origin as being lower in health.

Canfield (1983) administered the FOS and the Healthy Family Functioning Scale (HFFS) to 171 married subjects and the results of the study indicated a significant correlation

between FOS scores measuring levels of perceived health in the family of origin of subjects and HFSS scores measuring levels of perceived health in the subjects' current family.

Hovestadt et al. (1985) conducted an independent study of 246 undergraduate students. He examined perceived health levels in the family of origin (low, medium, high) and the marital status (divorced or married) of the subjects' childhood. A non-significant relationship but an interesting trend was noted between levels of perceived health in the family of origin and marital status of parents.

In a clinical sample, Holter (1982) examined perceived health in the family of origin, as measured by the FOS, for 25 male members of alcohol-distressed and 25 male members of non-alcohol-distressed marriages. He found a significant difference ($p < .01$) in perceived health of the family of origin between men in non-alcohol-distressed marriages and men in alcohol-distressed marriages. This latter study is significant since most of those alcohol-distressed marriages contain at least one offspring who is an adult child of an alcoholic.

Differential validity of the FOS have been demonstrated in three recent studies. Lee, Gordon, and O'Dell (1989) found that scores of 100 psychotherapy patients were significantly different from those of nonpatients on all subscales of the FOS. Mangrum (1989) reported significant

differences between the ratings of 158 adult male prison inmates and 442 college students on the FOS. Finally, Andrasi (1986) found that 38 adult children of alcoholics were significantly less positive in their ratings of their families of origin than a group of adult children of nonalcoholics (N = 94).

Design and Statistical Analyses

As noted above, the subjects were divided into two groups (adult children of nonalcoholics [ACNA] and adult children of alcoholics [ACA]). If a subject had a CAST score of one or less, he/she was placed in the ACNA group. A CAST score of two or more placed the subject in the ACA group. The data set consisted of frequencies, percents, group standard deviations, and group means for both groups. Chi squares analyses were run to determine if the groups differed on demographic variables (see Tables 2 and 3).

T-tests were then done to determine if differences existed in the ISS and FOS measures across groups (ACNA and ACA). Pearson product-moment correlation coefficients were obtained to test for the existence of relationships among the subjects' FOS and ISS subtest scores.

Summary

This chapter presented the methodology used in this research study. Hypotheses, the selection of the subjects, comparison groups and the sample characteristics were described. Measures were presented along with reliability

and validity studies. A description of the statistical analyses performed was also included.

CHAPTER IV

RESULTS

This chapter provides the results of the data analysis. The chapter is divided into three main sections which corresponds to each hypothesis.

Results Related to Testing Null Hypothesis 1

Hypothesis 1: There will be no difference in the internalized shame scale (ISS) scores across groups (ACNA and ACA groups).

Null hypothesis 1 was rejected. There was a statistically significant difference in the internalized shame scale (ISS) scores across the ACNA and ACA groups ($t(156) = -2.82, p < .005$). The mean scores and standard deviations are presented in Table 6.

According to the Manual for the Internalized Shame Scale (Cook, 1991), scores for the Shame total range from 0-96, for Self-Esteem from 0-24, for Inferiority from 0-60, and for Alienation from 0-36. The ISS Shame score means for non-clinical norm groups were 33 (females) and 30 (males) (see Appendix B for Norms for Shame Scores). The ACNA group mean (25.55) was found to be below the non-clinical norm group and the ACA group mean (32.83) was found to be equivalent to the non-clinical female norm group. The ISS

shame scores for both groups were within the normal range for a non-clinical sample.

Table 6

Internalized Shame Score Total Score Means and Standard Deviations by Group

Group	n	M	SD	t	p <
ACNA	100	25.55	14.27	-2.82	.005
ACA	58	32.83	17.74		

Note. The ISS Total Score is scored so that higher scores suggest higher levels of internalized shame. Norm: Non-Clinical Males = 30; Non-Clinical Females = 33.

Additionally, there were statistically significant differences found in the three subscales (inferiority, alienation, self-esteem) scores of the ISS across the ACNA and ACA groups. Independent T-tests were done and yielded the following results: Inferiority, $t(157) = -2.61$, $p < .010$; alienation, $t(93.27) = -2.53$, $p < .013$; and self-esteem, $t(156) = 2.46$, $p < .015$. The mean scores and standard deviations are presented in Tables 7-9.

The following interpretive guidelines were recommended for the other subscales: Self-Esteem scores of 18 or higher would indicate positive self-esteem and scores below 18 would be weak or negative self-esteem; Inferiority scores from 30-38 are moderately high, 39-45 are high, and above 45 are very high; Alienation scores from 18-23 are moderately

high, 24-27 are high, and above 27 are very high.

Table 7

Inferiority Subscale Score Means and Standard Deviations by Group

Group	n	M	SD	t	p <
ACNA	101	18.51	8.95	-2.61	.010
ACA	58	22.52	9.89		

Note. The Inferiority Subscale Score is scored so that higher scores suggest greater feelings of inferiority.

Table 8

Alienation Subscale Score Means and Standard Deviations by Group

Group	n	M	SD	t	p <
ACNA	100	7.13	2.26	-2.53	.013
ACA	59	10.42	8.76		

Note. The Alienation Subscale Score is scored so that higher scores suggest greater feelings of alienation.

Table 9

Self-Esteem Subscale Score Means and Standard Deviations by Group

Group	n	M	SD	t	p <
ACNA	99	19.11	4.13	2.46	.015
ACA	59	17.44	4.14		

Note. The Self-Esteem Subscale Score is scored so that lower scores suggest a weak or negative self-esteem.

The ACA group consistently scored higher than the ACNA group on the inferiority, alienation, and total shame scales. The ACA group also scored slightly lower on the self-esteem subscale of the ISS than the ACNA group. Both groups; however, fell within the normal range on the four scales (inferiority, alienation, self-esteem, and total shame scales).

Results Related to Testing Null Hypothesis 2

Hypothesis 2: There will be no difference in the family of origin scale (FOS) scores across groups (ACNA and ACA groups).

Null hypothesis 2 was also rejected. There was a statistically significant difference found in the family of origin scale (FOS) scores across groups (ACNA and ACA) ($t(152) = 3.81, p < .001$). The mean score and standard deviations are presented in Table 10. The two subscales

(autonomy, $t(156) = 3.93, p < .001$; intimacy, $t(156) = 3.83, p < .001$) of the family of origin scale were also found to be statistically significant. Refer to Tables 11-12 for the mean scores and standard deviations for the two subscales.

