



1993

## The Effect of Parental Alcoholism on the Development of Object Relations and Coping in the Offspring

Elaine D. Rado  
*Loyola University Chicago*

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LOYOLA UNIVERSITY OF CHICAGO

THE EFFECT OF PARENTAL ALCOHOLISM ON  
THE DEVELOPMENT OF OBJECT RELATIONS  
AND COPING IN THE OFFSPRING

A DISSERTATION SUBMITTED TO  
THE GRADUATE SCHOOL IN PARTIAL FULFILLMENT OF THE  
REQUIREMENTS FOR THE DEGREE OF  
DOCTOR OF PHILOSOPHY

DEPARTMENT OF PSYCHOLOGY

BY

ELAINE DOROTHY RADO

GRAYSON HOLMBECK, Ph.D

DISSERTATION ADVISOR

CHICAGO, ILLINOIS

MAY, 1993

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## ACKNOWLEDGEMENTS

I would like to thank the staff and administration of The Chicago Institute for Addictive Disorders and of HCA Chicago Lakeshore Hospital for providing access to subjects for this study, and helping to facilitate the collection of the data. My thanks also go to Grayson Holmbeck, the director of this dissertation, for guiding and supporting me through its development, implementation, and completion. I am also grateful to Jim Johnson and Dan Barnes who served as readers on my committee, and have consistently contributed to and supported my professional development over the past six years.

## VITA

The author, Elaine Dorothy Rado, was born on January 30, 1954 in Fairfield, Connecticut. She attended the State University of New York at Binghamton, receiving the degree of Bachelor of Arts in Studio Art in May of 1975. In May of 1978, Ms. Rado was granted the degree of Master of Education from Lesley College Graduate School, with a specialty in Art Therapy.

Ms. Rado worked for the State of Massachusetts over an eight year period as an Art Therapist and, later, as the head of the Rehabilitation Service for the Cambridge/Somerville Unit of Metropolitan State Hospital. She received her registration as an art therapist in 1981 from the American Art Therapy Association, and served on the Professional Standards Committee for that organization for two years.

In September of 1986 Ms. Rado entered the doctoral program in Clinical Psychology at Loyola University of Chicago. She earned a Master's degree in clinical psychology in 1989; the topic of her thesis was "Indicators of Empathy in the Rorschach Ink Blot Test". As a graduate student, she did clinical work at Illinois Masonic Medical Center and at Loyola University's Counseling and Career Development Center. She was also employed for two years by the Chicago Institute for Addictive Disorders. Her predoctoral internship was at the Ravenswood Hospital

Community Mental Health Center in Chicago, Illinois.

Currently, she is employed at Mount Sinai Hospital Medical Center's Pediatric Ecology Program, Chicago, Illinois.

## TABLE OF CONTENTS

COPYRIGHT . . . . .	ii
ACKNOWLEDGEMENTS . . . . .	iii
VITA . . . . .	iv
LIST OF TABLES . . . . .	viii

### Chapter

#### I. INTRODUCTION

Purpose of the Study . . . . .	1
Overview of the Study . . . . .	1
Structure of the Study . . . . .	5

#### II. REVIEW OF THE LITERATURE

Clinical and Theoretical Literature on the Children of Alcoholic Parents . . . . .	6
Overview of the Literature . . . . .	6
Direct Effect Models . . . . .	8
Indirect Models . . . . .	12
Summary . . . . .	22
Empirical Investigations into the Children of Alcoholic Parents . . . . .	23
Overview of the Research . . . . .	23
Interpersonal Relations . . . . .	29
Object Relations . . . . .	29
Attachment . . . . .	31
Peer, Family, and Marital Relations. . . . .	35
Impaired Parenting of COAs . . . . .	38
Summary . . . . .	43

Coping . . . . .	44
Overview of Coping . . . . .	44
Folkman and Lazarus's Model of Coping. . . . .	45
Coping in Childhood and Adolescence. . . . .	47
Coping in the Offspring of Alcoholic Parents . . . . .	52
Summary . . . . .	56
Hypotheses . . . . .	57
Justification for a Hospitalized Adolescent Sample . . . . .	58
 III. METHOD	
Subjects . . . . .	61
Measures . . . . .	63
Assessing Parental Alcoholism . . . . .	63
Object Relations . . . . .	68
Coping . . . . .	71
Control Measures and Variables . . . . .	72
Proceedure . . . . .	76
Hypotheses . . . . .	78
 IV. RESULTS	
Introduction . . . . .	80
Characteristics of the Sample . . . . .	80
Group Membership . . . . .	80
Group Demographics . . . . .	81
Family Dysfunction . . . . .	85
Tests of Hypotheses . . . . .	87
Hypothesis 1 . . . . .	87



Hypothesis 2 . . . . .	89
Hypothesis 3 . . . . .	91
Follow-up and Exploratory Analyses . . . . .	95
Follow-up Analyses . . . . .	95
Exploratory Analyses . . . . .	99
V. DISCUSSION	
Summary of Hypotheses and Results . . . . .	108
Demographic Control Variables . . . . .	109
Object Relations . . . . .	110
Adjustment . . . . .	113
Coping . . . . .	114
Theoretical Considerations in the Lack of Significant Results . . . . .	116
Methodological Considerations in the Lack of Significant Results . . . . .	120
Conclusions . . . . .	124
Future Directions . . . . .	125
REFERENCES . . . . .	128

LIST OF TABLES

Table	Page
1. Schematic of Brown's Model of Development . . . . .	20
2. Decision Rules for Group Membership . . . . .	82
3. Inclusion/Exclusion Criteria for Children of Alcoholics Group (COA) . . . . .	83
4. Descriptive Statistics for Demographic Variables . . . . .	84
5. Descriptive Statistics for the Family Functioning Scale (FFS) . . . . .	86
6. Descriptive Statistics for the Separation and Individuation Test of Adolescence Scales (SITA) . . . . .	88
7. Descriptive Statistics for the Attachment Style Inventory (ASI) . . . . .	90
8. Descriptive Statistics for the Achenbach Youth Self-Report Problem and Summary Scales (YSR) . . . . .	92
9. Descriptive Statistics for the Ways of Coping Scales (WOC) . . . . .	94
10. Attachment Style Inventory by Rater . . . . .	98
11. Ways of Coping: Within-Groups T-Tests for NCOAs . . . . .	100
12. Ways of Coping: Within-Groups T-Tests for COAs . . . . .	100
13. Correlations with the Youth Self Report as a Measure of Adjustment . . . . .	102
14. Attachment Style Inventory by Rater Combining COA and NCOA Groups . . . . .	105

## CHAPTER I

### INTRODUCTION

#### Purpose of the Study

The purpose of this study is to investigate hypothesized differences between adolescent offspring of alcoholic and non-alcoholic families with regard to object relations functioning and coping strategies. Examination of the clinical literature on children of alcoholic parents suggests that object relations and coping may be fruitful domains to study and, specifically for object relations, may be explanatory of the diverse results found in prior empirical investigations of behavior and symptomatology in the offspring of alcoholics.

#### Overview of the Study

In recent years, there has been increasing attention paid to the effects of alcoholism and substance abuse on offspring. It is estimated that there are approximately 7 million children under the age of 18 living with an alcoholic parent, and another 22 million adults who grew up in such families (Woodside, 1988; Zucker, 1986). As many of these individuals sought psychological assistance, questions

arose as to the relative impact of the parental alcoholism on the life adjustment of their offspring. Clinicians who treated many of these individuals developed a plethora of theories based on their clinical observations; direct models which postulated specific, negative outcomes. These models, discussed in section one of the literature review, preceded empirical investigation. The latter, once started, tended to be atheoretical in nature and did not support the more popular clinical theories (Owings-West & Prinz, 1987).

While the combined weight of these empirical studies does show an overall increase in risk of dysfunction for the offspring of alcoholics (Chassin, Barrera, & Rogosch, unpublished; el Guebaly & Offord, 1977; Heller, Benson, & Sher, 1982; Hibbard, 1989; Russell, Henderson and Blume, 1985; Wallace, 1988; Owings-West & Prinz, 1987; Zucker, 1986) there has been little success in documenting the discrete, consistent dysfunctions purported by many clinical theories. Certainly the studies conducted have been rife with methodological flaws, as has been noted in numerous reviews of the literature published over the past 13 years (Benson & Heller, 1987; Berkowitz and Perkins, 1988; Creighton, 1985; Jacob & Leonard, 1986; Jacob, Meisel, & Anderson, 1978; Owings-West & Prinz, 1987; Reich, Earles, & Powell, 1988; Rimmer, 1982; Roosa, Sandler, Beals, & Short, 1988; Tharinger & Koranek, 1988). Nevertheless, it is difficult to avoid the conclusion that the initial premise,

that is, the premise of a direct model with a specific outcome, is faulty.

Some researchers, pointing to the inadequacy of the direct models, suggest that the observed dysfunction in children of alcoholics' in childhood (COAs) and adulthood (ACOAs) is due to other factors inherent in all dysfunctional families (Burk & Sher, 1988). They conclude that there are no pathogenic mechanisms specific to familial alcoholism (Burk & Sher, 1988). Some go so far as to identify positive features which are generated by such childhood experiences (Garmezy, 1981; Ryff & Dunn, 1985; Werner, 1986, 1988).

There are, however, a few theorists who have taken these same findings (of an increased level of dysfunction in the offspring of alcoholic parents) and offered another explanation. They propose the presence of an early structural impairment in COAs which, in adolescence or adulthood, becomes manifest in a variety of overt symptoms or pathologies. This impairment, they hypothesize, is in the development of object relations (Brown, 1987; Hibbard, 1987). Object relations are defined as psychological structures, inner images of the self and the other, which are formed out of the residue of relationships to primary caregivers during infancy and early childhood. These structures shape perceptions of the self, of others, and of interpersonal relationships (St. Clair, 1986).

Such an impaired development is the guiding belief of the proposed study, as follows: early impairment of object relations development in COAs leads to a multitude of problems in adolescence, particularly in the areas of separation and individuation, in interpersonal relationships, and in coping (as is noted by clinicians who work with these patients). The complexity and heterogeneity of alcoholic family system (Jacob & Leonard, 1986; Steinglass, Bennett, Wolin, & Reiss, 1987; Zucker, 1986), the presence of many moderating variables which alter the course of development (Burk & Sher, 1988; Tharinger & Koranek, 1988), and the temperament of each child (Werner, 1986) all contribute to diverse outcomes. Perhaps for this reason, the empirical studies which focus on specific outcomes find inconsistent results despite an overall indication of increased dysfunction in this population.

It is the premise of the current study that, if this theory of impaired object relational capacity due to parental abuse of alcohol is valid, a consistent pattern of impairment in object relations should be identifiable in the dysfunctional offspring. In addition, appropriate measures should also identify a style of coping which has developed as a result of parenting impaired by alcohol abuse, one which reflects the limited coping strategies modeled in the alcoholic families. Ratings of behavior problems, in contrast, will be heterogeneous.

## Structure of the Study

To study the ideas described above, two groups of adolescents were assessed, with group membership based on the presence or absence of parental alcoholism in at least one of the first six years of the subject's life. Both groups were drawn from a population of psychiatrically hospitalized individuals to control for psychological and familial dysfunction (Lund & Landsman-Dwyer, 1979). Subjects were administered measures of object relational capacity and style, a measure of coping skills, behavioral and personality assessment measures, and family functioning instruments, including a measure for parental alcoholism. For each subject, a measure of the adolescent's style in relationships was also completed by several hospital staff members. Information about diagnosis, family structure, prior treatment, and family history of substance abuse and psychopathology was obtained from the hospital record and from a structured interview with each subject. This approach to data collection, which employs both objective measures, subjective evaluations, and archival information, enhances the convergent validity of the data. Statistical analyses were employed to test the hypothesis that parental alcoholism has an identifiable impact on the development of object relations and coping in the offspring.

## CHAPTER II

### REVIEW OF THE LITERATURE

#### Clinical and Theoretical Literature on Children of Alcoholic Parents

##### Overview of the Literature

An ever increasing body of literature on children of alcoholics has been produced by clinicians who work with these individuals. Such literature has spurred both a large self-help movement and empirical research in this area (Murray, 1989). Thus, it is important to review this material, both to provide a context for the current study and to establish the theory which guides it.

Clinical theories on the effects of parental alcoholism are all essentially developmental in nature (Hibbard, 1987). That is, all presume that the dominant presence of alcohol within a family will impact upon, and most likely impede the normal course of development in the children. Beyond this commonality, models of the effects of parental alcoholism on the offspring fall into two major groups. One group (e.g. Black, 1986, Wegsheider, 1981, Woititz, 1983), professes that **all** children from such families will become dysfunctional (Burk & Sher, 1988). Even those offspring who appear well adapted in childhood



will manifest impairment as they become adults because of the inflexibility of their defenses (Black, 1986). Of interest to these clinicians are the specific dysfunctions which characterize such individuals. In the models of Black (1986) and Wegscheider (1981), which focus on roles within the family, dysfunction results from the adoption of these defined, predictable roles which the child plays within the family. Other models, such as those of Woititz (1983), and of Cermak and Rosenfeld (1987) identify essential, central features of the alcoholic family structure and link the specific dysfunctions to it. These are all essentially direct effect models (Burk & Sher, 1988); parental alcoholism ipso facto leads to predictable pathology in the offspring.

A second group of theorists, such as Ackerman (1983), Hibbard (1987), and Brown (1988), places a greater emphasis on the process of the child's development within the alcoholic family, and less emphasis on defining specific outcomes. These clinicians, like those in the first group, postulate an increased likelihood of dysfunction in the offspring of alcoholics. They attribute this dysfunction to the central organizing role which alcohol plays in these families, and attempt to understand its impact on the psychological development of these children. This approach includes recognition that the effect is variable, and pays attention to the multiple moderating factors which may

ultimately effect the outcome of development (Tharinger & Koranek, 1988).

The direct models proposed by the first group will be reviewed only briefly. While they are seminal to the development of the body of literature and research, these models have not held up under empirical scrutiny. Further, these models play only a minor role in the development of the current study. The latter group, which is characterized by indirect models, offers theoretical structures which are more congruent with the current study. Therefore, these latter models will be presented in more depth, culminating with a model developed by Stephanie Brown (1988) which provides the theoretical rationale underpinning the study at hand.

### Direct Effect Models

One direction taken by the direct effect theorists is the development of alcoholic family roles (Tharinger and Koranek, 1988). The primary writers in this area are Black (1986) and Wegscheider (1981). Taking a family systems perspective, they see the function of family roles as maintenance of homeostasis within the alcoholic family structure (Tharinger & Koranek, 1988). In her model Wegscheider (1981) delineates five roles. **The Enabler** endeavors to rescue or buffer the alcoholic from the negative consequences of alcohol use. **The Hero** attempts to compensate for the family's deficits by attaining positive

recognition from the outside world, in this way enhancing family self-esteem. **The Scapegoat** takes on the blame for all of the family's problems, including blame for the alcoholic parent's drinking. **The Lost Child** withdraws and essentially places no demands on the severely strained family system. Last, **The Mascot** attempts to diffuse tension via humor and charm.

While taking a similar approach to Wegsneider (1981), Black (1986) identifies only three crucial roles. **The Responsible One** takes on the parental role, in this way providing structure and stability for him/her self and any siblings. **The Adjuster** takes cues from the environment as to desired behavior or responses, and like Wegsneider's Lost Child, avoids stressing the system. **The Placater**, as the name suggests, endeavors to smooth conflicts and focuses on helping others, often motivated by a sense of guilt. This child, Black suggests, often feels that he/she is to blame for the parent's drinking. Black, in particular, emphasizes the functionality of these roles which allow the offspring to appear well adjusted and "healthy" in childhood. However, she notes that these roles also limit development and cause increasing dysfunction over time. The limited and rigid roles adopted in childhood, and the concomitant coping methods which allowed the child to function within the alcoholic family, become crippling as the child moves from the family to a more varied environment, one with different

demands and expectations. She suggests further that such individuals develop an interpersonal style which places them at high risk for reinvolvement in an alcoholic system, either through their own use or through marriage to a substance abusing spouse (Black, 1986).

Woititz (1983, 1986) picks up where the role theorists leave off. That is, she starts by listing the inflexible, distorted beliefs manifest in the adult offspring of alcoholic families (ACOAs). Based on her extensive clinical experience with adult children of alcoholics, Woititz writes about the skewed "world-view" of these individuals which results from growing up with an ongoing sense of uncertainty. She summarizes this "world-view" in the following thirteen statements:

1. Adult children of alcoholics guess at what normal is.
2. Adult children of alcoholics have difficulty following a project through from beginning to end.
3. Adult children of alcoholics lie when it would be just as easy to tell the truth.
4. Adult children of alcoholics judge themselves without mercy.
5. Adult children of alcoholics have difficulty having fun.
6. Adult children of alcoholics take themselves very seriously.
7. Adult children of alcoholics have difficulty with intimate relationships.
8. Adult children of alcoholics overreact to changes over which they have no control.
9. Adult children of alcoholics constantly seek approval and affirmation.
10. Adult children of alcoholics feel that they are different from other people.
11. Adult children of alcoholics are either super responsible or super irresponsible.
12. Adult children of alcoholics are extremely loyal, even in the face of evidence that their loyalty is

undeserved.

13. Adult children of alcoholics are impulsive (Woititz, 1986).

Cermak observes many of these same features in his clients from alcoholic families (Cermak & Brown, 1982). However, he conceptualizes the central issue in alcoholic families as one of control rather than uncertainty. "ACAs commonly react to the interpersonal and intrapsychic complications of life by increasing their efforts to control both internal and external events. Whether the mechanism for maintaining control is mastery, manipulation, denial, or obsessing, the maintenance of control is unquestioned as a universal ideal" (Cermak & Rosenfeld, 1987). Parental alcoholism therefore impacts not only upon feelings about and management of one self, but also inhibits the development of trust, blocks expression of needs and feelings, and distorts conceptions of responsibility. This results in dysfunctional characteristics and beliefs comparable to those suggested by Woititz (1986; see above).