Data from normative samples (278 undergraduate and graduate students) indicate that scores between 63-134 correspond with a low level of perceived health; scores between 135-159 correspond with a moderate level of perceived health; and scores between 160-198 correspond with a high level of perceived health (Hovestadt et al., 1985). The ACNA group mean (136.48) fell within the lower limit of the "moderate level" family of origin health scale and the ACA group mean (115.66) fell within the "low level" family of origin health scale. The ACA group scored lower on both subscales (Autonomy, Intimacy). This finding suggests less perceived autonomy and intimacy in the ACA families of origins.

Table 10

Family of Origin Scale Score Means and Standard Deviations
by Group

Group	n	M	SD	t	p <
ACNA	96	*136.48	32.36	3.81	.001
ACA	58	**115.66	33.64		

Note. Norms: 198-160 high level of perceived family of origin health
 *159-135 moderate level of perceived family of origin health
 **134-63 low level of perceived family of origin health

Table 11

Autonomy Subscale Score Means and Standard Deviations by
Group

Group	n	M	SD	t	p <
ACNA	99	67.31	15.55	3.93	.001
ACA	59	56.93	16.86		

Note. The Autonomy Subscale Score is scored so that higher scores suggest more perceived autonomy in the family of origin.

Table 12

Intimacy Subscale Score Means and Standard Deviations by Groups

Group	n	M	SD	t	p <
ACNA	99	69.74	17.46	3.83	.001
ACA	59	58.68	17.70		

Note. The Intimacy Subscale Score is scored so that higher scores suggest more perceived intimacy in the family of origin.

Results Related to Testing Null Hypothesis 3

Hypothesis 3: There will be no significant interrelationships among the subjects' Family of Origin Scale (FOS) and Internalized Shame Scale (ISS) subtest scores.

Null hypothesis 3 was also rejected. There were significant interrelationships found among the subjects' FOS and ISS subtest scores. Pearson Product-Moment Correlations were utilized as a measure of association between total scores on the ISS and FOS (see Table 13). The ISS total scores were significantly correlated with FOS total scores ($r = -.57$, $p < .01$). Thirty-two percent of the variance in the ISS scores was accounted for by the FOS scores. Finally, it should be noted that the subscales of the FOS (autonomy, intimacy) were found to be inversely correlated to the ISS (see Table 13).

Table 13

Correlation Coefficients of Internalized Shame Scale (ISS)
Total Scores, ISS Subscale Scores, Family of Origin Scale
(FOS) Scores and FOS Subscale Scores

Scale	Shame	Alienation	Inferiority
Family of Origin Scale	-.57*	-.49*	-.57*
Autonomy	-.54*	-.47*	-.54*
Intimacy	-.57*	-.49*	-.58*

Note. *indicates $p < .01$.

Summary

This chapter has presented the results of the hypothesis testing. Statistical significance was found between the ACNA and ACA groups on the Family of Origin Scale and the Internalized Shame Scale. The ACA group reported lower levels of family of origin health (more family of origin dysfunction) and higher levels of internalized shame than the ACNA group. However, both groups (ACA, ACNA) fell within the normal range for a nonclinical population on the ISS. There was also found to be some support for the hypothesis that there is an interrelationship between the family of origin health and levels of internalized shame among the subjects. Subjects who reported higher levels of family of origin health (less dysfunction) also reported

lower levels of internalized shame.

CHAPTER V

DISCUSSION

This chapter presents a summary of the study, discussion of the data, limitations of the study, and implications for educators and clinicians. Recommendations for future research are also discussed.

Summary of Findings

The purpose of the study was to test for differences in internalized shame (ISS) and perceived family of origin health (FOS) between a sample of adult children of alcoholics (ACA) compared to a sample of adult children of nonalcoholics (ACNA). Family systems and shame theories provide a framework for understanding adult children of alcoholics. The following research questions were addressed:

1. Do internalized shame scores (ISS) of adult children of alcoholics differ significantly from adult children of nonalcoholics?
2. Do perceived levels of family of origin health of adult children of alcoholics differ significantly from adult children of nonalcoholics?
3. Are there significant interrelationships among the subjects' internalized shame scores and perceived level of

family of origin health?

A nonprobability sample (N = 162) of graduate psychology students enrolled in a private midwestern university participated in the study. A total of 260 questionnaires were mailed to potential respondents. The study yielded a return rate of 65% (N = 168). Of the returned questionnaires, six were excluded in the data analysis due to incomplete or missing data. The sample was divided into two groups, ACA (adult children of alcoholics) and ACNA (adult children of nonalcoholics) based on the scores of the Children of Alcoholics Screening Test (CAST). Subjects who scored two or more on the CAST were placed in the adult children of alcoholics group [(n = 60 (37%))]. A CAST score of one or less placed subjects in the adult children of nonalcoholics [(n = 102) (63%)]. Demographic characteristics of the sample reflected both the subjects' current life (sex, age, marital status, religion, ethnic background and type of counseling/therapy, e.g., individual, family), and family of origin characteristics. Chi-square statistical analyses were performed to determine if the groups differed on demographic variables and family of origin information. For the most part, the two groups (ACA, ACNA) were found to be equivalent. However, there were statistical significant differences found between the ACA group and ACNA group in two areas (frequency of grandparent drinking and the incidence of emotional abuse). The ACA

group had a greater frequency of alcoholic grandparents than did the ACNA group and emotional abuse was more common in the ACA group than the ACNA group.

Other measures used in this study were the Family of Origin Scale (FOS) and the Internalized Shame Scale (ISS). The FOS measures perceived levels of autonomy and intimacy in the subject's family of origin, and the level of "health" (or healthy functioning) within that family. The ISS measures levels of internalized shame. The shame scale includes two basic subscales (an inferiority scale and an alienation scale).

The data analysis consisted of frequencies, percents, group standard deviation and group means for both groups (ACA, ACNA). As noted above, Chi Squares were run to determine if the groups differed on demographic variables and family of origin information. T-tests were done to determine if differences existed in the ISS and FOS measures across groups (ACA, ACNA). Pearson product-moment correlation coefficients were used to test for the existence of relationships among the subjects' FOS and ISS subtest scores.

Based on the results of the analyses, Null Hypothesis 1 was rejected. There was a statistically significant difference found in levels of internalized shame across groups (ACNA, ACA). Adult children of alcoholics reported higher levels of internalized shame than adult children of

nonalcoholics. The ACA group also scored higher on the inferiority and alienation scales of the ISS. On the self-esteem scale, the ACA group reported lower self-esteem scores than the ACNA group. Despite these scale differences, the means of both groups fell within the normal range for a nonclinical population. No pathological shame existed in the ACA or ACNA group.