Lists of common characteristics or concerns are prevalent in the writing of other direct model clinicians as well. Frequently mentioned issues are feeling responsible for the parent's drinking (Bogdaniak & Piercy, 1987; Cork, 1969; Morehouse, 1979), impaired capacity to trust others resulting from the inconsistency of the alcoholic parent (Bogdaniak & Piercy, 1987; Gravitz & Bowden, 1986; Morehouse, & Richards, 1986), distrust of one's own

perceptions as a result of denial in the family (Gravitz & Bowden, 1986; Tharinger & Koranek, 1988), difficulty expressing feelings constructively (Bogdaniak & Piercy, 1987; Tharinger & Koranek, 1988), and problematic interpersonal relationships (Deutsch, 1982; Gravitz & Bowden, 1986; Morehouse & Richards, 1986).

The direct models grew out of the early efforts of clinicians to explain the dysfunction which they repeatedly encountered in adult children of alcoholic parents who sought treatment for their own problems. Their work is laudable in that it focused the attention of the scientific community on the potential repercussions of alcoholism on the offspring. These models also offered easily comprehensible systems which psychologically distressed ACOAs could adopt as they attempted to comprehend and address their own dysfunction. This simplicity, however, is also the primary flaw in such direct models, for they are unlikely to apply to the many variations across both individuals and family systems.

### Indirect Models

Indirect models focus on the process of the child's development within an alcoholic family, emphasizing a dynamic interaction between characteristics of the child, the parent, and the family environment. These models recognize and accommodate for the role of moderating variables within the alcoholic family, and do not predict a

specific outcome regarding the psychological adjustment of the offspring.

Ackerman (1983) suggests that inadequate parenting (which results from the dominance of alcohol in the family system) interferes with the resolution of age appropriate developmental crises. Using Erikson's (1963; see Ackerman, 1983) model of development, he identifies the impact of parental alcoholism upon the successful resolution of the developmental issues at each stage. The specific dysfunction in the child, then, would be linked with the child's age when the abusive drinking occurred. Second, Ackerman suggests that the unstable family environment, and a resulting lack of security for the child, may result in an excessive and rigid reliance on undesirable or even destructive defense mechanisms. Based on his clinical observations, he identifies regression, repression, projection, sublimation, and reaction formation as the predominant defense mechanisms seen in this population. He postulates that such an over-reliance on these primitive defensive maneuvers interferes with the development of self-concept or identity.

In an unpublished manuscript, Moore (1982, cited in Searles & Windle, 1990) identifies three primary factors of parenting whose disruption, he postulates, will impede adjustment in the child. These are the style and quality of the parent-child relationship, the style and consistency of

the parent's supervision, and the level and style of direct parental socialization (that is, the parents as role models). The degree of disruption is related to the severity and chronicity of the parental alcoholism and the extent to which it induces "secondary factors" such as marital problems, financial hardship, and social isolation. Moore offers a structured, systematic model, one which can be assessed empirically. Unfortunately, the model does little to differentiate the alcoholic family from other dysfunctional family systems.

Seilhammer and Jacob (1990) propose an indirect model which integrates the clinical theories of Ackerman (1983) and Moore (1982, cited in Searles & Windle, 1990) with the moderating variables identified in their own research and through a review of the other empirical literature. Their model postulates three main effects of parental alcoholism. **Ethanol Effects** are the direct effects of alcohol on cognition, mood and behavior. **Family Effects** include not only marital conflict and disruption of the family functioning, but also parentification of the child, and changes in the expression of affect and the resolution of problems. **Modeling Effects** refer specifically to the modeling of substance abuse as a primary coping mechanism. These three main effects disrupt parenting, creating unstable home environments which vary in degree of deficiency. The outcome, impacted by environmental and



constitutional moderators, is often impaired child adjustment.

Hibbard (1987) also takes an interactive approach in exploring the effects of parental alcoholism on the offspring. Working out of an object relations orientation, he states that "...the pathogenic mechanisms in ACA pathology consist of the absence of developmentally appropriate parenting" (p. 782). Hibbard observes that this, in itself, is not unique to alcoholic families. However, he adds that there are several "recurring mechanisms" which result in characteristic developmental pathology in the offspring of these families. Specifically, Hibbard believes that the atmosphere created by parental alcoholism is highly conducive to reliance in the offspring upon splitting, or "polarization of affect" as a primary defense mechanism. Hibbard suggests that children of alcoholic parents dissociate themselves from the negative affect, especially the aggression often introduced into the family by the alcoholism. A second mechanism is the unavailability or unsuitability of one or both parents for "introjective, identificational, or mirroring functions" (p.784), that is, the processes through which the child develops an internal sense of self. This is perhaps comparable to the feature which Moore calls parental socialization (Moore, 1982, cited in Searles & Windle, 1990). Third, Hibbard notes that alcoholic families

develop compensatory mechanisms in an attempt to cope with the alcoholism. While the mechanisms may take many forms, all are developmentally disruptive to the offspring. A fourth common feature is the high level of overt trauma often present in alcoholic families. Last, Hibbard suggests that children of alcoholics bear a deep-rooted sense of shame. This is more than shame about the alcoholic parent's behavior. It is also shame which is internalized by the child, as a result of both an identification with the alcoholic parent and collusion required by the child so as to maintain the family secret (the alcoholism).

Brown (1988) takes an approach similar to the other indirect models, but has developed these ideas much further. Based on systematic observations of ACOAs in group therapy over a period of 10 years, she has evolved a developmental model for children of alcoholic parents which addresses not only the structural impairment observed by Hibbard (1987), but also the impact of parental alcoholism upon cognitive and affective development of the offspring.

Like the other theories presented thus far, Brown purports that the presence of the alcoholism and the denial of its existence, taken together, will impede the normal course of early childhood development when a family is organized around alcohol. This occurs because the presence of alcoholism within the family diminishes the availability of the parenting figure, either because the parent is using

alcohol or because the attention of the non-using parent is focused on his or her spouse. Further, because of the effects of alcohol on mood, the behavior of the parents is inconsistent and unpredictable. As a result, essential attachment to the caregiver is either insecure, faulty, or pathological. Herein lies the genesis of the ACOAs character pathology and impaired object relations, as Hibbard suggests, above.

Brown (1988) proposes that subsequent psychological development is impaired by the prevalence of denial in the alcoholic family. As in other families dominated by pathology (Lidz, 1983, cited in Brown, 1988; Miller, 1981, cited in Brown, 1988), children in the alcoholic family must confirm the parents' reality and subjugate their own needs to the needs and defenses of the parents. In the alcoholic family, this means that the children must support and confirm the parents' denial. For these children then, developmentally appropriate separation, which requires reliance on one's own perceptions, capacities, and feelings brings about an intolerable awareness of parental distortions and, with it, a threat to an already unstable attachment. Any efforts by the child to achieve separation engender a "cognitive and affective disequilibrium...(that) is not predictable or manageable" (Guidano & Liotti, 1983, cited in Brown, 1988, p. 173).

Resolution of this disequilibrium cannot be achieved

by changing core beliefs because core beliefs are derived from the parents and, at this point, the self structure of the child is still defined by the parental attachment. The alternative is to refuse the incompatible perceptions and affects, and retain the parents' belief system.

Specifically, Brown suggests that the child adopts the alcoholic parent's distortions in thinking. The offspring thus embrace a belief system which "...explains increasing drinking and denies it at the same time. This ... includes (a reliance on) rationalization and denial, primitive cognitive defense mechanisms, and a distorted logic that reverses cause and effect" (1988, p.4).

Continued attachment, then, becomes "...based upon shared perceptions and identifications with the parents' beliefs" (Brown, 1988, p.171) and a rejection of one's own perceptions of the environment. Differentiation of the self from the primary care-giver becomes impossible (Beltis & Brown, 1981), and the personal identity subsequently constructed by the child maintains the family story. Summarizing, Brown identifies the following as her "core theory" (1988, p.5):

Attachment (in these families) -- early and ongoing -- is based on denial of perception which results in denial of affect which together result in developmental arrests or difficulties. The core beliefs and patterns of behavior formed to sustain

attachment and denial within the family then structure subsequent development of the self including cognitive, affective and social development (p.5).

Table 1 depicts the central features of object relations development in the offspring of alcoholic parents, inferred by Brown's model.

Pointing to models which posit the existence of multiple developmental lines which "...proceed together, reciprocally influencing and determining each other" (Guidano & Liotti, 1983, p.25), Brown lays out a template for further development of the children of alcoholics which suggests some commonalities and accounts for the many differences within this population. Specifically, she suggests that cognitive development cannot proceed in areas directly touched by the core conflict (the discordance between the child's own perceptions and those internalized from the alcoholic family structure). However, compartmentalization of experience and affect allows for continued development in areas which remain conflict-free. For example, in conceptualizing interpersonal relationships, the COA cannot transcend pre-operational or concrete operational thinking, this failure being the cognitive counterpart to denial. Thus, his/her conceptualization of interpersonal relationships will be global, concrete, dichotomous, and characterized by inappropriate assumptions of control and responsibility. However, this same

Table 1.

## Schematic of Brown's model of development

Insecure Attachment	Normal Separation	Regression to Insecure Attachment	Developmental Arrest
Child incorporates parents belief system as basis of the self.	Dawning recognition of discordance between internalized parental belief system and own perceptions of the world.	Child rejects own perceptions to maintain internalized sense of self and relationship to parents.	Child is unable to progress through normal development in any domain which touches this core conflict.
Child feels safe.	Child experiences discomfort.	Child feels safe.	Child feels constantly threatened.

individual might employ sophisticated cognitive processes in academic skills or in a trade. Such a domain-specific cognitive arrest may in part explain the variety of presenting problems in COAs who seek treatment. The nature and degree of dysfunction will vary with the severity of the core conflict. A more pervasive conflict will impinge upon and limit development in a wider range of intrapsychic and interpersonal domains.

As the child moves out of the family sphere in latency and adolescence, Brown (1988) suggests that he or she is faced with recognition of the differences between the beliefs of the family and those of the outside world. Questioning these core beliefs is experienced as akin to abandoning the family and losing one's identity, an experience exacerbated by the dichotomous thinking which characterizes COAs cognition in conflict-laden domains. The more advanced developmental tasks of identification and separation-individuation involve the integration of family and cultural values and the de-idealization of parental role models. These tasks require the ability to tolerate or resolve emotional ambiguities, merge apparent polar opposites, and other aspects of formal operational thought, a level of cognitive development which, once again, cannot be achieved in areas of conflict. Because of this, difficulties previously masked become manifest in adolescence.

## Summary

The differences hypothesized in the current study, between inpatients from alcoholic families and those from nonalcoholic families, will be extrapolated primarily from the developmental model by Brown (1988). This model was chosen for the following reasons: a) being a COA is inherently a developmental problem, b) Brown's model is fully developed and comprehensive, c) while based on clinical material, the data for this model was gathered within a consistent structure over a 10 year period by several clinicians, thus demonstrating some methodological rigor, and d) this model incorporates accepted theories of object relations development, cognitive-affective development, family systems, and alcoholism, thus capturing the multi-dimensionality of the effects of alcoholism noted by many researchers and clinicians (Clair & Genest, 1987; Hibbard, 1987; Murray, 1989; Owings-West & Prinz, 1987; Woodside, 1988).

The theoretical and clinical literature reviewed thus far offers clear support for the central hypothesis of the current study: that is, that parental alcohol abuse impairs the development of object relations in the offspring. I will now turn to the empirical literature on COAs to seek further support for this hypothesis.



## Empirical Investigations Into Children of Alcoholic Parents

### Overview of the Research

Although empirical investigation of the effects of parental alcoholism on their offspring has lagged behind the clinical literature, rapid gains have been made over the past ten years in both the quantity and quality of such studies. These more recent and empirically rigorous studies, however, are not the investigations used most often to support the clinical theories discussed above. That literature relies on studies conducted earlier (1960-1978), studies which most often are seriously flawed. For example, Cork's 1969 study of children from alcoholic families - The Forgotten Children - is cited by Ackerman (1983), Beltis and Brown (1981), Black (1986), Morehouse and Richards (1986), Priest (1985), Wallace (1987), Wilson and Offord (1978), and Woodside (1983), as supporting extreme dysfunction in children from alcoholic families. Reliance on Cork's flawed study occurs despite reviews published 13 and 14 years ago (see Jacob, et al., 1978, and El-Guebaly & Offord, 1977) in which Cork's methodological flaws were discussed and the validity of her sweeping conclusions questioned.

Unfortunately, such methodological problems were more the norm than the exception in these earlier studies (Heller, Benson, & Sher, 1982). One major problem has been the use of control groups. In many studies, they are either

absent (e.g. Cork, 1969) or inadequate. For example, Jacob, et al. (1978) observed a lack of matching on important demographic variables such as social class and family size. Inattention to matching for family disruption or parental psychopathology other than alcoholism is also often cited as a concern, as it limits generalization of the results, and muddies the role of important moderating and mediating variables (El Guebalay & Offord, 1977; Owings-West & Prinz, 1987).

Several reviews also raise a question of bias in the sample selection. Typically, subjects are the offspring of parents who are in treatment for alcoholism, or are self-identified ACOAs. The former are usually more severe cases (Owings-West & Prinz, 1987). The latter may be more inclined, because of the self-labeling, to attribute their difficulties to parental drinking. Owings-West and Prinz also note the predominance of paternal alcoholism in the studies conducted, and suggest that this too creates a bias in the sample as the effects of maternal alcoholism go unaddressed.

Another methodological problem in this body of literature is the wide variability in, or omission of, an operational definition of parental alcoholism. Owings-West and Prinz found that in 27 of the 46 studies reviewed, it is merely noted that one parent was in treatment for alcoholism, with no details on criteria available.

comparison across studies and generalization to the population at large are limited by the lack of criteria, or by the major differences in criteria presented. Measurement of dysfunction in subjects is also criticized. Many of the early studies (such as Cork, 1969) relied on anecdotal or narrative case findings. There has also been heavy reliance on indirect self-report (rather than direct observation), and single rather than multiple sources of information (Jacob et al., 1978; Owings-West & Prinz, 1987).

A final, important criticism is of the designs utilized by most studies in this field. These univariate designs which study one child dimension at a time preclude the study of multiple outcomes in child pathology (Owings-West & Prinz, 1987; Woodside, 1988). In addition, Rogosch, Chassin, and Sher (1990) suggest that the designs employed in ACOA research, to date, make it impossible to assess the role of mediators (variables that account for the relation between a predictor and a criterion) and moderators (variables which affect the direction and strength of the relation between a predictor and a criterion). Rogosch, Chassin and Sher (1990) observe, further, that even when such variables are considered, there remains a tendency both to blur the distinction between mediators and moderators, and a failure to apply appropriate statistical procedures in their analysis.

More recent studies, ones which demonstrate empirical

rigor, present a different set of problems in relation to the clinical theory. Most are atheoretical (Tharinger & Koranek, 1988), focus on the identification of specific symptoms, deficits, or pathology in the COA population, and, as a group, are inconsistent in their results (Burk & Sher, 1988; Owings-West & Prinz 1987; Tharinger & Koranek, 1988).

Typically, these more rigorous studies identify a behavioral dependent variable such as academic failure, school truancy, physical illness, or employment stability, a cognitive feature like IQ or field dependence, or a symptom of child pathology such as anti-social behavior, introversion, hostility, anger, substance abuse, or depression (Owings-West & Prinz, 1987; Rubio-Stipec, Bird, Canino, Bravo, & Alegria, 1991; Windle & Searles, 1990; Woodside, 1988). The study then attempts to measure the presence of the dependent variable in a group of children of alcoholics and in a control population, often ignoring variations in developmental level. This collapsing across age is done either in an attempt to attain larger samples, or in the search for broad patterns within the population (Johnson & Rolf, 1990; Knorrning, 1991; Owings-West & Prinz, 1987; Woodside, 1988). However, such an approach masks age specific outcomes. These newer studies also draw their subjects from community samples (rather than clinical samples) so as to eliminate a bias towards pathology (Tweed & Ryff; 1991, Woodside, 1988). However, selection of a

community sample may substitute a bias toward health, and possibly masks or washes out the presence of a more severe impairment in some COAs.

The best of these more recent studies include two control groups (one with children of normal parents and one with children of dysfunctional but non-alcoholic parents) so as to account for the effect of other dysfunctions in the parents (e.g. parental depression) (Owings-West & Prinz, 1987). Some studies find a significant relationship between the behavioral dependent variable and parental alcoholism. Others, often looking at an identical dependent variable, find no significant results. In this body of more rigorous empirical studies, the limitations placed on the method and design severely constrain generalization or comparison between studies. Thus it becomes difficult to understand discrepant or contradictory findings (Chassin, Barerra & Rogosch, unpublished study; Owings-West & Prinz, 1987). The result of this more rigorous research is individually valid studies which lose meaning when viewed within the larger body of literature.

The conclusion reached by reviewers of the more recent, empirically rigorous studies is that there is a relationship between alcoholism in the parents and an increased incidence of offspring symptomatology and dysfunction. However, the critical aspect of this parental behavior and any common child dysfunction remains

unidentified (Burk & Sher, 1988; Knorrning, 1991; Owings-West & Prinz, 1987; Rubio-Stipec et al., 1991; Tharinger & Koranek, 1988; Windle & Searles, 1990; Woodside, 1988). It cannot yet even be concluded that the critical factor is specific to alcoholism per se rather than the disruption alcoholism creates within the family, disruption which can also be created by other parental problems (Burk & Sher, 1988; Owings-West & Prinz, 1987). Most agree, however, that there is no support for the specific conclusions of the direct, causal models prevalent in the clinical literature, nor for the sweeping conclusion that all children from these families are effected negatively (Burk & Sher, 1988; Owings-West & Prinz, 1987; Tweed & Ryff, 1991; Woodside, 1988).

It is not within the scope of the current paper to review all of these studies, old or new. Nor is it considered germane, as the former are empirically flawed to such an extent that their conclusions are of limited value. Many of the latter are not relevant to the hypotheses of this study or the domains chosen for investigation. Most of these newer studies focus on the presence or absence of specific behaviors or symptoms as the outcome of life in an alcoholic family whereas the current study seeks support for a theory of developmental processes. The reader interested in learning about the studies not reviewed in this paper is referred to reviews by Owings-West and Prinz (1988), El Guebaly and Offord (1977), Burk and Sher (1988), and

Woodside, 1988.

It is the intent, in subsequent sections, to review the more recent studies which attempt to assess the effect of parental alcoholism upon the interpersonal functioning of the offspring (attachment, separation and individuation, and object relations development).

### Interpersonal Relations

Despite the frequency with which impaired interpersonal relationships is identified as a problem in case studies of ACOAs, that domain has received little empirical attention (Owings-West & Prinz, 1987). This section reviews empirically sound studies which identify interpersonal relations or a related construct (i.e. object relations, attachment, socialization, independence) or contributory factors (early childhood disruptions, impaired parenting) as a dependent variable.

Object Relations. Only two studies could be located in which the term "object relations" was specifically mentioned as a dependent variable. In one, Hibbard (1989) directly studied the level of object relational development in young adult children of alcoholics, employing only a normal control group. He combined scores derived from Exner's Egocentricity Index (Exner, 1986) (a measure of self-centeredness) and Blatt, Brenneis, Schimek, and Glick's (1976) object concept scales (a measure of the developmental

level for human object relations) for the Rorschach Ink Blot Test into a multivariate linear combination. Hibbard conceived of this variable as "...tapping developmentally based, intrapsychic dimensions of self-object representational capacity and self-versus other centeredness, both of which are relevant to object relational ability" (1989, p.506). Working with a small group (n=30) of ACOA and non-ACOA college students, Hibbard found a significantly greater level of object relational pathology in the ACOA group, as measured by this multivariate linear combination. A stepdown analysis demonstrated that the significant difference was due to both the elevated Egocentricity Level and the depressed Good Form Object Concept score in the group of ACOAs. Hibbard also found a higher level of personality disorders in the ACOA group as measured by the Millon Clinical Multiaxial Inventory. He suggests that this latter result supports a hypothesized link between impaired object relations and adult character pathology. While generally well constructed, this study is limited by the small sample size and the lack of a group which would control for the effects of other parental psychiatric disorders.

Beardslee and Vaillant (1986), working with longitudinal data initially collected by Glueck & Glueck (1968, see Beardslee & Vaillant, 1986), found no support for a hypothesized relationship between severity of alcoholism



and impaired object relations. The latter was assessed by a 25 point scale of social competence (Vaillant & Milofsky, 1980). The scale is described as measuring "...the capacity for human relations; ratings reflect relative success in accomplishing eight difficult tasks of adult object-relations" (p.586). Reviewing their results, however, the authors observe several problems in their study. First, the experimental group (COAs) was created post hoc from a control group of a study on delinquency. Thus, these subjects had been screened for delinquency and anti-social behaviors when initially selected at ages 11 to 14, creating a bias in subject selection for Beardslee and Vaillant's study. Second, no mediating or moderating variables [e.g. self-esteem, family rituals, or "psychodynamic factors" (p.590)] were included. Third, there was greater attrition amongst subjects from families with severe parental alcoholism, with the most missing data in the areas of overall mental health and social competence. Last, the initial data collection did not include information about the duration or timing of the parental alcoholism, thus confounding developmentally linked issues such as object relations.

Attachment. Three studies looked at attachment in the offspring of alcoholic parents. O'Connor, Sigman and Brill (1987) focused specifically on the relationship between attachment and maternal alcoholism by assessing 46 firstborn

children at age one. O'Conner et al. employed the Ainsworth Strange Situation Procedure (Ainsworth, Blehar, Waters, & Walls, 1978) and the four category system of classification developed by Main and Solomon (1986) to assess differences in infant attachment to abstinent-light, light-moderate, and moderate-heavy drinking mothers. They found that the majority of infants with mothers rated moderate-heavy in their drinking were insecurely attached. The authors also observed that most of the insecurely attached children of moderate-heavy drinking mothers fell into the Group D classification (groups B, C and D all describe insecure attachments). That group, labeled insecure disorganized/disoriented, are thought to be the least secure of all infants, and, according to Main and Solomon, may have experienced the most extreme of family conditions including maternal depression or maltreatment. This is certainly congruent with clinical descriptions of many alcoholic families.

O'Connor et al. (1987) made the interesting observation that under Ainsworth's three category rating system (as opposed to the four factor system which they employed), most of the offspring of alcoholic mothers would have been rated secure because of some positive attachment behaviors which are present along with the disorganization. Similarly, it is suggested that the dysfunction in COAs is often not identified because of the functional adaptations

made by some children (Tharinger & Koranek, 1988). It is possible that, like Ainsworth, many investigators have overlooked a crucial dimension which would distinguish the adapted but still impaired COAs from their healthy, non-COA peers. Thus the results of O'Connor's study support both the hypothesis that basic attachment and the subsequent development of object relations are impaired by maternal alcoholism and the hypothesis that there are identifiable features specific to the impairment of object relations in COAs.

A study of personality characteristics in the offspring of alcoholics by Berkowitz and Perkins (1988) also looked at attachment to others and is suggestive of a dysfunction in the area of object relations. Surveying the first and second year class of a private undergraduate institution, Berkowitz and Perkins found only two areas of significant difference between the children of alcoholics and their non-COA peers. Male COAs scored significantly higher on a measure of independence/autonomy, and female COAs significantly higher on a measure of self-depreciation. The authors offer an explanation of their results in accordance with some of the COA clinical literature. Berkowitz and Perkins (1988) suggest that the increased male autonomy may be a function of the COA's ambivalence about relying on others, because the alcoholic parent has proven so unreliable. The observed independence may also be an

effort to attain distance from a chaotic family. The female self depreciation, they postulate, "may reflect greater familial identification and greater personal sensitivity to the destructive aspects of parental alcoholism" (p.209). Berkowitz and Perkins observe that such a gender based difference in response to parental alcoholism is congruent with the model of gender developed by Gilligan (1982). Specifically, female identity and self-esteem remain strongly linked to success within interpersonal relationships with peers and with family members. Low self-esteem, then, could be a manifestation of early insecure attachment and impaired object relations.

Barnes and Benson (1979) were particularly interested in the effect of paternal alcoholism on female offspring. They examined five domains of functioning in female college undergraduates, comparing daughters of alcoholic fathers to female, non-COA peers. One domain is of particular relevance to the current study: that is, the COA's perception of herself and her parents. Subjects used the Leary Interpersonal Check List (LaForge & Suczek, 1955) to describe themselves, their mothers, and their fathers on eight characteristic modes of interpersonal relationships. Only one mode, skeptical-distrustful, distinguished the two subject groups (COA from non-COA), with COAs scoring higher. Mothers and fathers were also rated higher on the skeptical-distrustful scale by the COA offspring than were the parents

of their non-COA peers. This predominance of skepticism and mistrust in the daughter's perception of her own and her parents' interpersonal relationships may be the adult counterpart of the insecure disorganized/disoriented attachment observed by O'Connor, Sigman and Brill (1987; see above).

Peer, Family, and Marital Relations. Studies of interpersonal relations in the offspring of alcoholic parents are another source of information about object relational capacity. In a study of college students, Knowles and Shroeder (1990) administered the Minnesota Multiphasic Personality Inventory (MMPI) to offspring from alcoholic and non-alcoholic families. Scores on the MMPI validity and clinical scales, and Wiggins Content scales were analyzed. Knowles and Shroeder found significant differences on scale F and all clinical scales, with the COA group having scores which were higher, although still within the "normal range" ( $T < 70$ ). Differences between the groups on most of the Wiggins Content scales were also significant. The authors observed that the latter differences seem to be concentrated in the areas of interpersonal relationships, particularly family problems, as would be expected if object relations development had been impaired. It is interesting to note that despite significant differences in these areas, along with significantly higher scores on manifest hostility and social maladjustment, there was no difference between

the groups on authority conflict (T=54 for both groups). This lack of conflict with authority may be a manifestation of the hypothesized ambivalent and insecure parental ties described as characteristic in children of alcoholics. Despite their anger with the family, conscious rebellion and the resulting disengagement is psychologically unmanageable for COAs (Brown, 1988).

Also suggestive of increased difficulties in interpersonal relations are the results of a survey by Parker and Harford (1988). These authors used data collected in a cross sectional national drinking survey conducted in 1979 (Clark & Midanik, 1982, see Parker & Harford, 1988) to examine the relative impact of parental alcoholism on marital disruption in the offspring. Using statistical methods to control for alcohol problems in the offspring, Parker and Harford found a higher rate of marital difficulty, separation, and divorce in the ACOAs than in sociodemographically matched peers.

Tweed and Ryff (1991) also looked at interpersonal relations in their study of young adult COAs. Using a community sample, they compared COAs' performances on a scale of intimacy to non-COA peers but did not find any significant differences. There are two design features which may account for this absence of impaired interpersonal relationships. First, Tweed and Ryff themselves suggest that their use of a community sample, chosen to avoid a bias

towards pathology, may have skewed the results in the opposite direction. Second, the authors did not control for prior psychiatric treatment. The offspring of alcoholic parents had a higher rate of psychological treatment and psychiatric hospitalizations than their non-COA peers. It is possible that many of the COAs had addressed and to some extent remediated their intimacy problems in their psychiatric treatment.

A few studies observe social isolation in offspring of alcoholics, an outcome which may also be the result of impaired object relations. Goodwin, Schulsinger, Knop, Mednick, and Guze (1977) compared adopted and non-adopted daughters of alcoholics on several measures relevant to the current study. In their study, daughters raised by their alcoholic parents reported significantly fewer friends in childhood (few or no friends), and also a significantly higher rate of depression. One possible explanation is that the alcoholic family environment impaired the development of object relations, resulting in impaired social and interpersonal skills. However, the group of biological parents also had significantly higher levels of parental psychopathology than the group of adopting parents. Thus it remains unclear which factor (alcoholism or psychopathology) had the greater impact on offspring dysfunction. One goal of the current study is to identify the degree of variance which is in fact attributable to the parental pathology as

opposed to the impact of parental alcoholism.

Lund and Landsman-Dwyer (1979) studied a group of adolescents who had been placed in a residential treatment facility. Both the COA subjects and the controls in this study were dysfunctional teenagers from troubled families. Using the Devereux Adolescent Behavior Rating Scale, they found male offspring of alcoholic parents to score lower on Physical Inferiority/Social Reticence and higher on Approval/Dependency compared to their peers from non-alcoholic families. Such a result suggests that these adolescents experience an inner need for, and actively seek, support from adults. Such a need may not be evident in their behavior with peers where they are physically and socially assertive. Such inconsistent behavior may be indicative of an insecure attachment to caregivers, again possibly the result of impaired object relations, which may be defended against by aggression towards and social dominance of peers. In a conclusion which is congruent with the hypothesis of the current study, Lund and Landsman-Dwyer state that their findings "...indicate some specificity of the effects of parental alcoholism, rather than a generalized influence on offspring behavior, as evidenced by the fact that offspring of alcoholics did not display increased problems in all areas" (p.347).

Impaired Parenting of COAs. Another relevant group of studies specifically identifies disruption of parenting in



early childhood (as is suggested by the studies reviewed above) as a common feature amongst impaired children from alcoholic families. Using data from a longitudinal study of a community (that is, non-clinical) sample in Hawaii, Werner (1986) examined the effect of parental alcoholism on the offspring. Contrary to the predictions of pervasive dysfunction suggested by the clinical literature, Werner found that at age 18, 59% of the experimental subjects had **not** developed serious coping problems as evidenced by poor performance in school, at work or in the community. Comparing these "resilient" individuals to the impaired group, Werner identified a number of factors which she postulates increase the risk of a negative outcome. These include an alcoholic mother, siblings born within 20 months after the birth of the subject, relatively less attention from the primary caregiver in the first year of life, and more family conflict during the infancy (first two years) of the impaired offspring. All of these factors would suggest that the impaired subjects experienced a lower quality of caregiving in the first two years of life, a crucial factor in object relations development. It is noteworthy, also, that the resilient children were more often perceived by the caregiver as "cuddly and affectionate" as infants than were the impaired population. While this is certainly suggestive of temperament as a moderating variable, it also may indicate a lack of successful bonding or attachment between

the infant and the primary caregiver.

In another longitudinal study, Miller and Jang (1977) utilized a path analysis to test the hypothesis that "...parental alcoholism creates conditions in the family, varying in both severity and timing, that condition a child's later adult adjustment" (p. 25). Miller and Jang found that a greater degree of parental alcoholism, especially in the mother, had an increased negative impact on the offspring's psychological and social adaptation. Further, the presence of parental alcoholism was identified as a causal factor in the extent and type of family crises in childhood and in the offspring's degree of socialization failure. Again, the emphasis is on disruptions which occurred in early childhood due to parental alcoholism, disruptions which impede interpersonal development.

Jacob and Leonard (1986) employed two control groups in their study of the psychosocial functioning of a clinical sample of children of alcoholic fathers. The use of two control groups, children of normal fathers and children of depressed fathers, allowed Jacob and Leonard to separate the effects of parental dysfunction from those specific to alcoholism. Although the primary results of Jacob and Leonard's study are not relevant to the current study, a post hoc analysis conducted by the authors offers some insight into the parenting in alcoholic families. This post hoc analysis compared parental variables (recent alcohol

related problems, Beck Depression Inventory scores, and scores on the Minnesota Multiphasic Personality Inventory Scales) in impaired and non-impaired subjects within the depressed father and alcoholic father groups. No differences were found between parents of impaired and unimpaired offspring of depressed fathers. However, in the group of alcoholic fathers with impaired offspring, Jacob and Leonard found that the fathers had more alcohol related problems in the preceding month, higher scores on the Beck Depression Inventory, and higher scores on MMPI scales F, K, 6, 7, and 8 (scales which are elevated in individuals who are defensive, and extremely distressed, disorganized or psychotic). Spouses of these men scored significantly higher than wives of alcoholic fathers with unimpaired offspring on MMPI scales L, F, 1, 4, and 8 (indicative of defensiveness, somatization, and difficulties trusting others and expressing anger).

These results suggest that impaired children may come from families in which the alcoholism is more severe or more disruptive than in the families of non-impaired COAs. Further, and of particular relevance, Jacob and Leonard suggest that fathers of the impaired children are more disturbed psychologically and in this way cause more dysfunction in the mother and child. Alternately, a more disturbed father may sap the mother's attention and energy, reducing her ability to moderate the impact of the father

upon the child. In the frame of the current study, which hypothesizes impaired object relations as the root of later impairment in COAs, it could be suggested that, once again, parents of impaired children in alcoholic families are not available to provide adequate caregiving, thus impeding the normal development of object relations. It is noteworthy that the nature of the parental impairment which related positively to the offspring's dysfunction only emerged when functional and dysfunctional COAs were treated as separate groups.

In another study which employed two control groups, Benson and Heller (1987) also had difficulty discriminating between the daughters of problem drinking or alcoholic fathers and daughters of depressed fathers on measures of dysfunction. Both groups were found to score significantly higher than normal controls on a measure of neuroticism and on MMPI scale 4. Similarly, both groups reported less social support from their families and experienced their fathers as inconsistent in love and affection. While this does little to differentiate problems caused by alcoholism per se from other parental dysfunction, it does add further support to the hypothesis of a negative influence of parental alcoholism on interpersonal relationships. Possibly a post hoc study like that of Jacob and Leonard (1986) (described above) would have revealed factors which differentiate the COAs from the offspring of depressed

fathers.

Ellwood (1980) used both self-report and interviews to assess the impact of parental alcoholism on child development. He observed a lack of positive contacts between parents and children, characterized by family activities which were positive and enjoyable for the parents but considered by Ellwood to be inappropriate for the developmental age of the child. Such a result is suggestive of an inadequate or unsuccessful attachment to the child, indicated by a lack of awareness of the child's capacities, and of the primacy of parental needs in parent-child interactions. Such primacy is congruent with the theory proposed by Brown (1988) which postulates that the offspring of alcoholic parents must confirm their parents' reality and subjugate their own needs to the needs and defenses of the parents.

### Summary

The support provided by the above review for the presence of impaired interpersonal relations in offspring of alcoholics as a result of inadequate object relations development is admittedly inferential and diffuse. That is to be expected in an under-investigated area, where supportive literature must be drawn from studies of loosely related constructs. However, the studies presented evince recurrent themes of disturbed parenting in alcoholic families and of interpersonal dysfunction in the offspring.

Object relations theory provides a conceptual link between the two themes. That is, the predominance of alcohol in the family during the child's pre-school years will interfere with the necessary process of attachment and the subsequent development of the psychological structures which shape perceptions of the self, of others, and of interpersonal relationships. This disruption of normal development will manifest itself in an impaired capacity to maintain relationships, a dysfunction which might be masked by an array of other symptoms or behaviors. Such a model assumes a degree of object relations impairment in all COAs. However, the current study proposes to examine only dysfunctional offspring. It is assumed that, because of the greater severity of dysfunction in these individuals, such an impairment might be more readily assessed.

## Coping

### Overview of Coping

The central premise of the current study is that the presence of alcoholism in the parents results in an early, structural impairment in the offspring. In the first section of this literature review it was suggested that the interpersonal variable of object relations could be utilized to identify such an impairment. In the current section, coping, an intrapersonal variable, will be examined for the same purpose. I will first introduce a model of coping developed by Folkman and Lazarus (1985, 1988), chosen for

this study because it is sufficiently flexible so as to accommodate diverse theoretical orientations, and is operationalized in the revised Ways of Coping Checklist (Folkman & Lazarus, 1985, 1988). Second, I will briefly present some hypotheses on the development of coping styles and research on coping in adolescence. Last, I will review the literature on coping and alcoholism, and on coping in COAs.