These results are consistent with Carr's (1990) research findings (i.e., alcoholics from alcoholic families have "more shame" than alcoholics from non-alcoholic families). However, Carr (1990) used a clinical sample (alcoholics) rather than a nonclinical sample (college-students). To date no other empirical research on the specific issue of shame and adult children of alcoholics has been done. Since the ACA group scored within normal ranges on the ISS, the belief held by clinicians that "people growing up in alcoholic families are negatively affected by the experience" (Ackerman, 1984; Black, 1981; Owen, Rosenberg, & Barkley, 1985; Thanepohn, 1986; Wegscheider, 1981; Woititz, 1981) was not supported in this study. Researchers (Alterman, Searles, & Hall, 1989; Calder & Kostyniuk, 1989; Goodman, 1987; Seefeldt & Lyon, 1992) have warned clinicians against stereotyping individuals who grew up in alcoholic homes as necessarily having certain characteristics or problems. Goodman (1987) stated that "it is an error to assume that all ACOAs are members of the

"walking wounded" (p. 163). The data reported here provide some support for these cautionary statements.

Null Hypothesis 2 was also rejected. There was a statistically significant difference found in the family of origin scale (FOS) scores across groups (ACNA, ACA). Adult children of alcoholics reported lower levels of health (more dysfunction) than adult children of nonalcoholics. Adult children of alcoholics perceived lower levels of autonomy and intimacy in their families of origin than adult children of nonalcoholics. The results of this study support Andradi's (1987) findings. Using a nonclinical sample (graduate students), she found a significant difference ($p < .001$) in family of origin ratings (FOS) indicating the ACAs experience their families as less facilitative in the promotion of trust, autonomy, and feeling expression. Other researchers (Harwick, 1990; Hovland, 1991; Lafferty, 1990; Marlow, 1987; Pierucci, 1990; Tarter, 1991; Teece, 1990) have found that ACAs perceive their family environment as more dysfunctional than ACNAs.

Findings in this study are also supported by the clinical literature. For example, Brown portrays the "alcoholic family environment ... as chaotic, unpredictable, inconsistent, with arbitrary, repetitive and illogical thinking, and not infrequently, violence and incest" (1988, p. 47).

According to Johnson and Bennett (1989) self-report

studies using the Family Environment Scale indicate that alcoholic families report themselves to have higher levels of conflict than do nonalcoholic families. Jacob and Seilhamer (1987), Moos and Billings (1982), and Steinglass et al. (1987) have also studied alcoholic family interactions in homes and laboratories. Based on their findings, they observed alcoholic families as having displayed more hostile communication and greater difficulties in problem solving than nonalcoholic control families. Sher (1987); however, stated, "disturbed family interaction was not specific to alcoholic families and tended to characterize other problem families" (p. 24).

Null Hypothesis 3 was rejected. Statistically significant interrelationships existed among the subjects' levels of family health and internalized shame. Subjects who perceived a lower level of family origin health (more dysfunction) also reported more internalized shame. Pearson Product-Moment Correlation Coefficients were used as a measure of association. The ISS total scores were found to be significantly correlated with the FOS total scores ($r = .57, p < .01$). Thirty-two percent of the variance in the ISS scores was accounted for by the FOS scores. In addition, subscales of the FOS (autonomy, intimacy) were inversely correlated to the ISS subscales. Subjects who experienced their families of origin as less facilitative in promoting trust, feeling expression and autonomy also

reported higher levels of internalized shame.

No empirical studies using a nonclinical sample have examined the relationship between internalized shame and perceived family of origin health. Several researchers have studied other associated variables that support the results of this study. For example, Latham's (1988) study of individuation and intimacy used the Waring Intimacy Questionnaire (Waring, 1984) and the Family of Origin Scale (Hovestadt et al., 1985) to investigate significant aspects of the family of origin experience in subjects compared to controls. Family of origin experience was found to be correlated with specific aspects of intimacy (autonomy and affection). In a similar study, Carey (1986) explored the perception of family of origin relationships and intimacy. He found significant but weak correlations between perception of childhood relationships and intimacy for both groups.

Another study done by Gold (1989) examined the relationship of family of origin dysfunction and impairment in object relations between ACAs and controls. He reported correlations between aspects of family of origin dysfunction and impairment in object relations. Gold also indicated the significant impact family of origin dysfunction had on the impairment of object relations across both ACA and non-ACA groups.

Andrasi's (1987) study also provides some support for

the findings in this study. She found significant correlations between self-esteem and family of origin ratings for both ACAs and controls.

Other Findings

The ACA group had a greater incidence of grandparent alcoholism than did the ACNA group. The percent of ACAs who reported grandparent drinking problems was 57%; whereas, the percent of ACNAs who reported grandparent drinking was 21%. These results are consistent with earlier research findings. The frequency of alcoholism (problem drinking) is greater in alcoholic families than nonalcoholic families (Alterman & Tarter, 1986; Bohman, 1978; Cloninger, Bohman & Sigvardsson, 1981; Cadoret, Cain & Gove, 1980; Cotton, 1979; Goodwin, 1988; Goodwin, Schulsinger, Hermansen, Guze, & Winokur, 1973; Hesselbrock, Hesselbrock, & Stabenau, 1985; Hrubec & Omenn, 1981; Hesselbrock, Shaskan & Myer, 1983; Midanik, 1983; Sher, 1987).

A recent study done by Perkins and Berkowitz (1991) with a college student population (N = 860) found significantly greater problem drinking by students who reported having a parent or grandparent diagnosed or treated for alcoholism. They hypothesized that collegiate children and grandchildren of alcoholics are more vulnerable than other students to problem drinking.

Finally, demographic data also supported the belief of many clinicians about the strong relationship between

parental abuse and parental alcoholism. In this study emotional abuse was found to be more prevalent in the ACA group (46%) than the ACNA group (29%). According to Sher (1991), recent reviews of the empirical literature (Hamilton & Collins, 1985; Orme & Rimmer, 1981; Russell, Henderson & Blume, 1985; Steinglass & Robertson, 1983; West & Prinz, 1987) provide inconsistent findings. Sher stated,

the assumption that children of alcoholics (COAs) are more likely to be abused than non children of alcoholics (non COAs) still remains a viable one despite the continued need for a convincing empirical demonstration employing methodological improvements (1991, p. 26).