### Folkman and Lazarus's Model of Coping

Folkman and Lazarus (1985) describe coping as a dynamic process whereby individuals employ cognitive and behavioral resources in an attempt to manage the demands of internal and external stressors. They note three important features of this definition. First, coping is not distinguished by success or failure. Rather, coping encompasses all efforts to **manage** stressful transactions. The emphasis on management excludes automatic or unconscious efforts, thus distinguishing this construct from instinctual mechanisms or behaviors which cannot be controlled by volition. Second, coping in this model is a **process** rather than a trait in that the individual's thoughts about and behavioral response to the stressor change as the encounter unfolds. Third, coping is influenced by the individual's perception of both the situation and of his/her own ability to manage the situational demands (Folkman et al., 1986). In this way, it is **contextual**. The characteristics of the

person and of the situation equally affect and shape the individual's response (coping).

In Folkman and Lazarus's (1985) model of coping, management of stress can be accomplished in two ways. Problem-Focused coping efforts are used to direct thoughts and acts towards the alteration of the external situation (e.g. "made a plan of action and followed it"). Emotion-Focused coping strategies endeavor to regulate distressful affect stimulated by the stressor (e.g. "looked for the silver lining, tried to look on the bright side of things"). Other theorists label these mechanisms as approach and avoidant coping respectively (Billings & Moos, 1983; Wills, 1986) in that Problem-Focused coping strategies approach the problem and seek to alter the situation while Emotion-Focused strategies seek to alter the individual's affective response while avoiding the external stressor. Research by Lazarus and his colleagues has identified eight specific coping strategies, four of which are Problem-Focused and four which are Emotion-Focused. The former are Planful Problem Solving, Self-Control, Seeking Social Support, and Confrontive Coping. The latter include Distancing, Positive Reappraisal, Accepting Responsibility, and Escape-Avoidance (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Well adjusted individuals employ both Emotion-Focused and Problem Focused strategies with equal skill, with the choice of a specific strategy dictated by



individual differences and the person's perception of the situation (Lazarus & Folkman, 1984).

### Coping in Childhood and Adolescence

The majority of the research in coping has been conducted with adult subjects. It is valid to question whether the results of this research can be generalized to children and adolescents. Reviewing the empirical literature on child and adolescent coping, Compas (1987) concluded that the constructs of emotion-focused coping and problem-focused coping, and the conceptualization of coping as an effortful, dynamic process are applicable to these age groups. However, he also hypothesizes three differences. First, Compas suggests that temperament has a greater influence on the coping of children than adults. Second, he proposes that ongoing or unresolved attachment issues in children and adolescents may cause the use of social support coping strategies to become an additional source of stress. Third, Compas postulates that, for children and adolescents, there is a heightened environmental influence on the availability of the social resources which assist the individual in coping (e.g. supportive relationships with parents, peers, and adults outside of the family).

A second question regarding coping in childhood and adolescence is how it develops. Specifically, how do children learn to cope? Unfortunately, there is little empirical data to help answer this question. However, some

possible answers can be inferred from research in the areas of social learning theory and child development. Bandura and his colleagues (Bandura, Ross, & Ross, 1961) have identified many behaviors and mechanisms which children learn through parental modeling. Researchers who study coping strategies suggest that modeling may play a similar role in the transmission of coping behavior (Barnes, 1990; Hauser, et al, 1991; Kandel, Kessler, & Margulies, 1978, cited in Barnes, 1990; Krohne, 1979, Matthews, 1981, cited in Compas, 1987; Shulman, Seiffge-Krenke, & Samet, 1987). This view has also been proffered by numerous researchers and theoreticians studying the offspring of alcoholic parents (Barnes, 1990; Beltis & Brown, 1981; Begun & Zweben, 1990; Billings & Moos, 1983; Clair & Genest, 1987; Cronkite, Finney, Nekich, & Moos, 1990; Ellwood, 1980; Moos & Billings, 1982; Reich, Earls, & Powell, 1988). Specifically, the offspring's coping should mirror the limited coping strategies modeled by the alcoholic parent.

In alcoholic families, the relative role of this modeling would likely have particular power, for three reasons. First, the alcoholic family system is a powerful environmental force with marked proscriptions against particular behaviors and perceptions. Second, models of co-dependence suggest that the non-alcoholic parent will employ coping strategies similar to those used by the alcoholic spouse (see Potter-Efron & Potter-Efron, 1989). Third,

isolation from the community is characteristic of these families. The attempts to maintain secrecy about the parental alcoholism via isolation of the family decreases the offspring's contact with adults who might otherwise provide modeling of other coping strategies.

If this concept of coping strategy acquisition from parental modeling is valid, literature on coping and alcoholism in adults could be a fruitful source of information in developing hypotheses about coping in COAs. While the area of coping and alcoholism has not yet been studied extensively (Cooper, Russell, & George, 1988), there are a number of preliminary studies which provide consistent results across adult alcoholic populations (Billings & Moos, 1983; Conte, Plutchik, Picard, Galanter, & Jacoby, 1991; Cooper et al., 1988; Cronkite & Moos, 1984; Moos, Brennan, Fondacaro, & Moos, 1990; Penk, Peck, Robinowitz, Bell, & Little, 1988). These studies have all found a significant predominance of avoidant coping strategies in alcoholic subjects. These include blaming others and displacement of affect, suppression of thoughts and feelings, ingestion of food and/or substances, and expecting help/rescue from others. On the basis of such results, it can be postulated that COAs will also utilize comparable avoidant coping strategies.

Before moving on to examine coping in the adolescent offspring of alcoholic parents, normative adolescent coping

must be delineated. Although research in this area is sparse, available findings are suggestive of some central features. Perhaps the most important of these is the implication that coping strategies are developed progressively over time, with some strategies available only at later stages of development. Four studies support such a theory. Research by Compas, Malcarne, and Fondacaro (1988) suggests that emotion focused coping skills are still developing between ages 11 and 14, while problem focused skills are relatively stable across these ages. Ebata and Moos (1989) found that approach coping (i.e. problem-focused) is utilized more by older adolescents than by younger adolescents. Similar results were found by Labouvie-Vief, Hakim-Larson, and Hobart (1987). Hauser et al. (1991) found a relationship between coping skills and ego development, a developmental process which is in part a function of age. In their subjects, lower levels of ego development related significantly to more constricting and detaching coping processes (e.g. displacement, denial, isolation, regression). Higher levels of ego development were associated with differentiating and engaging coping strategies (e.g. concentration, intellectuality, objectivity). Thus, it appears that the emotion focused or avoidant strategies are employed to a greater degree by younger adolescents, although these skills are still being developed. Older adolescents, possibly because of their

higher level of cognitive development, utilize more problem-focused coping strategies.

The empirical studies on coping in adolescence also provide some information about the strategies employed by normal and dysfunctional teenagers. Patterson and McCubbin (1987) examined coping in functional adolescents (grades 10 - 12). Using a measure of adolescent coping which they developed for their study, the authors were able to rank order their 12 coping patterns for normal male and female adolescents. They found relaxing (i.e. listening to music, riding in a car, eating, daydreaming about ideal situations) to be the most common coping strategy for both sexes. Least often employed was seeking professional support. Second lowest in a ranking of frequency of use, for both males and females, was avoiding problems. In Patterson and McCubbin's measure that strategy is composed primarily of items endorsing substance abuse.

Several studies which compared functional and dysfunctional adolescents found a predominance of emotion-focused (avoidant) coping in the latter group (Compas, 1988; Ebata & Moos, 1989; Wills, 1986). However, within a group of psychiatrically hospitalized adolescents (ages 11 - 18), Schlant (1990) found that older teenagers (16-18) did use the approach strategies of accepting responsibility, planful problem solving, and positive reappraisal. Such strategies were used significantly less by the psychiatrically

hospitalized younger adolescents in her study.

From this limited information, it can be postulated that all adolescents prefer to cope by avoidance, and tend not to seek adult assistance in addressing problems and stressors. Nevertheless, the capacity to employ such support seeking and other approach coping strategies, as well as facility with emotion-focused coping processes does increase with age over the course of adolescence, even within a psychiatric population. In addition, girls may be more prone to employ social support as a coping strategy.

#### Coping in the Offspring of Alcoholic Parents

Within the literature on COAs there are several suggestions made about the effect of parental alcoholism on coping in the offspring. Brown (1988) places particular emphasis on the predominance of denial as a coping strategy. Wilson and Offord (1978) observed a preponderance of ignoring, withdrawing, and avoiding in their interviews with the offspring in 11 alcoholic families. Such withdrawal, along with inappropriate aggression (displacement) was also suggested by Begun and Zweben (1990). Many clinicians and researchers also observed an increased reliance on one type of avoidant coping mechanism most typically modeled in these families, that is, the use of substances (Beltis & Brown, 1981; Blane, 1988; Ellwood, 1990; Knorrning, 1991; Miller & Jang, 1977; Owings-West & Prinz, 1987). In addition, Blane (1988) observed a characteristic inflexibility in the

functioning of COAs which would affect their capacity to cope. It can be postulated that this rigidity also limits the repertoire of available coping strategies.

Empirical studies of coping in COAs are scarce: An exhaustive review of the literature identified only three. An early study which explored this topic was conducted by Rouse, Waller and Ewing (1973). The study evaluated levels of stress and approaches to coping in the adolescent (15 - 21) offspring of abstaining, moderate, and heavy drinking fathers. Using interview and self-report measures, Rouse et al. found that the offspring of fathers who drank utilized non-adaptive coping methods such as social isolation, smoking, and "trying to forget". In addition, Rouse observed a more limited repertoire of approaches to coping in the two COA groups. These results are congruent with both the suggestions of the clinical literature on COAs and with the results hypothesized regarding parental modeling of coping strategies.

A more recent study by Clair and Genest (1987) looked at coping as a moderator of adult adjustment in COAs. Using a community sample, this study compared the coping strategies of 18 to 23 year old offspring of alcoholic fathers to the strategies employed by their normal, non-COA peers. They found that the COA group tended to perceive their problems as beyond their control, and as predicted, employed more emotion-focused approaches to coping rather

than problem-focused coping. These patterns were not found in the non-COA subject group. Such results are consistent with previous studies which link the use of emotion-focused coping with problems which are appraised as uncontrollable (Folkman & Lazarus, 1980, cited in Clair & Genest, 1987). Looking at the specific strategies employed, Clair and Genest observed a predominance of avoidant coping techniques in the COA group. The authors suggested that these forms of coping are modeled by, and thus learned from, the alcoholic parent. Again, these results are in accord with those predicted from the parental modeling and COA literatures.

Scavnicky-Mylant (1990) used in-depth interviews and self-report to study the development of coping in 30 young adult (18 to 28) COAs. Specifically, the author wished to investigate whether or not coping techniques, as measured by the Jalowiec Coping Scale (Jalowiec, Murphy, & Powers, 1984) would change over time. There were three findings relevant to the current study. First, Scavnicky-Mylant found a predominance of emotive (i.e. getting angry, blaming others, worrying) and palliative (i.e. avoiding, ignoring, or turning to others to solve the problem) styles of coping over confrontive coping (i.e. setting goals, making changes, seeking help), at all ages in the COAs. Second, use of confrontive coping strategies by COAs increased in middle to late young adulthood, possibly related to therapeutic intervention and involvement in self-help groups such as



Alanon. Third, content analysis of the interviews identified an additional category of coping behavior which Scavnicky-Mylant (1990) calls reverse-coping. By utilizing this strategy, the individual focuses on the feelings and behaviors of someone else (i.e. helping or comforting someone rather than seeking help and comfort for him/herself). She likens this category to a fourth coping factor - other directed coping - found by Jalowiec et al. (1984) in their earlier studies. Scavnicky-Mylant suggests, further, that reverse coping is a manifestation of co-dependency and therefore unique to members of alcoholic families. Intriguing as these results may be, major methodological flaws limit the utility of Scavnicky-Mylant's study. Data regarding coping before age 18 were attained in the following manner: "Subjects were first asked to visualize themselves during a specific retrospective age period and to describe themselves in relationship to their family. They were then asked about any family, as well as personal problems coming up for them during each age period and to describe what they saw themselves doing" (p. 131). Such a minimally structured, retrospective approach allows for excessive influence of current conceptions on recollection. At the very least, a non-COA sample would have helped to control for such an effect. In addition, subjects were self-selected from a restricted population of individuals involved in some form of alcohol or alcoholic

family treatment, creating a biased sample.

### Summary

There is a notable paucity of research on the development of coping strategies, on coping in adolescence, in alcoholics, and in COAs. However, there is a good deal of convergence in the findings across these four areas of study, such that some hypotheses can be formed regarding the coping strategies used by adolescent offspring of alcoholic parents.

It appears that all adolescents may prefer avoidant coping strategies which they describe as "relaxing", particularly in early to mid-adolescence. However, throughout adolescence, normal and psychiatric non-COA adolescents are able to employ the problem-focused, approach coping strategies when necessary. In addition, as they progress through adolescence, normal teenagers become increasingly skilled and effective in their use of the emotion-focused strategies. Psychiatric adolescents do not develop this increased sophistication and skill in coping. They maintain a repertoire of less sophisticated, less effective, emotion-focused and problem-focused coping strategies.

Adolescent COAs are even more limited in coping strategies than both their normal and psychiatric non-COA, peers. Coping modeled in the home is predominantly avoidant/emotion-focused, oriented towards regulating the

affective response and getting away from the source of stress. In addition the isolation of the alcoholic family decreases contact with adults who might model alternative coping behaviors. Thus the adolescent COA not only prefers emotion-focused, avoidant coping strategies, but quite possibly does not know of any others.

The efficacy and sophistication of the emotion-focused strategies employed by the COAs may improve with age as occurs in normal adolescence, although poor psychological adjustment would limit the degree of improvement. A likely outcome is that better adjusted offspring of alcoholic parents may be very skilled at avoidant coping, while remaining quite impaired in the use of approach or problem-focused coping strategies. The more dysfunctional COAs, to be assessed in the current study, would be similarly impaired in the use of approach coping strategies, but would remain minimally skilled in the employment of avoidant strategies as well.

### Hypotheses

The present study was designed to examine the impact of parental alcoholism upon adolescent offspring. It was postulated that such a pervasive environmental influence may be exhibited through an early impairment of the structures which govern interpersonal relationships, and some aspects of intrapsychic functioning. Object relations was chosen as a variable which might be used to identify such an

impairment. The intrapersonal variable of coping was chosen for the same purpose. Given the relevant findings in the literature on children of alcoholics and on coping, the following hypotheses are proposed.

1) The dysfunctional adolescent offspring of alcoholic parents exhibits a more extreme impairment in object relations than the psychiatric controls. The nature of the impairment reflects an anxious attachment, failure of differentiation, and unsuccessful separation-individuation. The nature of the object relations impairment in the offspring of alcoholic parents is not significantly related to a particular DSM-III-R diagnosis, or an objective measure of behavior.

2) The dysfunctional children of alcoholics are more constricted in their repertoire of coping skills than the psychiatric controls. Those coping mechanisms employed by the COAs are predominantly avoidant in nature, while the non-COA, psychiatric, subjects utilize both approach and avoidant strategies of coping.

A more detailed listing of the hypotheses will be provided following a description of the measures employed in the current study.

#### Justification for a Hospitalized, Adolescent Sample

Following a review of the literature on object relations, adolescent development, and children of

alcoholics, and an examination of the methodological problems in prior studies of COAs, two decisions were made regarding the population for the current study. The first decision was to study adolescents. This age group was chosen for the following reasons. First, models of adolescent development suggest that adolescents experience a "second individuation process" (Blos, 1962) during which dormant or inadequately resolved issues from the first separation-individuation process are revived. Such a revivification makes adolescence an optimal age for studying the early impairment of object relations hypothesized in the current study. Second, the increased intrapsychic turmoil and the new challenges of adolescence increase the likelihood that previously adequate adjustments which allowed the child to function effectively in the alcoholic family environment will cease to be effective. Thus the dysfunction masked throughout childhood, which is suggested by the clinical literature on COAs, may become manifest in adolescence (Tweed & Ryff, 1991).

The second decision in the selection of subjects for this study was the choice of a clinical population rather than a community sample. Studies which employ clinical samples have been accused of a bias towards pathology (Owings-West & Prinz, 1987). However, a complementary bias towards health has been identified in studies which employ community samples, leading to the conclusion that neither is

inherently superior (Tweed & Ryff, 1991; Woodside, 1988). For the purposes of the current study, it became clear that a clinical sample would be more appropriate. This was concluded because, first, the goal of this study was to identify the nature of a hypothesized disturbance in the dysfunctional offspring of alcoholics as a result of impaired development. As Sroufe (1991) observes, such principles can often be seen with greater clarity through the study of abnormal development. Second, it is not clear that the level of object-relations impairment in functional COAs is measurable without more specific direction from empirical research. Therefore, by including functional offspring of alcoholics, one runs the risk of masking significant results (Barnes & Benson, 1979).

Drawing subjects from a group of adolescents hospitalized for psychiatric disorders has the added benefit of eliminating bias from other sources. There is greater heterogeneity amongst the alcoholic families than can be found when COAs are drawn from programs which treat alcoholic parents (Owings-West & Prinz, 1987). In addition, use of a psychiatric control group will allow such potential confounds as child psychopathology and family dysfunction which are not a result of parental alcoholism to be controlled (Lund & Landsman-Dwyer, 1979,; Owings-West & Prinz, 1987).

## CHAPTER III

## METHOD

## Subjects

The subjects were adolescents hospitalized between February of 1991 and November of 1991 at a private psychiatric hospital in a large midwestern city. These patients ranged in age from 12 to 19 and were typically hospitalized for depression or acting out behaviors (e.g., school truancy, refusing to follow family rules, illegal activities, running away). Most had been brought to the hospital by their families against their will, although the legal status for hospitalization was voluntary. The majority of these hospitalizations were funded by third party payments, with a small percentage being self-paid. The facility does not accept public aid. Thus, all patients had at least one parent or guardian who was employed. Within that limitation, the socioeconomic range of this population was broad (from blue collar to extremely wealthy). While the unit was racially mixed, Caucasian adolescents predominated. The sample for the current study was 78% Caucasian and 22% other races.

During the period of data collection, 70% of the adolescents hospitalized on this 30 bed unit were invited to

participate in the study. Exclusion criteria were acute psychosis, mental retardation, reading skills below the fifth grade level as measured by the Woodcock Johnson broad reading grade equivalent, anticipated length of stay of less than two weeks, or parental refusal of consent. Of those invited, 85% agreed to participate in the study. The primary reason for refusing to participate was disinterest in a task which the individual perceived as being similar to school work. The completion rate was 86%. Nine subjects left the hospital before completing all measures, and three were unable to concentrate on the task because of interfering thoughts and feelings.

Seventy-three subjects completed all measures. Twelve were eliminated based on exclusionary criteria for group membership (see Results section). The remaining 61 subjects ranged in age from 12 to 17, with a mean age of 15 years. Fifty-one percent of the subjects were males. Sixty-five percent of the subjects had been given internalizing diagnoses, 35% had received externalizing diagnoses, 26% had at least one prior hospitalization, and 59% had previously been in outpatient therapy. The mean full scale IQ for the subjects was 101, with a range from 70 to 135. Forty-four percent of the subjects had families whose constellation had not changed since the subject's birth, and 33% had at least one parent who had been hospitalized psychiatrically.

Group membership in this study was based on the



presence or absence of alcoholism in a primary caregiver for a period of at least one year in the first six years of the subject's life. Forty-four percent of the subjects met this criterion (see exclusionary criteria below).

## Measures

### Assessing Parental Alcoholism

The presence of alcoholism in a primary caregiver during the first six years of the subject's life was assessed in four ways: the patient's social history obtained from the primary parenting figure, the hospital admission interview of the adolescent, a structured interview for the evaluation of substance abuse, and a measure designed to assess parental use of alcohol. The latter three were based on the report of the offspring.

The validity and reliability of offspring reports of parental drinking have been assessed in several studies. DiCicco, Davis, and Ornstein (1984) reasoned that a child's reaction to parental use of alcohol accurately reflected the degree to which this behavior impacted negatively upon the family (a criterion for alcoholism). Therefore, they asked children in grades seven to ten "Have you ever wished that either one or both of your parents would drink less?". Results were consistent with the evaluations of clinicians and with demographic information regarding the alcoholism rate in this community. Further, the results were stable over a ten week interval.

O'Malley, Carey, and Maisto (1986) employed a questionnaire which focused directly on the quantity, frequency, and negative consequences of parental alcoholism to assess the validity of offspring report. The measure was administered to 49 students (ages 18 to 35) and their parents. They found a significant correlation between student and parent reports of parental drinking patterns ( $p < .001$ ).

Sher and Descutner (1986) administered a 13 item shortened version of the Michigan Alcohol Screening Test (SMAST; Selzer, 1971) to 88 college student sibling pairs in a study which assessed the reliability of offspring report of paternal alcoholism. Assessing each item separately, Sher and Descutner found adequate levels of inter-sibling reliability on global judgments, high agreement on specific behavioral consequences (e.g. getting arrested or seeking help), and low agreement when inference was required (e.g. parental guilt about drinking). The overall scores also showed adequate reliability of offspring report.

Clayborn (1987, cited in Berkowitz & Perkins, 1988) utilized three offspring report measures of parental alcoholism in his study of a college student population. All three [Children of Alcoholics Screening Test (CAST, Jones, 1983, described below), and two single item questions] yielded prevalence rates for parental alcoholism of approximately 15%, a rate similar to that found by

national surveys (Berkowitz & Perkins, 1988). Reviewing several of the studies described above, Berkowitz and Perkins concluded that most COAs can be identified by a single objective question which addresses the child's perception of the parent's use of alcohol. Unfortunately, there have been no validity or reliability studies of this nature conducted with a hospitalized population.

Having reviewed the validity and reliability of offspring reports of parental alcoholism, I will now review the measures used to assess parental alcoholism in the current study.

The Adolescent Profile of Psychoactive Substance Abuse (APPSU; Iennarella & Frick, unpublished) is a 205 item structured interview designed to assess past and current use of substances, the consequences of this use, and risk for the use of substances in the future. The content of this measure is based upon current research on patterns of adolescent substance abuse and identified risk factors. Included in the latter is a family history of substance abuse. To obtain this information, the subject is asked "During the past 12 months, have any of the following people used alcohol or other drugs too much?" and "Have any of the following people ever used alcohol or other drugs too much?". Each family member is listed (father, mother, stepfather, stepmother, other parenting figure, brother(s), sister(s), grandfather, grandmother, and other family

member(s)). Response is on a five point Likert scale (never, seldom, sometimes, fairly often, and often). For any positive response (e.g. father's use of alcohol or other drugs is rated "fairly often"), information is elicited about the family member's (father, in this case) choice of substance, rate of use, and the subject's age when the use occurred. No validity or reliability studies have been conducted on this interview.

The Children of Alcoholics Screening Test (CAST; Jones, 1983) is a 30 item questionnaire which employs a yes/no format to measure childrens' attitudes toward, perceptions of, and feelings about their parents' use of alcohol. A positive endorsement of six or more items is the criterion for the presence of parental alcoholism. Internal consistency for this measure is high; Jones reported a Spearman-Brown split-half reliability coefficient of .98 for child, adolescent, and adult samples. Dinning and Berk reported a similar figure (Spearman-Brown= .96) in their 1989 study of this measure. Assessing external validity, Jones reported high consistency between the CAST results and the cases which were assessed independently by a clinician (80% of the sample). For the remaining 20%, weaker external validity was provided: the subjects had reported parental treatment for alcoholism on an earlier survey.

Each of the 30 items on this measure significantly discriminated between COA and non-COA groups ( $p < .05$ ).

Jones also reported that a cutoff score of six reliably identified 100% of clinically diagnosed and self-reported COAs. However, Dinning and Berk (1989) suggested that males and females may require different cut-off scores. In their study of 494 students in the eleventh grade, the mean CAST score for females was significantly higher than for males. Jones did not distinguish between gender when he established his cut-off score of six. Therefore, employment of his norms may increase the risk of false positives in the female subjects.

In the current study, instructions for the CAST were modified so that subjects could also respond regarding other parenting figures. The following statement was inserted into the original directions: Aside from your mother or father, a parent may be a stepmother or stepfather or a grandparent if you lived with that person when you were a child. Added after the CAST questions was an additional page with a list of parenting figures (e.g., mother, stepfather, grandmother). The instructions state "You may have found that the questions you just answered apply to more than one parent. Please put a check next to anyone in the list below that these questions applied to".

The Hospital Admission Interview is a semi-structured interview administered by the psychiatrist on duty when the patient was admitted. That interview becomes part of the patient's hospital record. Relevant to the current study

was a question about family use of substances. The patient's initial report of any family history of alcoholism was recorded here.

The Social History is obtained from one or both parents by the patient's social worker, usually within the first week of hospitalization. This semi-structured interview included specific questions regarding any history of alcoholism within the immediate and the extended family.

In some cases, parental alcoholism was initially denied (e.g., in the admission interview and the social history) but was disclosed, by the patient or the family, over the course of treatment. In those cases, documentation of parental alcoholism by the psychiatrist, psychologist, social worker, or chemical dependence counselor in the patient's record was substituted for the hospital admission interview or the social history in determining group membership.

### Object Relations

The primary measure used to assess object relations in this study was a shortened version of the Separation and Individuation Test of Adolescence (SITA; Levine, Green and Millon, 1986). This adaptation of the original 103 item questionnaire includes all items ( $n=66$ ) which load on the seven factorially-derived content scales as well as three items that comprise a validity scale. The 34 items eliminated were all fillers. Questions are Likert-type with

five possible responses ranging from "never true" or "strongly disagree" to "always true" or "strongly agree".

According to the authors of this measure, the SITA is designed to assess "resolutions of Mahler's separation-individuation phases as they might express themselves during later developmental periods" (Levine, et al., 1986, p.124). This is accomplished by creating a profile of the scores received on the seven factorially-derived dimensions. These dimensions are entitled Nurturance Seeking, Enmeshment-Seeking, Engulfment Anxiety, Dependency Denial, Separation Anxiety, Self-Centeredness, and Healthy Separation. The authors explain that a configuration of high scores rather than an elevation on one factor is anticipated because the seven dimensions of separation-individuation are inter-related. They hypothesize (but do not empirically investigate the possibility) that such a configural analysis of the elevated factors would permit a clearer delineation of the separation-individuation conflicts involved than would examination of individual scores. Levine et al. (1986) used a-priori predictions of factor loadings on each of the seven theoretically derived scales to assess "internal structural" validity. Reliability is provided by McClanahan and Holmbeck's (in press) report of consistently high alpha coefficients for all seven scales (from .64 to .77). External criterion validity has been demonstrated by significant correlations between the SITA scales and

measures of personality typologies (Levine et al., 1986), psychological adjustment (McClanahan & Holmbeck, 1992), and family functioning (McClanahan & Holmbeck, 1992).

The second measure of object relations in this study was the Attachment Style Inventory (ASI; Sperling & Berman, 1991). This instrument assesses attachment style (Avoidant, Dependent, Hostile, and Resistent/Ambivalent) within different categories of close relationships (e.g. friends, mother, sexual partner). Each style is described in a brief paragraph and the subject rates the goodness of fit of each descriptor paragraph on a nine point Likert-type scale. They then identify one of the four as the "best" description for each type of relationship. The degree of "worry" or "ease" about the relationship being examined is also rated on a nine point Likert type scale. Sperling and Bermans assessment of the degree of worry or ease is purported to measure attachment security. A global attachment score for each style is derived from the mean of the scores of the relationships assessed.

Validation is provided in a triad of studies. ASI's of 34 female college undergraduates demonstrated a low to moderately negative correlation between attachment security and the Avoidant, Hostile, and Resistant/Ambivalent styles, and a moderate, positive correlation between attachment security and a Dependent style of attachment (Sperling, Berman, & Fagen unpublished). In a study of 16 female



inpatients who carried a diagnosis of Borderline Personality Disorder, the Hostile attachment style was frequently endorsed as being the most characteristic. Such a rating was rare in the college student population. Attachment security was also much lower in the hospitalized sample (Sperling, Sharp, & Fishler, 1991). Last, the two samples were combined to test the relationship between the most characteristic attachment style and the subscales of the Bell Object Relations Inventory (Bell, Billington & Becker, 1986, in Sperling et al.). Results were significant, showing a consistency between these attachment patterns and clinical and theoretical expectations (Sperling, Berman & Fagen, unpublished).

Sperling and Berman's measure was adapted for this study to assess relationships with staff and relationships with friends. Two versions were created - a first person version to be completed by the subject, and a third person version to be completed by a staff member based on their experience with and observations of the subject.

### Coping

Coping was assessed with the 66 item Revised Ways of Coping Checklist (Folkman & Lazurus, 1985). Items which describe a broad range of coping strategies are rated as "not used", "used somewhat", "used quite a bit", or "used a great deal". Repeated factor analyses of the items have identified eight types of coping strategies with alpha

coefficients ranging from .61 to .79. Folkman et al. (1986) identified these as Distancing, Accepting Responsibility, Escape-Avoidance, Positive Reappraisal, Planful Problem Solving, Self-Control, Seeking Social Support, and Confrontive Coping. Studies using diverse populations report similar factorial structures (Aldwin & Revenson, 1987; Folkman et al., 1987; Vitaliano et al., 1985).

These coping strategies can be divided into two groups. Emotion-Focused coping strategies are used to manage emotional responses to stress. These strategies are Distancing, Positive Reappraisal, Accepting Responsibility, and Escape-Avoidance. The Problem-Focused coping strategies are Planful Problem Solving, Self-Control, Seeking Social Support, and Confrontive Coping. These approaches are employed to alter the stress inducing situation.

The eight scales discriminate between clinical samples (Coyne et al. 1981, Vitaliano et al, 1987). Alpha coefficients are described by Vitaliano et al as "respectable" and range in various studies from .59 to .91 (Coyne et al. 1981, Folkman & Lazarus, 1985, Folkman, et al. 1986). Construct validity has been demonstrated by the congruence between theoretical predictions and subsequent results (Folkman and Lazarus, 1980, Folkman et al., 1986, Folkman & Lazarus, 1985).

#### Control Measures and Variables

Ten demographic variables and two measures were

employed to assess possible differences between groups which could potentially confound the results of the study. The continuous demographic variables were age, full scale IQ, the number of prior psychiatric hospitalizations of a subject, and the family's socio-economic status. The full scale IQ was obtained from the psychological test report in the subject's chart. Prior psychiatric hospitalizations were entered as an ordinal number, with a range of 0 to 4 (the maximum number of prior hospitalizations of any subject in the sample). The Duncan rating scale, developed by The Boys Town Center for the Study of Youth Development was used to rate the family SES. In families where both parents worked outside of the home, the higher of the two ratings was used.

The discrete demographic variables assessed were gender, race, family structure, diagnostic group, prior outpatient therapy, and psychiatric hospitalization of a parent. All six were organized into a bipartite format to facilitate statistical analysis. Gender, of course, consisted of male and female. The variable race was divided into Caucasian and Other. These two categories were employed because of the small numbers in each other racial groups (African-American, Hispanic, Asian-American, mixed racial). Family structure was evaluated as Original or Changed. Original included only families whose constellation was unaltered since the subject's birth. All

others were categorized as Changed. These two categories were chosen because of the variety of family structures into which subjects had been born. Categorizations such as intact/broken, or single parent/two parent did not accurately reflect the variety, nor did they address the area of interest in this study, that is, the stability of the family structure. The subject's primary DSM-III R discharge diagnosis was evaluated as either an internalizing or an externalizing disorder. The disorders considered internalizing were Major Depression, Dysthymia, Obsessive-Compulsive Disorder, Post Traumatic Stress Disorder, Anorexia Nervosa, and Narcissistic Personality Disorder. The externalizing disorders were Conduct Disorder, Attention Deficit Hyperactivity Disorder, Oppositional-Defiant Disorder, Borderline Personality Disorder, and Parent-Child Problem. Information regarding prior outpatient therapy of the subject, and psychiatric hospitalization of a parent was obtained from the subject's chart, and rated simply yes or no.

The Family Functioning Scale (FFS) developed by Bloom (1985) was used as a control measure in the current study. This 75 item self-report measure of family dysfunction was derived from a confirmatory factor analysis of several existing self-report family measures. The fifteen scales which comprise the measure are considered to be independent (Bloom, 1985), and have demonstrated high ( $\geq .75$ ) within-

factor internal consistency levels. Comparisons between divorced and intact families have produced adequate validity estimates.

Each of the fifteen factorially derived dimensions of family functioning on the FFS is composed of 15 Likert-type questions. These dimensions can be subsumed under three headings. These are System Maintenance, the Value Dimensions, and the Relationship Dimensions. The current study employed only the scales encompassed within the Relationship Dimension. Those scales are labeled Cohesion, Expressiveness, Conflict, Family Sociability, Family Idealization, and Disengagement.

The Achenbach Youth Self Report (YSR; Achenbach & Edelbrock, 1987), an empirically derived, self-report, symptom checklist, was employed in the current study to assess the behavioral manifestations of child psychopathology. The YSR is designed to obtain a standardized self-report of adolescents' competencies and problems. Results are factored into two broad band syndromes (Internalizing and Externalizing) and six narrow band syndromes for females (Depressed, Unpopular, Somatic Complaints, Thought Disorder, Delinquent, and Aggressive) and seven for males (the six for females plus Self-Destructive/Identity Problems). Test-retest reliabilities for the seven narrow band scales range from .39 to .87 after one week and .28 to .67 after eight months. The

Internalizing and Externalizing scales show test-retest reliabilities of .79 to .92 after one week and .40 to .78 after eight months. Support for content and discriminant validity are presented in the YSR manual.

#### Procedure

Data for this study were collected as part of a large, multivariate study on risk factors for adolescent substance abuse. Data collection started in February of 1991 and continued through November of 1991. All appropriate adolescents (see Subjects section for criteria) admitted to the facility were invited to participate. Subjects were approached by this examiner five to ten days after admission and told the following: "We are conducting a study on the unit which will help us understand why some kids use alcohol and drugs while others don't". Potential subjects were informed of the length of administration, the content of the questionnaires (e.g. your personality, your family, and how you deal with your problems), confidentiality, were given a brief description of the paper and pencil format, and then invited to participate. Teenagers who agreed to participate signed a voluntary consent form, and, if under 16, were told of the need for parental consent. The latter was obtained initially by phone. The consent form was then either mailed to the parent or delivered in person, depending on the parents' next scheduled visit to the hospital. All consent forms given or sent to parents were signed and returned.

There was no pressure to comply nor were there consequences for non-compliance.

Protocols were administered between the second and fourth weeks of hospitalization. This time frame was chosen for both clinical and pragmatic reasons. It allowed the subjects some time to adjust to the milieu before participating in the study while accommodating for the relatively short length of stay (average length of stay is 30 days).

The APPSU was administered individually to each subject by this author or another Chemical Dependence counselor. The self-report questionnaires were administered in small groups of four to six adolescents during "Study Time", an hour when there was no activity scheduled for the patients. Administration took place on the unit, in a room which was quiet and relatively free from outside distractions. Completion of the questionnaires in this group format took between two and one half and four hours (three to four sessions), depending on the subject's facility in reading and comprehension, his/her thoroughness in addressing the task, and his/her attention span. Two measures, the MAPI and the Achenbach, were given to the subjects after the second session to complete in their rooms, so as to expedite the data collection. Instructions for each questionnaire were printed on all measures. In this way, measures could be self-administered, allowing

subjects to work at their own pace without pressure from the test administrator or from their peers.

Unit staff were asked to complete the staff-report version of the ASI after each subject had completed the study protocol. Thus staff had an average of four weeks acquaintance with each subject prior to evaluating his/her interpersonal style. Two staff-report ASIs were obtained for each subject. These were completed by either a primary mental health counselor, a social worker, or a teacher.