More males (63%) were alcoholics than females (37%). This finding is also consistent with other empirical data. In the ACA group, more than 50 percent of the alcoholic parents started drinking during their offspring's preschool/school age years. Over 80 percent of the alcoholic parents stopped drinking during their offspring's adolescence/young adulthood years. The data suggest that most of the parental drinking occurred during the formative years of the ACAs life.

Limitations of the Study

Methodological problems in research on adult children of alcoholics limit the generalizability of the findings. Limitations to the generalizability of this study include the design of the study, sample (type, selection), and the measures.

Design

An ex post-facto design can only lead to descriptive information about pre-existing situations, many variables cannot be controlled (e.g., gender, birth order). According to Kerlinger (1986), several weaknesses are inherent in the ex post-facto design: (1) the risk of improper interpretation; (2) the inability to have control over independent (predictor) variables; and (3) the lack of power to randomize. However, in many social science research projects, Kerlinger (1986) stated that ex post-facto designs are valuable because many social science research problems do not lend themselves to experimental manipulations.

Sample

A nonprobability sampling procedure was utilized. Inability to provide firm conclusions and to make generalizations from the research data are two major limitations of a nonprobability sample. Conclusions made in this study pertain to the characteristics of the 162 subjects who participated. This sample also included only adult children of alcoholics who attended college. There is no reason to expect that this sample reflects the characteristics of the entire population of adult children of alcoholics. As mentioned earlier, one of the aims of this study was to examine a "nonclinical" population of adult children of alcoholics.

Another limitation has been imposed due to the

voluntary nature of the sample selection. Questionnaires were mailed to all graduate psychology students enrolled in the graduate school. Participation in the study was voluntary. Given this situation, it cannot be determined whether the attitudes and experiences of respondents (65%) differed significantly from nonrespondents (35%).

Measures

Self-report, retrospective, and individual data were collected in this study. No external, corroborative data were utilized. The extent to which distortion due to selective or inaccurate reporting is reflected in this study is unknown. However, it should be noted that the reliability of self-report measures of parental alcoholism has been empirically supported in the research literature. In Cotton's (1979) review of literature on the incidence of parental alcoholism, she cites several research studies in which it was found that there was a greater incidence of underreporting of the occurrence of alcoholism in first-degree relatives. Haberman (1966) found that subjects were less likely to accurately describe the excessive drinking of their relatives, but could accurately describe their own excessive drinking. Therefore, it is probably safe to say that if adults report a drinking problem in their family of origin, they are probably accurately reporting.

Some researchers (Bloom, 1985; Sigafos, Reiss, Rich, & Douglas, 1985); however, question the accuracy of self-

report assessments in measuring family functioning. For example, comparisons between observational methods and self-report on the concept of family cohesion generally show low associations (Bloom, 1985; Hannum & Mayer, 1984; Oliveri & Reiss, 1984). Other studies (Fisher, Giblin & Hoopes, 1982; Fisher, Giblin & Regas, 1983) found discrepancies between therapists' and family members' prioritizing of significant dimensions of family functioning. However, the purpose of this study was to focus on the subjects' perception and report of events in their current and family of origin experiences.

These measures were chosen for this study for several reasons: (1) they focused on clinical issues (e.g., family of origin health-family functioning, parental drinking, adult children of alcoholics and shame); (2) their reported reliability and validity studies; and (3) they supported the theoretical rationale. Another limitation deals with the construct validity of the family assessment and shame instruments. For example, do the instruments measure what they purport to measure? The Internalized Shame Scale (ISS) and the Family of Origin Scale (FOS) are relatively new instruments. Some researchers (Lee, Gordon & O'Dell, 1989) reported that the Family of Origin Scale subscales of autonomy and intimacy seem to be measuring the same construct. Mazer, Mangrum, Hovestadt, Brashear (1990) challenged Lee's et al. (1989) conclusions because of the

small number of individuals (100) used in each factor analyses. According to Gorsuch (1974), 100 cases is simply not an adequate population from which to extract a reliable factor solution from a 40 variable instrument.

Several measures of shame have been used in empirical studies. These include the Perlman Scales (Perlman, 1958), Susceptibility to Embarrassment Scale (Cattell & Scheier, 1960), Korpi's Shame and Guilt Test (Korpi, 1977), Adapted Shame/Guilt Scale (Hoblitzelle, 1982), Smith-Beall Shame and Guilt Test (Beall, 1972; Smith, 1972), Fear of Negative Evaluation Scale (Watson & Friend, 1969), and a system of content analysis that indicates references to shame or guilt in verbal interactions (Gottschalk & Gleser, 1969). To date, the Internalized Shame Scale (ISS) (Cook, 1987a, 1987b, 1989) probably represents the best developed measure for research and clinical uses. However, more validation studies need to be done on both instruments (ISS, FOS).

Implications for Educators and Clinicians

In this study, 37 percent of the sample was reared in an alcoholic home. This percent is higher than the national average (11%). Adult children of alcoholics often pursue careers in the helping professions (e.g., social work, psychology, nursing, and medicine). According to Black (1981), "many individuals who choose to become professional caretakers do so because they have learned how to take care of others as a function of their role in their family of

origin" (p. 177). Since adult children of alcoholics are often overrepresented in the helping professions, they may be at risk for developing alcohol-related problems. Several studies (Claydon, 1987; Haack & Harford, 1984; Perkins & Berkowitz, 1985, 1991) have reported a significant relationships between parental alcoholism and a college student's alcohol abuse (drinking pattern).

The findings of this study have several implications for educators and counselors:

1. Adult children of alcoholics were overrepresented in this sample when compared to the national average. Alcohol education should be an integral part of counseling psychology programs (curricula). Alcohol educational programs can help students develop a greater awareness of their potential for alcohol abuse and/or problem drinking.
2. Supervisors can assist students who have lived with parental alcoholism to be aware of their countertransference issues with their clients. Therapists must also identify and work through their own shame issues.
3. In this study most of the parental drinking occurred during the ACAs childhood years; therefore, it is recommended that school psychologists/counselors continue to develop and implement early detection and prevention drug/alcohol programs for young children. Inservice programs can assist classroom teachers in the identification of children at risk and help these children utilize

appropriate support systems.

4. Almost half of the adult children of alcoholics reported emotional abuse in their family of origin, therapists must assess the possibility of abuse (sexual, physical, emotional) when alcoholism is identified in the family.