Demographic and descriptive data were obtained from the clinical chart. Sources included information obtained at the time of hospitalization by the admitting psychiatrist, a social history taken by the social worker from at least one parent, an evaluation of academic performance by a special education teacher, and psychological testing. Data obtained from the chart included the following: age, race, gender, DSM-III-R discharge diagnosis, family structure, parental employment, family and subject history of psychiatric dysfunction and/or treatment, and the WISC-R full scale score.

### Hypotheses

Based on the review of the literature, hypotheses were developed for two areas. The first area was the relationship between the measures of Object Relations and the presence of parental alcoholism. The second area was the relationship between measures of coping strategies and



the presence of parental alcoholism. It was assumed, in the hypotheses, that any differences between the groups on the control variables or control measures would be controlled in the statistical analysis by entering the identified variables/scores as co-variates.

- H1a. The COA group will score higher on the SITA scales of Dependency Denial and Separation Anxiety than the non-COA group.
- H1b. The COA group members will show the ASI styles Resistent/Ambivalent and Dependent more often than non-COA group members.
- H2. Group membership will not be related to scores on the YSR scales.
- H3a. The COA group will employ more Emotion-Focused coping strategies than the non-COA group.
- H3b. The COA group will employ less Problem-Focused coping strategies than the non-COA group.
- H3c. The COA group will employ significantly more Emotion-Focused coping strategies than Problem-Focused coping strategies, while the non-COA group will employ both Problem-Focused and Emotion-Focused coping strategies equally.

## CHAPTER IV

### RESULTS

#### Introduction

The data were analyzed with the Statistical Package for the Social Sciences-X (SPSS-X; Release 4). Following identification of group membership, that is, children of alcoholic parents (COA) or children of non-alcoholic parents (NCOA), covariates were identified and hypotheses were tested.

#### Characteristics of the Sample

##### Group Membership

Group membership was determined from the Social History, the CAST, the APPSU, and other information obtained in the hospital admission interview or over the course of treatment. A social history which contained a parent's acknowledgement of parental alcohol abuse was given the most weight. However, parental denial or omission of alcohol abuse was deemed less valid than a subject's report of parental alcoholism, when this report was consistent across measures or substantiated elsewhere. Subjects whose parents significantly abused substances, but did not abuse alcohol,

were excluded from the study. The decision rules for group membership are detailed in Table 2.

As a second step in the process of identifying group members, the presence of parental alcoholism before the subject reached age seven was assessed. Criteria for inclusion are listed in Table 3. When the presence of parental alcoholism prior to age seven could not be established, the subject was removed from the study.

### Group Demographics

The NCOA group consisted of 34 subjects; 21 males and 13 females with a mean age of 15.3 years. The COA group had 27 subjects. In this group, there were 11 males and 16 females with a mean age again of 15.3 years. Group demographics are listed in Table 4.

T-tests or Chi-Squares were conducted to identify any significant differences between the groups on the demographic variables. Significant results were found for three variables. The mean Full Scale IQ (FSIQ), as measured by the WISC-R, was 22 points higher for the NCOA group ( $\bar{M}=107$ ) than the COA group ( $\bar{M}=95$ ), a difference which was highly significant [ $t(59)=3.58, p=.001$ ]. Family structure differed at the .01 level [ $\chi^2(1) = 7.78, p=.005$ ], with the NCOA families demonstrating significantly greater stability over time than the COA families. The subject groups also differed significantly on Duncan's rating of parental SES,

Table 2

Decision Rules for Group Membership

Alcohol Postive		Alcohol Negative	
Social History	+	Social History	-
		CAST	-
		APPSU	-
or		or	
Social History	-	Social History	-
CAST	+	CAST	+
APPSU	+	APPSU	-
		Other Information	-
or		or	
Social History	-	Social History	-
CAST	+	CAST	-
APPSU	-	APPSU	-
Other Information	+	Other Information	-
or		or	
Social History	-	Social History	-
CAST	-	CAST	-
APPSU	+	APPSU	-
Other Information	+	Other Information	+

Note. CAST=Children of Alcoholics Screening Test;  
 APPSU=Adolescent Profile of Psychoactive Substance Abuse.

A + indicates positive report of alcohol abuse by a parenting figure.

A - indicates no report of alcohol abuse by a parenting figure.

Table 3

Inclusion/Exclusion Criteria for Children of Alcoholics Group (COA)

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Inclusion Criteria

Parental alcohol use prior to subject's seventh birthday reported by parent in social history.

Parental alcohol prior to subject's seventh birthday reported by subject, e.g. as present "all my life" or "as long as I can remember".

Parental alcohol use prior to subject's seventh birthday reported in admission information.

Parental alcohol use prior to subject's seventh birthday reported by attending psychiatrist or psychologist.

Exclusion Criteria

Subject has clearly stated that parental alcohol abuse started after subject's seventh birthday.

No documentation of alcohol abuse prior to subject's seventh can be found, although a history of parental alcohol abuse is documented.

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Table 4

Descriptive Statistics for Demographic Variables

Variable Name	NON-COA <u>n</u> =34	COA <u>n</u> =27
Age		
<u>Mean</u>	15.29	15.26
<u>SD</u>	(1.29)	(1.43)
Gender		
Male	21	11
Female	13	16
Race		
Caucasian	28	20
Other	6	7
Full Scale IQ		
<u>Mean</u>	107.44	95.33 **
<u>SD</u>	(14.14)	(13.06)
Family Structure		
Original	21	7 *
Changed	13	20
Diagnostic Group		
Internalizing	25	15
Externalizing	9	12
Prior Therapy		
Yes	21	15
No	13	12
Prior Hospitalizations		
<u>Mean</u>	0.50	0.44
<u>SD</u>	(0.99)	(0.85)
Parental Psych History		
Yes	7	7
No	27	20
SES		
<u>Mean</u>	59.19	44.74 *
<u>SD</u>	(19.57)	(22.78)
Gender of Alcoholic Parent		
Male	-	22
Female	-	5

\*\* $P=.001$  \* $p<.01$

with the mean SES for the NCOA subjects ( $\underline{M}$ =59.19) being significantly higher than that of the COA group ( $\underline{M}$ =95.33) [ $\underline{t}$ (59)=2.70,  $\underline{p}$ =.009]. These three variables were entered as covariates in all subsequent MANCOVAs.

The gender composition of the two groups differed at the  $\underline{p}$ =.10 level of significance [ $\underline{\chi}^2$  (1)=2.67,  $\underline{p}$ =.10]. There were more males ( $\underline{N}$ =21) than females ( $\underline{N}$ =13) in the NCOA group, while females ( $\underline{N}$ =16) were more prevalent than males ( $\underline{N}$ =11) in the COA group. While this is an interesting observation, the marginal level of significance precluded the inclusion of gender as a covariate.

### Family Dysfunction

The six scales which compose the Relationship Dimension of Bloom's Family Functioning Scale (FFS) were utilized to identify any differences between the groups which might be accounted for by family dysfunction. Significant differences would identify scales which should be included as additional covariates in subsequent analyses. Descriptive statistics are reported in Table 5. A MANCOVA was employed so as to control for Type I error. In this, and in all subsequent MANCOVAs reported in this study, the assumptions of multivariate normality, correlated dependent variables, and homogeneity of variance were met. For the FFS MANCOVA, group membership (COA or NCOA) was the independent variable. The scales which compose the

Table 5

Descriptive Statistics for the Family Functioning Scale (FFS)

Variable Name	NON-COA <u>n</u> =34	COA <u>n</u> =27
FFS Cohesion		
<u>Mean</u>	+0.41	-0.44
<u>SD</u>	(4.81)	(4.55)
FFS Expressiveness		
<u>Mean</u>	-1.18	-1.67
<u>SD</u>	(4.65)	(4.98)
FFS Conflict		
<u>Mean</u>	+1.97	+1.68
<u>SD</u>	(4.42)	(4.58)
FFS Family Sociability		
<u>Mean</u>	+1.94	+1.52
<u>SD</u>	(4.97)	(3.78)
FFS Family Idealization		
<u>Mean</u>	-3.68	-3.11
<u>SD</u>	(4.55)	(4.76)
FFS Disengagement		
<u>Mean</u>	+1.54	+2.11
<u>SD</u>	(3.62)	(3.71)

Note. Range of means is -10 to +10, scored in the direction of the scale name. Means are sums.



relationship dimension of the FFS, that is, Cohesion, Expressiveness, Conflict, Family Sociability, Family Idealization, and Disengagement, were the dependent variables. FSIQ, SES, and family structure were included as covariates. No significant difference was found between the groups in this analysis [ $F(6,51)=.901, p=.502$ ]. Therefore, it was not necessary to include any FFS scales as covariates.

### Tests of Hypotheses

#### Hypothesis 1

Hypothesis 1 addressed the possible relationship between group membership and the construct of object relations. The two measures employed in this study to measure object relations were examined in separate analyses. Hypothesis 1a concerned separation-individuation as measured by the SITA. It was hypothesized that the COA group would score higher than the NCOA group on the scales Dependency Denial and Separation Anxiety, with a higher score indicating greater endorsement of the scale. No predictions were made regarding differences on the other five scales. Descriptive statistics for the SITA scales are reported in Table 6. A MANCOVA was employed to test this hypothesis. Group membership was the independent variable with the seven SITA scales as dependent variables. FSIQ, SES, and family structure were included as covariates. Results of the MANCOVA were not significant [ $F(7,50)=.962, p=.469$ ].

Table 6

Descriptive Statistics for the Separation and Individuation Test of Adolescence Scales (SITA)

Variable Name	NON-COA $\bar{n}=34$	COA $\bar{n}=27$
SITA Separation Anxiety		
<u>Mean</u>	2.81	2.88
<u>SD</u>	(0.95)	(0.61)
SITA Engulfment Anxiety		
<u>Mean</u>	3.18	3.41
<u>SD</u>	(0.61)	(0.67)
SITA Dependency Denial		
<u>Mean</u>	2.12	2.10
<u>SD</u>	(0.61)	(0.53)
SITA Nurturance Seeking		
<u>Mean</u>	3.08	3.23
<u>SD</u>	(0.76)	(0.74)
SITA Enmeshment Seeking		
<u>Mean</u>	3.35	3.23
<u>SD</u>	(0.64)	(0.61)
SITA Self-centeredness		
<u>Mean</u>	3.41	3.20
<u>SD</u>	(0.51)	(0.60)
SITA Healthy Separation		
<u>Mean</u>	3.84	3.85
<u>SD</u>	(0.52)	(0.50)

Note. Range of means is 1 to 5, scored in the direction of the scale name. Means are item means.

Hypothesis 1a was not supported.

Hypothesis 1b examined attachment style to staff and to peers as measured by the ASI. It was hypothesized that the COA group would be rated higher in their attachment style to both staff and peers on the ASI styles labeled Resistent/Ambivalent and Dependent than would the NCOA group. A higher rating indicates a more highly perceived fit between the individual and that style. No differences between groups were hypothesized for the ASI styles labeled Avoidant and Hostile. Descriptive statistics for the ASI scales are reported in Table 7. Two MANCOVAs were employed to test this hypothesis, one for the ASI rating of relationship to staff, and one for the relationship to peers. In each MANCOVA, group membership was the independent variable with the four ASI scales as dependent variables. In both analyses, FSIQ, SES, and family structure were included as covariates. Results of the MANCOVA for attachment style to staff were not significant [ $F(4,53)=1.84, p=.134$ ]. Results of the MANCOVA for attachment style to peers were not significant [ $F(4,53)=.458, p=.766$ ]. Hypothesis 1b was not supported.

## Hypothesis 2

Hypothesis 2 addressed the supposition that parental alcoholism does not lead to any specific problematic behavior or pathology in the adolescent. It was hypothesized that the groups would not differ on the YSR

Table 7

Descriptive Statistics for the Attachment Style Inventory (ASI)

Variable Name	NON-COA <u>n</u> =34	COA <u>n</u> =27
ASI-Staff-Avoidant		
<u>Mean</u>	14.73	12.91
<u>SD</u>	(4.60)	(4.24)
ASI-Staff-Dependent		
<u>Mean</u>	11.28	12.35
<u>SD</u>	(4.25)	(3.96)
ASI-Staff-Hostile		
<u>Mean</u>	14.23	11.59
<u>SD</u>	(5.49)	(4.19)
ASI-Staff-Resistant/Ambivalent		
<u>Mean</u>	13.81	12.37
<u>SD</u>	(4.25)	(4.03)
ASI-Peer Avoidant		
<u>Mean</u>	11.88	11.06
<u>SD</u>	(3.71)	(3.91)
ASI-Peer-Dependent		
<u>Mean</u>	16.00	16.37
<u>SD</u>	(5.20)	(4.35)
ASI-Peer-Hostile		
<u>Mean</u>	11.23	10.63
<u>SD</u>	(4.45)	(3.75)
ASI-Peer-Resistant/Ambivalent		
<u>Mean</u>	12.15	12.07
<u>SD</u>	(4.40)	(4.16)

Note. Range of mean is 3 to 27, scored in direction of scale name. Mean is a sum.

problem scales, or on the YSR summary scales of internalizing and externalizing behaviors. Group means on the YSR scales are reported in Table 8.

Because the YSR scale construction differs for males and females, this hypothesis was tested by separate MANCOVA's for each gender. No significant differences were found between the COA group and the NCOA group on any of the problems scales for males [ $F(7,20)=.471, p=.844$ ] or for females [ $F(6,19)=.325, p=.916$ ]. To assess differences between COA and NCOA groups on the two summary scales (Internalizing and Externalizing) mean T-scores of the two summary scales were calculated for both groups. T-tests for differences between groups on these summary scales yielded no significant differences between groups, for either variable. Hypothesis 2, a hypothesis of no difference between the groups on a measure of behavior, was supported.

### Hypothesis 3

Hypothesis 3 examined the use of coping strategies by the two groups. In Hypothesis 3a, it was suggested that the COA group would use significantly more Emotion-Focused coping strategies than the NCOA group. Hypothesis 3b suggested that the COA group would employ significantly less Problem-Focused coping strategies than the NCOA group. Descriptive statistics for the WOC scales are reported in Table 9. These hypotheses were tested conjointly by a MANCOVA which had the eight WOC scales as dependent

Table 8

Descriptive Statistics for the Achenbach Youth Self Report Problem and Summary Scales (YSR)

Variable Name	NON-COA <u>n=20</u>	COA <u>n=11</u>
YSR Male - Somatic Complaints		
<u>Mean</u>	58.45	57.64
<u>SD</u>	(1.00)	(1.52)
YSR Male - Self- Destructive		
<u>Mean</u>	62.40	59.18
<u>SD</u>	(1.70)	(2.35)
YSR Male - Thought Disorder		
<u>Mean</u>	60.05	59.27
<u>SD</u>	(1.65)	(2.18)
YSR Male - Delinquent		
<u>Mean</u>	67.05	66.54
<u>SD</u>	(2.13)	(3.27)
YSR Male - Aggressive		
<u>Mean</u>	63.75	61.00
<u>SD</u>	(2.16)	(2.92)
YSR Male - Depressed		
<u>Mean</u>	62.05	58.18
<u>SD</u>	(1.99)	(1.99)
YSR Male - Unpopular		
<u>Mean</u>	62.40	57.91
<u>SD</u>	(1.70)	(2.24)
YSR Female - Somatic Complaints		
<u>Mean</u>	60.54	62.31
<u>SD</u>	(1.54)	(2.26)
YSR Female - Depressed		
<u>Mean</u>	63.15	62.94
<u>SD</u>	(9.36)	(9.89)
YSR Female - Thought Disorder		
<u>Mean</u>	63.08	66.31
<u>SD</u>	(2.27)	(2.29)

Table 8 (cont.)

Variable Name	NON-COA n=20	COA n=11
YSR Female - Delinquent		
<u>Mean</u>	65.08	65.25
<u>SD</u>	(2.96)	(2.35)
YSR Female - Unpopular		
<u>Mean</u>	58.31	57.44
<u>SD</u>	(1.51)	(0.80)
YSR All - Internalizing	n=34	n=27
<u>Mean</u>	58.24	55.81
<u>SD</u>	(11.87)	(12.48)
YSR All - Externalizing	n=34	n=27
<u>Mean</u>	63.76	61.17
<u>SD</u>	(10.57)	(11.77)

Note. Means are T-scores. Internalizing and Externalizing statistics are not divided by gender.

Table 9

Descriptive Statistics for the Ways of Coping Scales (WOC)

Variable Name	NON-COA <u>n</u> =34	COA <u>n</u> =27	Range
WOC-Confrontive			
<u>Mean</u>	1.51	1.39	0 - 3
<u>SD</u>	(0.64)	(0.61)	
WOC-Distancing			
<u>Mean</u>	1.25	1.22	0 - 3
<u>SD</u>	(0.68)	(0.63)	
WOC - Self Control			
<u>Mean</u>	1.21	1.40	0 - 3
<u>SD</u>	(0.44)	(0.45)	
WOC - Seeking Social Support			
<u>Mean</u>	1.33	1.46	0 - 3
<u>SD</u>	(0.80)	(0.71)	
WOC - Accepting Responsibility			
<u>Mean</u>	1.33	1.36	0 - 3
<u>SD</u>	(0.68)	(0.79)	
WOC - Escape-Avoidance			
<u>Mean</u>	1.50	1.48	0 - 3
<u>SD</u>	(0.59)	(0.74)	
WOC - Planful Problem Solving			
<u>Mean</u>	1.18	1.26	0 - 3
<u>SD</u>	(0.70)	(0.65)	
WOC - Positive Reappraisal			
<u>Mean</u>	0.95	1.07	0 - 3
<u>SD</u>	(0.65)	(0.52)	
WOC - Emotion Focused			
<u>Mean</u>	5.04	5.13	0 - 12
<u>SD</u>	(1.49)	(1.75)	
WOC - Problem Focused			
<u>Mean</u>	5.23	5.52	0 - 12
<u>SD</u>	(1.53)	(1.77)	

Note. Scales are scored in the direction of the scale name. Means of the summary scales (Emotion Focused and Problem Focused) are sums of item means. All others are item means.



variables. Group membership was the independent variable, and FSIQ, SES, and family structure were included as covariates. Results were not significant [ $F(8,49)=.153$ ,  $p=.996$ ]. Neither hypothesis 3a nor Hypothesis 3b were supported.

It was hypothesized in 3c that the COA group would utilize more Emotion-Focused coping strategies than Problem-Focused coping strategies, with no such difference in the NCOA group. To test this hypothesis, a within-groups comparison of the summary variables Emotion-Focused coping and Problem-Focused coping was conducted. Paired T-tests were employed. No significant differences were found within either group (NCOA:  $t(33) = -.57$ ,  $p=.573$ ; COA:  $t(26)=-1.29$ ,  $p=.209$ ). No evidence was found to support the hypothesis that COA subjects would rely predominantly on Emotion Focused coping strategies, rather than Problem Focused strategies. As predicted, the NCOA subjects demonstrated no preference for either coping style.

#### Follow-up and Exploratory Analyses

Follow-up and exploratory analyses were conducted to better understand the lack of significant results in this study. For clarity of presentation, the follow-up analyses are presented first, and are organized by hypothesis.

#### Follow-up Analyses

It was proposed in Hypothesis 1a that the COA group

would score more highly than the NCOA group on the SITA scales Dependency-Denial and Separation Anxiety. As a follow-up to the non-significant MANCOVA conducted to test this hypothesis, the univariate results were examined, to identify any trends which might guide further study. No such trends were found for Dependency-Denial or Separation Anxiety. However, there was a trend towards difference between the groups on the scale Self-Centered [ $F(1,56)=.2.98, p=.090$ ], with the mean COA score being higher (COA  $M=2.81$ ; NCOA  $M=2.59$ ).

Hypothesis 1b postulated that the COA group would score higher than the NCOA group on the ASI styles labeled Avoidant and Hostile, in their relationships with staff and with peers. Univariate results of the two MANCOVAs were again examined as a follow-up on the non-significant results of the MANCOVA.

The first of these MANCOVAs addressed the subject's relationship style with staff. Univariate results of this MANCOVA identified three non-significant trends. These included a trend towards difference on the attachment styles labeled Avoidant [ $F(1,56)=2.86, p=.096$ ], Hostile [ $F(1,56)=3.44, p=.069$ ], and Resistant/Ambivalent [ $F(1,56)=3.50, p=.067$ ]. Mean scores were higher for the NCOA group in all three styles (Avoidant: NCOA  $M=14.73$ , COA  $M=12.91$ ; Hostile: NCOA  $M=14.23$ , COA  $M=11.59$ ; Resistant/Ambivalent: NCOA  $M=13.81$ , COA  $M=12.37$ ) These

results suggest that the NCOA subjects tended to be more Avoidant, Hostile, and Resistant/Ambivalent in their relationship style with staff than did the COA subjects.

The second MANCOVA addressed the relationship style with peers. An examination of the univariate results of that MANCOVA revealed no trends towards difference whatsoever between the two groups.

As part of an examination of the possible impact of social desirability on the self report ratings (see exploratory analyses below), ASI ratings were also examined separately by rater. Four MANCOVA's were conducted comparing COAs to NCOAs on ASI attachment style to staff rated by staff, to peers rated by staff, to staff rated by subject, and to peers rated by subject. Descriptive statistics are reported in Table 10. Some interesting results were found in the MANCOVAs which employed staff ratings only. The overall MANCOVA for staff rating of the subject's relationship style with staff was not significant [ $F(4,53)=1.68, p=.168$ ]. However, the univariate analyses, examined for investigatory purposes, revealed a significant difference between the groups on the ASI style Dependency [ $F(1,56)=4.00, p=.050$ ]. COAs were rated by staff as more dependent on staff ( $M=4.18$ ) than their NCOA peers ( $M=3.51$ ). This result is congruent with Hypothesis 1b.

The MANCOVA for staff ratings of peer relationships was also non-significant [ $F(4,53)=1.26, p=.296$ ]. However,

Table 10

## Attachment Style Inventory (ASI) by Rater

ASI Style	Subject		Staff	
	NCOA	COA	NCOA	COA
Avoidant with Staff				
<u>Mean</u>	3.88	3.18	7.78	4.87
<u>SD</u>	(2.40)	(2.32)	(2.04)	(1.76)
Dependent with Staff				
<u>Mean</u>	4.29	4.00	3.51	4.18
<u>SD</u>	(2.22)	(2.39)	(1.57)	(1.48)
Hostile with Staff				
<u>Mean</u>	4.56	3.22	4.84	4.18
<u>SD</u>	(2.74)	(2.37)	(2.10)	(1.73)
Ambivalent-Resistant with Staff				
<u>Mean</u>	4.38	3.81	4.72	4.31
<u>SD</u>	(2.64)	(2.70)	(1.78)	(1.75)
Avoidant with Peers				
<u>Mean</u>	3.18	3.07	4.37	3.98
<u>SD</u>	(2.62)	(2.27)	(1.62)	(1.64)
Dependent with Peers				
<u>Mean</u>	6.53	6.41	4.66	4.98
<u>SD</u>	(2.27)	(2.55)	(1.96)	(1.67)
Hostile with Peers				
<u>Mean</u>	2.88	2.85	4.22	3.91
<u>SD</u>	(1.68)	(2.08)	(1.83)	(1.58)
Ambivalent-Resistant with Peers				
<u>Mean</u>	3.67	3.18	4.29	4.48
<u>SD</u>	(2.63)	(2.37)	(1.77)	(1.81)

Note. Range for mean score is 1 to 9.

the univariate analysis for Avoidant style was significant at the .05 level [ $F(1,56)=4.04$ ,  $p=.049$ ]. Here, the NCOA subjects were rated higher on the Avoidant style in their relationships with peers ( $M=4.37$ ) than were the COA subjects ( $M=3.98$ ). This result is congruent with the univariate results obtained when raters were combined (see above). No trends or significant differences between COAs and NCOAs were found on the multivariate or univariate analyses of ASI ratings completed by the subjects regarding their relationship to staff [ $F(4,53)=.634$ ,  $p=.640$ ] or to peers [ $F(4,53)=.315$ ,  $p=.867$ ].

Hypotheses 3a and 3c examined the prevalence of coping strategy (Emotion-Focused vs. Problem-Focused) in each group. It had been hypothesized that COAs would use more Emotion-Focused strategies (3a), while NCOA's would show no preference (3c). To follow up the non-significant results of Hypothesis 3a, and to take a closer look at the choice of specific coping strategies by both groups of subjects, within groups T-tests were conducted for all eight coping strategies. To control for Type I error, the maximum probability for significance was set at  $p=.01$ . Significant results are reported in Tables 11 and 12. For each group, three T-tests reached significance. In all six of these, the coping strategy used significantly less often was Positive Reappraisal, an emotion focused strategy.

Table 11

Ways of Coping: Within Groups T-Tests for NCOAs

Coping Style	Mean	t value	sig.
Confrontive Coping with Positive Reappraisal	1.509 .954	3.25	***
Seeking Social Support with Positive Reappraisal	1.333 .954	2.66	*
Escape Avoidance with Positive Reappraisal	1.504 .954	3.51	***

\* $p=.01$  \*\*\* $p=.001$ 

Table 12

Ways of Coping: Within Groups T-Tests for COAs

Coping Style	Mean	t value	sig.
Self Control with Positive Reappraisal	1.402 1.070	3.73	***
Seeking Social Support with Positive Reappraisal	1.456 1.070	3.09	**
Escape Avoidance with Positive Reappraisal	1.476 1.070	2.72	**

\* $p=.01$  \*\*\* $p=.001$

### Exploratory Analyses

Three exploratory analyses were also conducted. The purpose of these analyses was to examine other factors which may have impacted upon the data and contributed to the lack of significant results.

The first exploratory analysis involved within groups correlations which examined the relationship between the SITA, ASI, FFS, and WOC variables and the YSR as measure of adjustment. The goal of this analysis was to assess whether there were differences between groups in the relationship of object relations, attachment style, family functioning, or coping strategy, to adjustment. For each group (COA and NCOA) the YSR summary scores labeled Internalizing and Externalizing were correlated with the seven SITA scales, the eight ASI styles, the six Bloom scales, the eight coping strategies, and the two coping styles. A high score on the YSR Internalizing or Externalizing scale was considered an indication of poor adjustment. Significant results are reported in Table 13. It should be noted that these results are sample specific.

Little relationship was found between ASI styles and adjustment in either group. However, the SITA scales Engulfment Anxiety and Self-Centered were positively related to high externalizing behavior in the COA group. The only significant relationship for NCOAs was between Dependency Denial and high internalizing behaviors.

Table 13

Correlations with the Youth Self Report as a Measure of Adjustment

Variable Name	NCOA <i>n</i> =34		COA <i>n</i> =27	
	Int.	Ext.	Int.	Ext.
ASI Avoidant of Staff				-.4878 <i>f</i>
ASI Resistant-Ambivalent to Staff	.5053 <i>f</i>			
SITA Engulfment Anxiety				.4385*
SITA Dependency Denial	.3830*			
SITA Self Centered				.4453*
Bloom Family Cohesion		-.4324*		
Bloom Family Conflict	.5054 <i>f</i>	.3885*		
Bloom Family Sociability	-.3987*		-.3938*	.5795 <i>f</i>
Bloom Family Idealization		-.4048*	.5529 <i>f</i>	
WOC Emotion Focused Coping	.4645 <i>f</i>	.4501 <i>f</i>	.4106*	.5295 <i>f</i>
WOC Seeking Social Support			.4371*	
WOC Positive Reappraisal			.4347*	
WOC Escape-Avoidance	.5851 <i>f</i>	.5489 <i>f</i>	.4581*	.6265 <i>f</i>

Note. ASI=Attachment Style Inventory; SITA=Separation and Individuation Test of Adolescence; Bloom=Bloom's Family Functioning Scale; WOC=Ways of Coping.

\**p*=.05; *f**p*=.01



Bloom's FFS scales correlated with adjustment more often than the object relations measures, particularly for the NCOA group. For the NCOA subjects, Family Conflict correlated positively with both measures of poor adjustment, while Family Cohesion and Family Sociability, and Family idealization all correlated negatively with externalizing behaviors. In the COA group, Family Sociability correlated negatively with both Internalizing and Externalizing behaviors, and Family Idealization correlated negatively with Internalizing behaviors. Specific coping strategies more often bore a relationship to adjustment in the COA group. It is noteworthy that high Emotion-Focused coping correlated positively with poor adjustment (high YSR) for both COAs and NCOAs. Despite the significance of that summary score (Emotion-Focused coping) for the NCOA's, only one of the four strategies that compose Emotion-Focused coping, Escape-Avoidance, actually correlated positively with poor adjustment. In the COA group, Escape-Avoidance, Support-Seeking, and Positive Reappraisal all correlated positively with poor adjustment, and particularly with internalizing behaviors.

The second exploratory analysis was conducted to assess the possible impact of social desirability on self-report in this study. Possible impact was hypothesized after reviewing the means for several self-report measures. It was observed that subjects appeared less likely to

endorse socially undesirable items on the SITA, where they were describing themselves, but had no problem doing so on the FFS, where they were describing their families. Further, YSR scores for both groups were subclinical, an unlikely condition for hospitalized subjects. The availability of a measure completed by both the subject and another rater, that is, the ASI, made investigation of this hypothesis plausible.

For this analysis, the groups (COA and NCOA) were combined. Staff ASI ratings were compared with the subjects' ASI ratings, for each relationship style. Results, shown in Table 14 are suggestive of some impact of social desirability on the subject's self-report. In rating relationships to peers, significant differences were found between staff and subject ratings for all four relationship styles. Subjects were less inclined than staff to report interpersonal discomfort with peers, and more inclined to report dependency with peers, as would be expected if social desirability is having an impact. In contrast, a significant discrepancy between raters was found on only one of the attachment styles when relationships to staff were rated. Staffs' ratings of the Avoidant style were significantly greater than the subjects self-rating. These results support the probable impact of social desirability, in that subjects had little trouble reporting discomfort with staff, reporting levels comparable to that observed by

Table 14

Attachment Style Inventory by Rater Combining COA and NCOA Groups

ASI Style	Staff	Subject	p
Avoidant with Staff			
<u>Mean</u>	5.15	3.57	.000
<u>SD</u>	(1.92)	(2.37)	
Dependent with Staff			
<u>Mean</u>	3.81	4.16	.285
<u>SD</u>	(1.56)	(2.28)	
Hostile with Staff			
<u>Mean</u>	4.55	4.13	.138
<u>SD</u>	(1.56)	(2.66)	
Ambivalent-Resistant with Staff			
<u>Mean</u>	4.54	4.13	.334
<u>SD</u>	(1.76)	(2.66)	
Avoidant with Peers			
<u>Mean</u>	4.20	3.13	.010
<u>SD</u>	(1.63)	(2.45)	
Dependent with Peers			
<u>Mean</u>	4.80	6.47	.000
<u>SD</u>	(1.83)	(2.38)	
Hostile with Peers			
<u>Mean</u>	4.08	2.87	.000
<u>SD</u>	(1.72)	(1.86)	
Ambivalent-Resistant with Peers			
<u>Mean</u>	4.38	3.44	.024
	(1.77)	(2.51)	

Note. Range for mean score is 1 to 9.

staff raters, but minimized discomfort with peers in their self-report.

The third exploratory analysis examined the possible impact of subject's age on their level of object relations, attachment style, and coping strategies. To accomplish this, each sample (COA and NCOA) was divided into two groups on the basis of age. The younger group was composed of subjects younger than 15. The older group contained subjects who were 15 or older. The point of division was based on the mean age of subjects in both groups ( $M=15.3$ ).

MANCOVAs employing two levels of independent variables (age and sample) were run with the three sets of dependent variables examined earlier (SITA, ASI, WOC). The overall MANCOVA for the SITA variables was not significant [ $F(7,49)=.787, p=.601$ ]. There was also no significant interaction between age and group [ $F(7,48)=.665, p=.700$ ].

The overall MANCOVA for the ASI ratings of relationships to staff was not significant [ $F(4,51)=.617, p=.652$ ]. Similarly, there was no significant interaction between age and group [ $F(4,51)=1.16, p=.341$ ]. No significant results were found in the analysis of relationship style with peers [ $F(4,51)=.664$ ]. Here, too, there was no significant interaction between age and group [ $F(4,51)=.359, p=.837$ ]. Thus, it appears that subject's age did not impact on level of object relations development or on attachment style to staff or to peers.

The overall MANCOVA for the WOC demonstrated a trend towards significance [ $F(8,47)=2.04, p=.061$ ] for the three way interaction between age, group, and coping strategy. An examination of the univariate analyses revealed a significant difference in only one coping strategy, Distancing [ $F(1,54)=8.81, p=.004$ ]. In the NCOA group, the coping strategy Distancing, was used less often by younger adolescents ( $M=1.05$ ) than by older teens ( $M=1.55$ ). In contrast, younger COAs ( $M=1.45$ ) employed distancing more often than the older COA adolescents ( $M=1.09$ ). No significant results were found for the MANCOVA which examined the two way interaction between age and group [ $F(1,54)=1.29, p=.270$ ]. These analyses of the WOC suggest that the presence or absence of parental alcoholism has an impact on the coping strategy of the offspring, an impact which changes as the offspring advances through adolescence. While COAs employ distancing strategies less often as they enter the second half of adolescence, the older adolescent NCOAs increase their use of distancing as a strategy for coping.

## CHAPTER V

### DISCUSSION

#### Summary of Hypotheses and Results

The present study examined the relationship between parental alcoholism and offspring development in two areas, object relations and coping. A supposition of this study was that the presence of parental alcoholism in early childhood would impede the development of necessary internal structures in the offspring. The hypothesized outcome of such an impediment would be a distinctive profile of impaired object relations, characterized by separation anxiety and denial of dependency needs. A second hypothesis was that the prevalence of denial in the alcoholic family would heavily influence the style of coping in the offspring, and limit the offspring's capacity to utilize problem focused coping strategies. It was also hypothesized that the two groups of hospitalized adolescents would not differ significantly in behavior problems, symptom picture, or level of dysfunction in the family. Of the three hypotheses, only this last hypothesis was supported by the data. The groups did not differ significantly on the measures of family dysfunction, on type or level of behavior

problems, or on symptom picture.

### Demographic Control Variables

The only significant differences between the groups were for three of the 10 features identified as possible moderating variables, specifically, family structure, SES, and FSIQ.

As might be expected from the disruptive effect which alcoholism has upon relationships, the original family structure was maintained for only one fourth of the COA subjects. This is consistent with reports in the literature of higher rates of familial separation and divorce associated with parental alcoholism (Knorrning, 1991, Murray, 1989). Possibly related to this unstable family structure over time, the SES of the COA families was considerably lower than that of the non-COA families, a difference found in other studies as well (Miller & Jang, 1977; Rubio-Stupic, et al., 1991; Wilson & Offord, 1978).

The last area of difference, while anticipated from the literature, (Owings-West and Prinz, 1987) is less readily explained. The mean full scale IQ for the COA group was 12.1 points lower than that of the non-COA subjects. Owings-West and Prinz (1987) report similar findings in six studies of IQ in COAs, and point to increased rates of delinquency, hyperactivity, family disruption, and risk of abuse or neglect in alcoholic families as possible causes.

The current study was not designed to assess the etiology of the observed difference in FSIQ. However, it is interesting to note that this difference in FSIQ observed in other studies is present in the current study, where the control group is composed of children who have experienced comparable levels of family dysfunction, hyperactivity, acting out behavior, and psychological disturbance.

### Object Relations

The hypothesized differences in object relations were not supported by the current study. However, a follow-up analysis of the SITA data revealed a significant trend which allows some further, albeit highly speculative, examination of the impact of parental alcoholism on object relations. A trend towards a difference ( $p=.09$ ) between the groups was found for the SITA Self-Centered scale, with the COA group scoring higher than the NCOA subjects. This scale was designed by Levine et al. (1986) to identify the residual effects of Mahler's practicing stage of separation-individuation (Mahler, Pine, & Bergman, 1975). Levine et al. suggested that individuals scoring highly on this scale are highly narcissistic, and have made substantial progress in separation-individuation. Such individuals would be described as grandiose, entitled, and overly self-involved. They are perceived as having little interest or investment in others (American Psychiatric Association, 1987).