5. Counselors should be sensitive to the impact of parent and grandparent (e.g., multigenerational) alcoholism. A thorough assessment of family of origin background may provide a greater understanding of current psychological functioning. The Family of Origin Scale (FOS) and the Internalized Shame Scale (ISS) can be used as diagnostic tools.

6. Family therapists need to be sensitive to the intergenerational transmission of shame. Family therapy can help all generations with respect to examining shame feelings/experiences that have crippled the "psychological health of the family." Family intervention strategies need to promote feelings of intimacy and autonomy among family members.

7. Counselors can encourage and provide opportunities for clients to release some of their shameful feelings. Clients can learn to identify their shameful experiences and how they originated in childhood. By understanding the source of the shame feelings and what initiates them, the client can gain a greater understanding of his/her current

psychological functioning.

8. Counselors need to have a greater sensitivity to shame. The therapy process should avoid using shame activating strategies as tools for change. Therapists need to create a "safe environment" where clients feel free to explore shame experiences.

9. Counselors can explore the clients' perceived family of origin health and help the client examine basic unresolved issues between the client and his/her parents.

10. Based on the results of this study, counselors/therapists may want to look at some of the positive attributes and strengths (e.g., offsetting contributing factors; protective factors) an individual may acquire from growing up with an alcoholic parent.

11. Counselors need to view adult children of alcoholics as a heterogeneous rather than a homogeneous population. Although adult children of alcoholics may share many similar experiences from having been reared in an alcoholic family, they are not all affected in the same manner.

12. In this study, adult children of alcoholics perceived higher levels of internalized shame and more family dysfunction than adult children of nonalcoholics. Therapists/counselors can help adult children of alcoholics explore shame and family of origin experiences. Counselors can assist in the process of restoring the "severed

interpersonal bridge." Kaufman (1974) theorized that the restoration process helps clients go beyond shame and move toward a self-affirming identity (p. 568).

Recommendations for Future Research

The focus of this research project was to test for differences in internalized shame and perceived family of origin health between a sample of adult children of alcoholics compared to a sample of adult children of nonalcoholics. The results suggest that this sample of adult children of alcoholics differs from the sample of adult children of nonalcoholics on shame and perceived family of origin health measures. However, more research needs to be done to prevent the overgeneralization of findings to other populations.

Suggestions for future research in the area of adult children of alcoholics include: (1) Comparative studies on clinical and nonclinical populations of adult children of alcoholics may provide a greater understanding of the heterogeneity of adult children of alcoholics; (2) More outcome research studies assessing the effectiveness of adult children of alcoholics treatment approaches (interventions) need to be done. Little is known about the efficacy of these treatment programs; (3) the investigation of a wider range of subjects (e.g., minority groups: Hispanics; African Americans; Asians) and other health care professionals (nurses, social workers, physicians); (4) the

systematic collection of longitudinal, external, and corroborative data on adult children of alcoholics as they go through developmental stages (e.g., Erikson); (5) the examination of possible protective and offsetting contributing factors in a nonclinical adult children of alcoholics population (e.g., What are the characteristics of the resilient offspring of alcoholics and of their early caregiving environment?); (6) more validity and reliability studies on shame and family of origin measures e.g., more evidence to support the "shame" construct (construct validity); (7) exploration of the impact of intergenerational alcoholism on the drinking patterns of a nonclinical adult children of alcoholics population; and (8) additional efforts to ground adult children of alcoholics research in existing theories/models (e.g., developmental, biopsychosocial, behavioral, cognitive, family system, and shame).

*protective factors - are factors which decrease the likelihood of maladaptive behavior and increase the likelihood for future positive adaptations, even though the individual has been challenged by stressful events (Miller & Tuchfeld, 1986, pp. 235-236).

*offsetting contributing factors - are factors which encourage adaptive outcomes in children of alcoholics and potentially guard the child of an alcoholic from maladaptive behavior (Ackerman, 1986, pp. 1-7).

Adult children of alcoholics research is in the early stages of development. Therefore, more research is needed to fully understand the relationship between being raised in an alcoholic home and adult personality and behavior. Brown (1986) commented on the necessity for research and the ACA movement:

As in many social movements, the sudden awareness, new legitimacy, and emotional intensity have been profoundly powerful and helpful for countless children and adults. The unfortunate side of this burst of awareness and interest is the lack of a solid clinical research and theoretic foundation that would offer direction for intervention and treatment (p. 207).

Conclusion

The adult children of alcoholics movement has received widespread public recognition and acceptance. Until recently, empirical researchers had not addressed the questions raised by the adult children of alcoholics movement. One of the goals of this study was to bridge the gap between research and clinical practice. The findings from this study suggests that there are some differences between adult children of alcoholics and adult children of nonalcoholics. There appear to be some similarities.

Adult children of alcoholics perceived higher levels of internalized shame than adult children of nonalcoholics. However, both groups were within the normal range. No pathological shame appeared to exist in the groups. Some adults growing up in alcoholic families may not be negatively affected by the experience. The experience and

adjustment may depend on other factors (e.g., severity and type of alcoholism, age and perceptions of the child, significant others, constitutional characteristics of the individual and qualities of the early family environment) (Ackerman, 1984; Goodman, 1987; Werner, 1986).

Adult children of alcoholics also experienced more family dysfunction (lower level of perceived health) in their families of origin than adult children of nonalcoholics. The impact of the family of origin health affects individuals in very unique ways. Goodman (1987) theorized that

one's perceptions are as unique as are one's fingerprints, and these perceptions are determined by many factors (e.g., age, cognitive ability, birth order, type and quality of relationship with the alcoholic and the nonalcoholic spouse) (p. 163).

This study suggests that a relationship exists between level of internalized shame and perceived family of origin health. Individuals who had more shame experiences tended to view their families as more dysfunctional.

One of the major methodological problems common to empirical studies on adult children of alcoholics was addressed in this study. Few studies use comparison group/s. Additionally, most studies have used "clinical" populations. An investigation of a "nonclinical" population provided an opportunity to better understand adult children of alcoholics who are healthy and productive.

The challenge for future researchers in the area is not

only to clarify basic findings but also to integrate those findings into existing theories of human behavior. Solid clinical research will provide the foundation for sound clinical practice thereby closing the gap between research and practice.