However, according to self-psychological models, the underlying dynamic which fuels such behavior is actually an over-reliance on opinions and responses of others in the maintenance of self-cohesion and positive self-esteem (Stolorow & Lachman, 1980). Highly narcissistic individuals are seen as quite dependent upon others, and may have made only limited, unstable progress through separation-individuation. McClanahan and Holmbeck's (in press) study of the SITA suggests that this dynamic is indeed tapped by the Self-Centered scale. McClanahan (1990) reported a positive correlation between the Self-Centered scale and the Nurturance and Enmeshment-Seeking scales of the SITA. Explaining this, he suggested that "self-centered people need to feel appreciated by others in order to affirm their sense of self-importance and value" (p.67), a supposition which is congruent with Stolorow's position.

Seen from this perspective then, a high score on the Self-Centered scale is consistent with Brown's (1988) model regarding the impact of parental alcoholism on the development of internal structures in the child. Brown postulates that the COA is unable to separate his/her perception of reality from that of the parents because of the prevalence of denial in the family system. It follows that such a developmental failure would result in an over-reliance on the behaviors, beliefs, and responses of the parents in particular and others in general, as the child

endeavors to evaluate his/her own identity and sense of self worth.

McClanahan and Holmbeck's (in press) study also provides some support for the possibility that the elevation of the Self-Centered scale in the COA group is related to inadequate separation from the alcoholic parents. Contrary to their hypothesis, McClanahan and Holmbeck found a significant negative correlation between the SITA scale Self-Centered and measures of emotional autonomy from father and mother in a study of non-clinical college students. McClanahan (1990) concluded that these subjects in his study were unable to "maintain a healthy disposition without parental support" (p.72), essentially a conditional form of healthy functioning. Similarly, it is hypothesized that COAs are unable to maintain adequate functioning if separation from the parent is attempted.

A follow-up analysis of the ASI data helps to further fill out the picture painted above. Contrary to the original hypothesis of the current study, it was the NCOA subjects who demonstrated a minimal trend ( $p > .10$ ) towards being more avoidant in their relationships with staff than the COA subjects. This trend towards a difference between the groups was stronger ( $p = .07$ ) for the Hostile and Resistant/Ambivalent styles, with the NCOA subjects endorsing more hostility and more resistance/ambivalence in relationships with staff than did the COA subjects.

These differences between groups were explored further with four multivariate analyses which divided the data by both relationship and rater. While the overall analyses, again, were not significant, univariate results on the ratings completed by staff indicate that COAs are significantly ( $p=.05$ ) more dependent upon staff than the NCOAs, and that NCOAs are more avoidant of relationships with peers ( $p>.05$ ) than are COAs.

In both sets of analyses, COAs exhibit a greater involvement with and dependence upon adult authority figures than the NCOA subjects. The COAs also communicate less anger. Such a finding is congruent with the COA's elevated narcissism, as it is conceptualized above. In the absence of the alcoholic parent (in this case, due to hospitalization), COAs turned to staff for the interpersonal responsiveness which, for them, is vital to the maintenance of cohesion and self esteem. It is possible that the COAs were better able to mask any anger towards staff in the interest of preserving these vital attachments. However, any conclusions remain highly speculative because of the exploratory nature of these analyses.

### Adjustment

A central tenet of the current study is the supposition that COAs cannot be identified on the basis of symptoms or behavior alone. Support was found for this hypothesis. The groups did not differ significantly on the

YSR problem scales nor on the summary scales of Internalizing and Externalizing behaviors. Further, a follow-up analysis of the relationship between the dependent variables and adjustment suggests that similar behaviors across the two groups are the manifestation of very different internal experiences. Externalizing behaviors in the COA group correlated positively with the SITA scales Engulfment Anxiety and Self Centered. The former describes individuals who experience interpersonal relationships as a threat to their independence and sense of self. The latter, as was discussed above, describes individuals who need external confirmation to maintain a sense of self (Levine, et al., (1986). In contrast, externalizing behavior for NCOAs correlated with the SITA scale Dependency Denial. These individuals are detached. They reject, or fail to comprehend any feelings of closeness to others (Levine, et al., 1986). It can be postulated, then, that the need to act out is driven by different problems in object relations development for COAs than for NCOAs. Such behavior in the COAs may be associated with anxiety around the loss of self experienced when vital interpersonal connections are made. In the NCOAs, acting out behavior may be related to a lack of interpersonal connectedness.

### Coping

The hypothesized differences between the two groups in predominant coping strategy and coping style found no

support in the current study. Follow up analyses were of minimal use comprehending this lack of significant results. A within-groups analysis of coping strategy indicated only that, in both groups, subjects tended not to use the emotion focused strategy of positive reappraisal. This strategy "describes efforts to create positive meaning by focusing on personal growth ...(often with) a religious dimension" (Folkman & Lazarus, 1988). The absence of this strategy in both groups suggests that this may not be a tactic typically adopted by hospitalized adolescents. Normative data is not available to assess whether positive reappraisal is used by normal adolescents.

For both groups, reliance on emotion-focused coping strategies related significantly to poor adjustment, as measured by the YSR. However, the poorly adjusted COAs in the current study employed high levels of three emotion-focused strategies. These were escape-avoidance, seeking social support, and positive reappraisal. In contrast, the poorly adjusted NCOAs scored more highly only on escape-avoidance. One possible explanation of this difference is that NCOAs are able to utilize social support and positive reappraisal successfully to cope with stress, so use of these methods does not impact negatively upon adjustment. The COAs appear to be less successful in their efforts to employ these two coping strategies.

The possibility that significant results may have been

masked by collapsing all adolescents across age was examined in an exploratory analysis. While age was found to have no impact on object relations or on attachment style, it did impact upon the use of one coping strategy, Distancing. The results of this analysis suggest that COAs decrease their use of Distancing with age, while the use of that strategy by NCOAs increases with age. Distancing, an emotion focused strategy, involves efforts to detach from the source of stress, and to minimize its significance (Folkman & Lazarus, 1988). Examples of items on this scale include "Went on as if nothing happened" and "Made light of the situation; refused to get too serious about it". This finding lends some support to the role of parental denial in influencing offspring coping strategies, as the distancing items appear to reflect cognitive components of denial. Possibly then, with age and additional contact with the external world, the older COAs relinquish some of their reliance on denial and therefore employ distancing less. However, such an explanation does not offer insight into the presence of the opposite pattern in the NCOAs. Further this finding may be sample specific, and is of questionable validity because it suggests a longitudinal conclusion which is based on cross-sectional data.

#### Theoretical Considerations in the Lack of Significant Results

The lack of support for the central hypotheses of the

current study point to the conclusion that parental alcoholism has no specific effect on the development of object relations or coping strategy. This conclusion is congruent with the work of Burk and Sher (1988). They believe that the difficulties manifest in COAs are more a function of the secondary effects of parental alcoholism, specifically family dysfunction, abuse, neglect, and inconsistency, and are heterogeneous in nature.

However, other explanations for the lack of significant results should be explored. One possibility, pointed to by the follow-up analyses in the current study, is a faulty or overly simplistic conceptualization of the specific impact that parental alcoholism would have on object relations development.

While admittedly of weak significance, a relationship was found between the SITA scale Self-Centered and COA status. As discussed above, this scale may capture a presentation of confidence and rejection of interpersonal needs which masks an over-reliance on the opinions and responses of others. Possibly this scale, and the stage it describes, reflects the presence of a "false-self".

The false-self was a concept introduced by Winnicott to describe a self-structure which develops in response to the needs and demands of the caretakers, rather than the developmental needs of the child (Winnicott, 1965). Developing the concept further, Guntrip described the false

self as the "conscious self of everyday living struggling to deal with life in the ways expected...(while trying) to suppress an inner self that is in a state of childlike, or even infantile, fear, and dependent need" (1964, p.71).

Beltis and Brown (1981) applied the concept of the false self to the COA. They proposed that the young COA, having achieved only an insecure attachment to the parents, is pushed prematurely into self-sufficiency by a depleted or disinterested parent once the child exhibits some autonomy. Survival for the child then depends on his/her ability to "manage" the parents, so that they will be able to meet both the physical and psychological needs of the child. Thus, while such children appear mature and competent, they are in reality extremely dependent, needy, and reliant upon others for their basic needs and their sense of self.

Incorporating this hypothesis, that is, that the false self presentation will color a self-report of object relations, it appears necessary to adjust the theoretical model to include a more complex picture of object relations status.

Another possible flaw in the theoretical structure of this study is the assumption that object relations development, when impaired before age seven, will not rebound if the toxic parent is removed from the household. Many subjects in the current study had not lived with the alcoholic parent for many years, and often had an additional, non-alcoholic parenting figure introduced into



the family. Deficit models of self structure such as self psychology suggest that the effect of unavailable parenting figures in early childhood can be remediated in treatment (Elson, 1986). Extending this concept, it is possible that this effect can also be remediated in the home environment, when needed parenting becomes available. Studies which compare the offspring of active and recovering alcoholics appear to support this hypothesis (Billings & Moos, 1983; Callan & Jackson, 1985; Moos & Moos, 1984). These studies have found significantly less physical and emotional problems in the offspring of recovering alcoholics than the offspring of active alcoholics.

The ongoing presence or absence of the alcoholic parent in the household may be particularly relevant to the development of coping strategies for COAs. Studies of the development of coping indicate that emotion focused coping strategies are still developing between the ages of 11 and 14 (Compas, et al., 1988), and that problem focused skills become more predominant with the increased ego development of middle and late adolescence (Hauser et al., 1991). Thus, children who are no longer living in an alcoholic household, and particularly those who are exposed to other role models, quite likely are able to continue normal development of coping strategies.

## Methodological Considerations in the Lack of Significant Results

The present study was designed to circumvent many of the methodological flaws identified in previous studies of COAs, and reviewed above. Specifically, the current study developed operational definitions for parental alcoholism, child pathology, object relations, and coping, and (with the exception of coping) utilized multiple methods for assessing these variables. The current study employed a control group which exhibited comparable levels of disturbed behavior and family dysfunction. Bias in subject selection was reduced by selecting a population on the basis of the child's pathology rather than the parent's drinking status. The current study controlled for possible moderating variables such as IQ, SES, and prior treatment, and employed a multivariate design so as to assess the impact of moderators on outcome. Nevertheless, several problems in the choice of sample and measures become apparent in retrospect.

A hospitalized sample was selected for the current study because of a bias towards health identified in studies which employed a community sample (Tweed & Ryff, 1991; Woodside, 1988). However, a comparable bias towards pathology, which was deliberately included in order to highlight abnormal development (Sroufe, 1991), may have blurred the structural distinction between COAs and NCOAs. Thus, it is possible that the hypothesized differences may

be present and measurable in a somewhat healthier population. However, in an inpatient sample, those differences may be overshadowed by other factors, such as severe co-morbidity, or an extreme family dysfunction which is rooted in problems other than parental alcoholism alone.

Two measures were employed by this study to assess object relations, in an effort to provide cross-validation. However, it is not clear that the measures tapped the same constructs. The SITA was developed in accordance with object relations theories, based on Mahler's model of separation and individuation (Levine, et al., 1986). Object relations were defined in the current study as psychological structures, inner images of the self and the other, which are formed out of the residue of relationships to primary caregivers during infancy and childhood (St. Clair, 1986).

The theoretical substrate of the ASI is the intersection of attachment theory and developmental psychoanalytic theory (Sperling, et al. unpublished). Sperling, et al. identified the point of intersection as mental representations, a concept defined by Main, Kaplan and Cassidy as "a set of conscious and/or unconscious rules for the organization of information relevant to attachment and for obtaining or limiting access to that information, that is, to information regarding attachment-related experiences, feelings, and ideations" (in Sperling, et al., p.5). Based on these descriptions, it appears that the ASI

and the SITA are attempting to assess comparable internal structures from parallel theoretical frameworks. However, it is possible that the ASI, as used in the current study, lacked an important dimension which is essential to the measurement of such a complex concept. In addition to rating the four attachment styles on goodness of fit, the ASI also asks for a rating of worry or ease with the relationship. The latter rating is included to assess the individual's level of security. Unfortunately, that rating could not be included in the data analysis because many of the raters became confused and did not correctly follow the instructions, most likely the result of a cognitive set established on the first part of the measure. The subsequent exclusion of the security dimension from the data analysis may have decreased the sensitivity of the ASI to the subtler aspects of object relations.

It is possible that the Ways of Coping was not the optimal choice for the assessment of coping in the current study. That measure was developed for and validated entirely on adult populations. Compas (1987) points out that children and adolescents operate in a different adaptive context than adults, with greater dependency on the environment. Further, they have not necessarily developed the psychological, cognitive, or biological readiness needed to employ all adult coping strategies. Use of a coping measure designed specifically for adolescents, instead of

the WOC, or still better, in addition to that measure, may have provided important information.

A more general problem with the measures used in this study is the impact of social desirability on self report. While Stacy, Widaman, Hayes and Matteo (1985) have concluded that self report measures are reliable and valid for this population, the pattern of results in the current study suggests that social desirability may have unduly influenced the results. Specifically, subjects may have underrated themselves on personal characteristics and interpersonal behaviors which they perceived as negative, while highlighting those which they felt painted a more positive self-portrait. With both groups reporting only socially desirable characteristics, other, less desirable characteristics specific to each group would be masked. In retrospect, such a distortion could be anticipated in individuals with a false-self structure (discussed above) as self-report measures primarily tap conscious self-representations.

Some problems in the design of the current study can also be observed. The sample size, while considered sufficient, was still small. This may have limited the effect size and increased the possibility of Type II error. That problem would have been exacerbated in the exploratory analysis into the impact of age. That analysis, which required the division of subjects into four groups, rendered

the cell sizes even smaller. The resulting loss of power raises questions regarding the validity of the nonsignificant results. It is possible that age group does interact with group status to affect object relations development and coping, and that the current study lacked the sensitivity needed to assess that impact.

A second design problem may be insufficient attention paid to interpersonal moderating variables. While efforts were made in the current study to assess the impact of moderating variables, crucial factors may have been overlooked. Factors such as contact with extended family, involvement with teachers or other adults, and the efficacy of prior treatment may have had an important influence on object relations development or coping. It would have been important to also utilize information about the alcoholic parent as possible moderating variables. The duration of the alcoholism, the alcoholic's style of drinking, and the impact of alcoholism on family rituals and structures, are all factors thought by some researchers to be significant moderators of outcome (Seilhamer & Jacob, 1990; Wolin, Bennett, Noonan & Teitelbaum, 1980).

### Conclusions

The goal of the current study was to identify a pattern of object relations development and coping strategy which might be unique to COAs, possibly the legacy of parental alcoholism. The hypotheses regarding these

patterns were not supported, suggesting that the problems observed in COAs do not derive from dysfunctional features which are specific to the alcoholic family. However, the follow-up and exploratory analyses conducted in the current study do add to the body of knowledge regarding object relations and children of alcoholics. Specifically, adolescent COAs seem to retain a stronger need for connection to adults than their non-COA peers, suggesting a derailment or delay in the tasks of normal adolescent development (Blos, 1962). The intensity of the need for connection may be masked by a pseudo-independence, apparent self-absorption, and overvaluation of skills and capabilities, a style which is consistent with clinical descriptions of adult COA's.

On the topic of coping, the current study contributes minimally to knowledge regarding the impact of parental alcoholism. However, there is an indication that COAs are not successful in their attempts to utilize the emotion focused coping strategies Seeking Social Support, Positive Reappraisal, and Escape-Avoidance to alleviate internalizing symptomatology. It also appears that the coping strategy Escape-Avoidance is ineffective in relieving internalizing or externalizing symptomatology in either adolescent subject group.

#### Future Directions

While the specific hypotheses regarding object

relations development in COAs were not supported, the results of the follow-up and exploratory analyses warrant further study. Most fruitful might be an assessment of object relations by projective measures. This would circumvent the problems of self-report for individuals with a strong false-self presentation, and control for the general impact of social desirability. Hypotheses for such a study could be guided by speculations from the current data regarding the centrality of narcissism, with its underlying components of nurturance seeking and enmeshment seeking, in the internal structure of the COA subjects.

Assessment of coping through observational measures may also be considered. A less cumbersome alternative would be a measure of coping designed specifically for adolescents, under the supposition that adolescent coping is different than coping in adults, and therefore cannot be assessed by an adult measure. The most desirable option would be the use of multiple measures in a sample sufficiently large so as to allow for division by age as well as parental drinking status.

It will be important in future studies to draw COA and NCOA subjects from both clinical and community populations. Such a four group study could help clarify the relative contributions of pathology and dysfunction which are unrelated to parental alcoholism, and eliminate the possibility of bias towards health or pathology.



Another consideration in sample selection is the current presence of an active alcoholic in the household. Inclusion solely of COAs have lived with an alcoholic parent their entire lives may highlight the acute effects of parental alcoholism on the child. While those results would be less generalizable to the larger COA and ACOA population, they might provide direction for further study.

Last, the role of moderating variables will continue to require careful attention. A carefully constructed, structured social history, obtained from both the child and a parent, could provide the necessary information about relationships outside the family. Information could also be obtained regarding the duration of the alcoholism, the alcoholic's style of drinking, and its specific impact upon the family.

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The dissertation submitted by Elaine Rado has been read and approved by the following committee,

Dr. Grayson Holmbeck, Ph.D.  
Assistant Professor  
Loyola University of Chicago

Dr. James Johnson  
Professor, Psychology  
Loyola University of Chicago

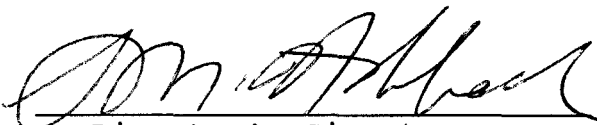
Dr. Daniel Barnes  
Director, Counseling and Career Development  
Loyola University of Chicago

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 Ph.D.

1/18/93

Date



Director's Signature