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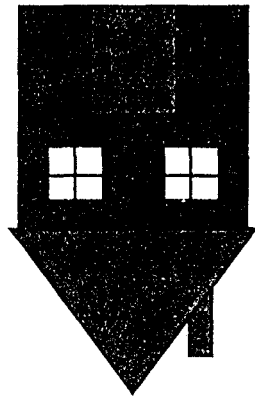
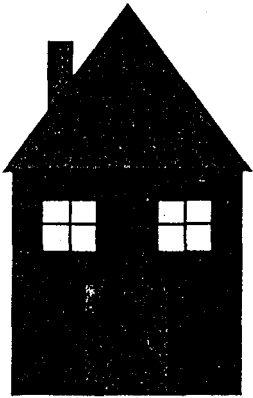
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APPENDIX A

What Was Your Experience?



General Information

Please answer the following questions by placing an (X) in the appropriate blank or filling in the information.

1. Sex: _____ Female _____ Male
2. Age: _____
(write in)
3. Marital Status (check one):
 Single
 Married
 Divorced, Single
 Divorced, Remarried
 Separated
 Widowed
 Cohabiting (living with companion)
4. Religion (check one):
 Catholic
 Protestant (specify denomination) _____
 Jewish
 Other (specify) _____
 No religious affiliation
5. How religious would you say you are at the present time? (check one):
 Very religious
 Somewhat religious
 Not too religious
 Not at all religious
6. Primary ethnic or racial identification (check one):
 African-American/Black
 Asian
 Caucasian/White
 Hispanic
 Other (specify) _____
7. Birth Order: In your family of origin (the family in which you grew up), which child were you in the birth order (example: 1st born, 2nd born, etc.) _____ born

8. Prior to age 16, were you predominantly raised by your:
- Biological Parents
 - Adoptive Parents
 - Biological Mother and Stepfather
 - Biological Father and Stepmother
 - Mother Alone
 - Father Alone
 - Other (Relative, Foster Parent)
- (Describe) _____
9. Prior to age 16, indicate your family of origin's socioeconomic level (check one).
- upper level
 - middle level
 - lower level

ISS

DIRECTIONS: Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the left that indicates that frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. DO NOT OMIT ANY ITEM.

SCALE

1-NEVER 2-SELDOM 3-SOMETIMES 4-FREQUENTLY 5-ALMOST
ALWAYS

SCALE

- 1 2 3 4 5 1. I feel like I am never quite good enough.
- 1 2 3 4 5 2. I feel somehow left out.
- 1 2 3 4 5 3. I think that people look down on me.
- 1 2 3 4 5 4. All in all, I am inclined to feel that I am a success.
- 1 2 3 4 5 5. I scold myself and put myself down.
- 1 2 3 4 5 6. I feel insecure about others opinions of me.
- 1 2 3 4 5 7. Compared to other people, I feel like I somehow never measure up.
- 1 2 3 4 5 8. I see myself as being very small and insignificant.
- 1 2 3 4 5 9. I feel I have much to be proud of.
- 1 2 3 4 5 10. I feel intensely inadequate and full of self doubt.
- 1 2 3 4 5 11. I feel as if I am somehow defective as a person, like there is something basically wrong with me.

- 1 2 3 4 5 12. When I compare myself to others I am just not as important.
- 1 2 3 4 5 13. I have an overpowering dread that my faults will be revealed in front of others.
- 1 2 3 4 5 14. I feel I have a number of good qualities.
- 1 2 3 4 5 15. I see myself striving for perfection only to continually fall short.
- 1 2 3 4 5 16. I think others are able to see my defects.
- 1 2 3 4 5 17. I could beat myself over the head with a club when I make a mistake.
- 1 2 3 4 5 18. On the whole, I am satisfied with myself.
- 1 2 3 4 5 19. I would like to shrink away when I make a mistake.
- 1 2 3 4 5 20. I replay painful events over and over in my mind until I am overwhelmed.
- 1 2 3 4 5 21. I feel I am a person of worth at least on an equal plane with others.
- 1 2 3 4 5 22. At times I feel like I will break into a thousand pieces.
- 1 2 3 4 5 23. I feel as if I have lost control over my body functions and my feelings.
- 1 2 3 4 5 24. Sometimes I feel no bigger than a pea.
- 1 2 3 4 5 25. At times I feel so exposed that I wish the earth would open up and swallow me.
- 1 2 3 4 5 26. I have this painful gap within me that I have not been able to fill.
- 1 2 3 4 5 27. I feel empty and unfulfilled.
- 1 2 3 4 5 28. I take a positive attitude toward myself.
- 1 2 3 4 5 29. My loneliness is more like emptiness.
- 1 2 3 4 5 30. I always feel like there is something missing.

C.A.S.T.

Directions: Please check either Yes or No for each question. Answer as candidly as possible. If you have no knowledge about a particular behavior, answer No. If your parent drank at one time and no longer drinks alcohol, answer as if s/he was still drinking. If deceased, answer as if s/he was still alive.

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

15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?
16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
17. Did you ever feel that you made a parent drink alcohol?
18. Have you ever felt that a problem drinking parent did not really love you?
19. Did you ever resent a parent's drinking?
20. Have you ever worried about a parent's health because of his or her alcohol use?
21. Have you ever been blamed for a parent's drinking?
22. Did you ever think your father was an alcoholic?
23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
24. Did a parent ever make promises to you that he or she did not keep because of drinking?
25. Did you ever think your mother was an alcoholic?
26. Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?
27. Did you ever fight with your brothers and sisters about a parent's drinking?
28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

What Was Your Experience?
Family of Origin Scale

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

<u>Key:</u>	1 (SD) = Strong disagree that it describes my family of origin					
	2 (D) = Disagree that it describes my family of origin					
	3 (N) = Neutral					
	4 (A) = Agree that it describes my family of origin					
	5 (SA) = Strongly agree that it describes my family of origin					
		SD	D	N	A	SA
1.	In my family, it was normal to show both positive and negative feelings.	1	2	3	4	5
2.	The atmosphere in my family was unpleasant.	1	2	3	4	5
3.	In my family, we encouraged one another to develop new friendships.	1	2	3	4	5
4.	Differences of opinion in my family were discouraged.	1	2	3	4	5
5.	People in my family often made excuses for their mistakes.	1	2	3	4	5
6.	My parents encouraged family members to listen to one another.	1	2	3	4	5
7.	Conflicts in my family never got resolved.	1	2	3	4	5
8.	My family taught me that people were basically good.	1	2	3	4	5
9.	I found it difficult to understand what other family members said and how they felt.	1	2	3	4	5

- | | | | | | | |
|-----|---|---|---|---|---|---|
| 10. | We talked about our sadness when a relative or family friend died. | 1 | 2 | 3 | 4 | 5 |
| 11. | My parents openly admitted it when they were wrong. | 1 | 2 | 3 | 4 | 5 |
| 12. | In my family, I expressed just about any feeling I had. | 1 | 2 | 3 | 4 | 5 |
| 13. | Resolving conflicts in my family was a very stressful experience. | 1 | 2 | 3 | 4 | 5 |
| 14. | My family was receptive to the different ways various family members viewed life. | 1 | 2 | 3 | 4 | 5 |
| 15. | My parents encouraged me to express my views openly. | 1 | 2 | 3 | 4 | 5 |
| 16. | I often had to guess at what other family members thought or how they felt. | 1 | 2 | 3 | 4 | 5 |
| 17. | My attitudes and my feelings frequently were ignored or criticized in my family. | 1 | 2 | 3 | 4 | 5 |
| 18. | My family members rarely expressed responsibility for their actions. | 1 | 2 | 3 | 4 | 5 |
| 19. | In my family, I felt free to express my own opinions. | 1 | 2 | 3 | 4 | 5 |
| 20. | We never talked about our grief when a relative or family friend died. | 1 | 2 | 3 | 4 | 5 |
| 21. | Sometimes, in my family, I did not have to say anything, but I felt understood. | 1 | 2 | 3 | 4 | 5 |
| 22. | The atmosphere in my family was cold and negative. | 1 | 2 | 3 | 4 | 5 |
| 23. | The members of my family were not very receptive to one another's views. | 1 | 2 | 3 | 4 | 5 |
| 24. | I found it easy to understand what other family members said and how they felt. | 1 | 2 | 3 | 4 | 5 |

- | | | | | | | |
|-----|---|---|---|---|---|---|
| 25. | If a family friend moved away, we never discussed our feelings of sadness. | 1 | 2 | 3 | 4 | 5 |
| 26. | In my family, I learned to be suspicious of others. | 1 | 2 | 3 | 4 | 5 |
| 27. | In my family, I felt that I could talk things out and settle conflicts. | 1 | 2 | 3 | 4 | 5 |
| 28. | I found it difficult to express my own opinions in my family. | 1 | 2 | 3 | 4 | 5 |
| 29. | Mealtimes in my home usually were friendly and pleasant. | 1 | 2 | 3 | 4 | 5 |
| 30. | In my family, no one cared about the feelings of other family members. | 1 | 2 | 3 | 4 | 5 |
| 31. | We usually were able to work out conflicts in my family. | 1 | 2 | 3 | 4 | 5 |
| 32. | In my family, certain feelings were not allowed to be expressed. | 1 | 2 | 3 | 4 | 5 |
| 33. | My family believed that people usually took advantage of you. | 1 | 2 | 3 | 4 | 5 |
| 34. | I found it easy in my family to express what I thought and how I felt. | 1 | 2 | 3 | 4 | 5 |
| 35. | My family members usually were sensitive to one another's feelings. | 1 | 2 | 3 | 4 | 5 |
| 36. | When someone important to us moved away, our family discussed our feelings of loss. | 1 | 2 | 3 | 4 | 5 |
| 37. | My parents discouraged us from expressing views different from theirs. | 1 | 2 | 3 | 4 | 5 |
| 38. | In my family, people took responsibility for what they did. | 1 | 2 | 3 | 4 | 5 |
| 39. | My family had an unwritten rule: don't express your feelings. | 1 | 2 | 3 | 4 | 5 |
| 40. | I remember my family as being warm and supportive. | 1 | 2 | 3 | 4 | 5 |

8. How old were you when your parent(s) stopped having a drinking problem? Check one or more below.
- 0-5 years
 6-12 years
 13-17 years
 18 years & older
 my parent(s) is still drinking
 not applicable - my parent(s) does not have a drinking problem
9. Has your parent/s ever been diagnosed with an emotional/psychological problem (excluding alcoholism)?
 yes no If yes, specify _____
10. Has your parent/s ever been diagnosed with a major physical illness/problem? (eg. cancer, heart disease)
 yes no If yes, specify _____
11. Have you ever been sexually abused/molested?
 yes no uncertain
12. Have you ever been physically abused?
 yes no uncertain
13. Have you ever been emotionally abused?
 yes no uncertain
14. Have you ever been involved in an organized self help group (eg. Alanon, Alateen, Adult Children of Alcoholics, Alcoholics Anonymous, Overeaters Anonymous)? yes no If yes, which one(s)?
15. Have you ever sought counseling or psychotherapy?
 yes no

APPENDIX B

Norms for Shame Scores

%ile	1	2	3	4	5			
99	70	78	87	93	96			
98	65	74	85	92	92			
97	63	67	79	90	90		92	
96	61	64	74	89	87	92	91	89
95	58	61	73	88	86	92	90	89
90	50	54	67	78	80	90	79	86
85	46	49	63	75	76	89	66	75
80	43	46	61	70	73	89	57	73
75	40	43	58	65	68	85	52	69
70	37	40	56	62	65	81	49	67
65	35	38	55	60	61	80	47	66
60	33	36	53	57	58	78	46	63
55	30	34	51	55	55	77	45	58
50	28	32	48	53	50	74	39	57
45	27	29	46	50	48	74	38	56
40	24	27	43	48	45	72	35	52
35	23	25	41	46	41	67	33	49
30	21	24	39	43	38	66	32	44
25	20	22	36	39	34	60	24	43
20	18	19	33	35	31	53	20	42
15	14	17	28	31	28	44	16	33
10	12	14	22	29	23	27	12	22
N	382	748	142	177	168	25	41	28
Mean	30	33	47	53	51	69	42	55
SD	15	16	17	19	21	22	22	21
Mean Age	25	24	33	35	41	24	15	15
Age Range	17-63	17-62	18-74	18-78	19-79	15-46	12-18	13-17

NORM GROUPS: 1-Non-Clinical Males 2-Non-Clinical Females
 3-Male Alcoholics 4-Female Alcoholics 5-Depressed (male and female)
 6-Eating Disordered Females 7-Male Adolescents in group homes
 8-Female Adolescents in group homes

NOTE: When separate norms are given for males and females this was based on the fact that the means differed from each other at $< .05$.

From Cook, D.R. (1991). Manual for the Internalized Shame Scale (ISS). Wisconsin: University of Wisconsin-Stout.

APPENDIX C

Paradigm for the Family-of-Origin Scale

Construct	Meaning in a healthy family
<u>Autonomy Concept</u>	
A. Clarity of expression	Thoughts and feelings are clear in the family.
B. Responsibility	Family members claim responsibility for their own actions.
C. Respect for others	Family members are allowed to speak for themselves.
D. Openness to others	Family members are receptive to one another.
E. Acceptance of separation & loss	Separation and loss are dealt with openly in the family.
<u>Intimacy Concept</u>	
A. Range of feelings	Family members express a wide range of feelings.
B. Mood & tone	Warm, positive atmosphere exists in the family.
C. Conflict resolution	Normal conflicts are resolved without undue stress.
D. Empathy	Family members are sensitive to one another.
E. Trust	The family sees human nature as basically good.

Note. From "A Family-of-Origin Scale" by A.J. Hovestadt, W.T. Anderson, F.P. Piercy, S.W. Cochran, and M. Fine (1985), Journal of Marital and Family Therapy, 11, p. 291.

APPENDIX D

February 23, 1992

Alan Hovestadt, Ed.D.
Counselor Education & Counseling Psychology
3102 Sangren Hall
Western Michigan University
Kalamazoo, MI 49008-5195

Dear Dr. Hovestadt:

I am writing this letter to ask for permission to use the Family Origin Scale (F.O.S.) in my research on adult children of alcoholics. Your scale will assist me in understanding the nature of family relationships (family health).

I am a doctoral student at Loyola University of Chicago. I am examining the differences between adult children of alcoholics and adult children of nonalcoholics.

Thank you for your cooperation. I am looking forward to hearing from you. Please call collect if you have any questions (312-508-3249).

Sincerely,

Shirley A. Butler, M.S.
Doctoral Candidate
Loyola University of Chicago

____ Yes, I give you permission to use the Family of Origin Scale for your research purposes.

Signature

February 23, 1992

David R. Cook, Ed.D.
237 Harvey Hall
University of Wisconsin-Stout
Menomonie, WI 54751

Dear Dr. Cook:

I am writing this letter to ask for written permission to use the Internalized Shame Scale (ISS) in my research on adult children of alcoholics. I spoke with you on the phone last year and you sent me the manual and copies of the instrument. My dissertation committee has approved my proposal. Your scale is an important aspect of my research.

Thank you for your cooperation. I am looking forward to hearing from you. Please call collect if you have any questions (312-508-3249).

Sincerely,

Shirley A. Butler, M.S.
Doctoral Candidate
Loyola University of Chicago

____ Yes, I give you permission to use the Internalized
Scale for your research purposes.

Signature



5 NORTH WABASH AVE.
SUITE 1409
CHICAGO, IL. 60602
(312) 938-8661

February 28, 1992

Loyola University
Dept of Counseling Psychology (Dissertation)
5506 Groveside Road
Rolling Meadows, IL 60008
Shirley Butler
(Invoice #5509)

You have our permission, as publisher of the CAST, to use the CAST for your research at Loyola University regarding "*Internalized shame and perceived family health of ACoAs*". It is understood that you will be making up to 500 copies of the CAST and will pay a royalty fee of \$30. If you come across any CAST studies not included in our research abstracts please send a copy of the study's abstract and title page.

You also have permission to include a copy of the CAST any in-class paper, thesis or dissertation including publication by the UMI Master's / Dissertation Abstract service. Colleges generally send a student's research to UMI upon their graduation. If yours does not, we will pay half of the UMI publication costs. If you submit it for publication elsewhere, the CAST test must be removed and replaced with our company address for interested readers.

Please send us the results (at least the title page and full abstract - the whole paper, if possible) of your finished paper so that your findings may be included in future CAST test manuals. Please contact us if we can be of any further assistance.

Good luck,

Michael A. Lavelli, M.A.
President, Camelot Unlimited



APPENDIX E

April 3, 1992

Dear Student:

I need your help!! I am a sixth year doctoral student in the Counseling and Educational Psychology Department at Loyola. I would like you to participate in my dissertation research. My dissertation topic deals with family of origin relationships and how those relationships affect present functioning.

Please complete the questionnaire and return it in the enclosed stamped self-addressed envelope by April 20, 1992. The questionnaire takes approximately 40 minutes to complete. Do not write your name on the questionnaire so that your responses remain anonymous. If you would like the summary of results, place your name and address on the postcard.

Thank you for your help. If you have any questions, call me at 312-508-3249.

Sincerely,

Shirley A. Butler, MSN
Doctoral Candidate

December 4, 1991

Sally A. Butler
6525 North Sheridan Road
Chicago, Illinois 60626

Dear Sally:

I recently mailed you a questionnaire. I would like you to participate in my research project. Your responses are valuable. If you have misplaced your questionnaire please call me (312-508-3249). I will send you another one. If you have already mailed the questionnaire, thank you.

Thanks for your support.

Sincerely,

Shirley A. Butler

APPENDIX F

Correlation Coefficients of Internalized Shame Scale (ISS) Total Scores, ISS Subscale Scores, Family of Origin Scale (FOS) Scores, FOS Subscale Scores, and Children of Alcoholics Screening Test Scores (CAST)

	SELFEST	SHAME	INFER	ALIEN	AUTON	INTIM	FOSTOT	CASTSCO
SELFEST	1.0000	-.6977**	-.7253**	-.5724**	.4611**	.4761**	.4765**	-.2333**
SHAME	-.6977**	1.0000	.9570	.9289**	-.5428**	-.5715**	-.5666**	.3486*
INFER	-.7253**	.9570**	1.0000	.7816**	-.5449**	-.5770**	-.5719**	.3232**
ALIEN	-.5724**	.9289**	.7816**	1.0000	-.4716**	-.4891**	-.4866**	.3388**
AUTON	.4611**	-.5428**	-.5449**	-.4716**	1.0000	.9394**	.9834**	-.3723**
INTIM	.4761**	-.5715**	-.5770**	-.4891**	.9394**	1.0000	.9860**	-.3774**
FOSTOT	.4765**	-.5666**	-.5719**	-.4866**	.9834**	.9860**	1.0000	-.3689**
CASTSCO	-.2333**	.3486**	.3232**	.3388*	.3723**	-.3774**	-.3689**	1.0000

Note. *Signif. LE .05
 **Signif. LE .01 (2-tailed)

APPROVAL SHEET

The dissertation submitted by Shirley A. Butler has been read and approved by the following committee:

Dr. Gloria J. Lewis, Director
Associate Professor, Counseling and Educational
Psychology, Loyola

Dr. Ronald R. Morgan
Associate Professor, Counseling and Educational
Psychology, Loyola

Dr. Donna J. Rankin
Associate Professor, School of Nursing, Loyola

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

April 14, 1993
Date

Gloria J. Lewis
Director's Signature