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The Relationship Between Parental Mental Health, Family Rituals, Family Environment, And The Resiliency Of Adolescents Of Alcoholic Parents

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**THE RELATIONSHIP BETWEEN PARENTAL MENTAL HEALTH, FAMILY
RITUALS, FAMILY ENVIRONMENT, AND THE RESILIENCY OF ADOLESCENTS
OF ALCOHOLIC PARENTS**

BY

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**Submitted in partial fulfillment of the
requirements of the Degree of Doctor of Philosophy
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Philippians 4:13 “ I can do all things through Him that strengthens me.”

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CHAPTER I

Introduction to the Problem

Purpose of the Study

This study examined the mental health functioning and drinking behaviors of male and female adolescents of adult alcoholics (COAs) and explored their perceptions of how well their families functioned. The mental health functioning, drinking behaviors, perceptions of current family environment, as well as perceptions of family-of-origin functioning of alcoholic parents and their non-alcoholic spouses were also explored in this study. Relationships between adolescents and their alcoholic and non-alcoholic parents on the above variables were examined in this intergenerational study.

The impact of parental alcoholism on children's development has received increasing attention in the clinical and empirical literature over the past 25 years. There are an estimated 26.8 million children of alcoholics in the United States alone (Emshoff & Price, 1999) and greater than 11 million children under the age of eighteen (COA Foundation, 1998). According to the National Longitudinal Alcohol Epidemiological Survey (Grant, 2000), approximately 1 in 4 children are children of alcoholics and approximately one 1 out of 6 adolescents may be a child of an alcoholic parent (Roosa, Sandler, Gehring, Beals, & Cappo, 1988). Despite the attention paid to this sizable population, reviews of the literature indicate that very little methodologically sound research has been conducted involving the possible modeling impact of same-gender

parent on an adolescent (Booz-Allen & Hamilton Inc., 1974; Jacob, Graves, Hanson & Jessor, 1978; Russell, Henderson & Blume, 1985).

The variable of gender, both gender of child and gender of alcoholic parent, has been cited in previous research as a possible important factor for further research, but has not been specifically studied. Prior research has also suggested that family environment may be a significant variable when examining the mediating effects of parental substance abuse upon offspring, yet few studies have actually investigated this variable. In this study, the impact of gender--both gender of child and gender of alcoholic parent--as well as the role of one's family environment were explored in addition to looking at "generational transmission" of self-esteem, drinking behavior, and level of depression.

Chapter one involved reviewing the history behind the use of the "children of alcoholic" label and potential problems in identifying unique characteristics in this population. Depression, self-esteem, family environment, drinking behavior, family rituals, and gender variables are introduced. The statement of the problems and hypotheses, the identification of variables and definitions of terms, and the significance of the study are presented.

Background of the Problem

Cork (1969) is credited with the seminal work recognizing alcoholism's potential impact on children of alcoholic parents. From this beginning, much interest began to be generated by mental health workers and members of various self-help groups. Inherent in this enthusiasm was the frequently observed pattern of behaviors and symptoms common to many offspring of alcoholics who were identified as growing up in "dysfunctional"

family systems by virtue of having at least one problem drinking parent.

In the early literature, children of alcoholics (COAs) were referred to as "the forgotten children" (Cork, 1969 p. 5), "the hidden tragedy" (Bosma, 1972, p. 74), "the ignored millions" and as a "neglected problem" (Slobada, 1974, p. 604). Adult children of alcoholics (ACOAs) were also perceived as perpetuating a shared pattern of behaviors and characteristics, including "having difficulty with follow through", "having difficulty having fun", "being self-critical", "constantly seeking affirmation and approval", and "having difficulty with intimate relationships"(Woititz, 1983, p. 45). Numerous other dimensions and characteristics of the COA/ACOA profile were cited throughout the many available descriptive articles on the subject (e.g., Black, 1981; Callahan & McDonnell, 1987; Gravitz and Bowden, 1984; Sexias & Youcha, 1985; Wegscheider, 1980,1981).

Many researchers and clinicians believe that COAs are at high risk for not only alcohol and substance abuse, but also for serious psychological problems, behavioral and learning difficulties, and physical illnesses into adulthood (Ackerman, 1987b; Brown, 1988; Cermak, 1986, 1988; Clair & Genest 1987; Goodwin, 1972, 1979a; McKenna & Pickens, 1983; O'Gorman, 1975; Scavicky-Mylant, 1990; Velleman & Orford, 1990; Windle & Searles, 1990).

Unfortunately, because of numerous methodological weaknesses inherent in the COA/ACOA literature, as will be elaborated on in Chapter Two, it is extremely difficult to draw any definitive conclusions about many of the basic premises or characteristics of this population as described in the popular literature. One of the most salient weaknesses

appears to be a lack of sound research to defend the position that there is "homogeneity" among COAs/ACOAs (Ackerman, 1987a; Barnard & Spoentgen, 1987; Berkowitz & Perkins, 1988; Clair & Genest, 1987) and a set of shared personality characteristics which are allegedly directly caused by being raised in an alcoholic family.

Until recently, the "independent variable" in alcoholism and family studies has simply been "parental problem drinking" or "alcoholism". With growing recognition that outcomes for offspring of problem-drinking parents are rather varied (e.g., Scavnicky-Mylant, 1990; Wright & Heppner, 1993), attention has turned to providing more detailed and differentiated descriptions of child or adolescent experiences while growing up with one or more alcoholic parents. Not all offspring of alcoholic parents have experienced the same degrees of stress during their growing years and, in many cases, other factors or intervening variables, both inside and outside of a family, may have operated to buffer the degree to which a child has been exposed to stress.

Potential Intervening Factors for Children of Alcoholics

Following this researcher's review of the previous literature regarding the offspring of alcoholic parents, there appeared to be several areas that might merit investigation in the search for variables and may explain differences in outcomes among children of alcoholics. These include gender of parent with alcoholism and gender of adolescent, disruption versus preservation of family rituals, presence or absence of excessive drinking at home by parents, temperamental characteristics, coping skills, social learning/modeling and gender identification.

Gender of parent with alcoholism and gender of adolescent.

Several possibilities have emerged in studying the experience of gender in alcoholic processes. Miller and Jang (1977) suggested a worst outcome, overall, for offspring when the parent of the same gender as the child has a drinking problem. A meta-analysis of the relationship between gender-of-parent and gender-of-offspring on the transmission of alcoholism indicated, across family studies, parental alcoholism to be associated with increased rates of alcoholism in both sons and daughters when having an alcoholic father (Pollock, Schneider, Gabrielli & Goodwin, 1987). Maternal alcoholism was associated with an increased alcoholism rate only in daughters. This implication for future research has only recently been "rediscovered" by several researchers as significant in understanding the dynamics of an alcoholic family system (e.g., Benson, 1994; Jones, 1993).

Werner (1986) is one of the researchers who have suggested that COAs may have a worst outcome when it is the mother who is the parent with the drinking problem. Velleman and Orford's (1990) work with young adult offspring demonstrated that offspring of problem-drinking mothers recalled significantly more negative childhood experiences than adolescents of problem-drinking fathers recalled.

These research findings are significant in respect to an apparent gender bias in the past COA/ACOA literature with its focus on predominately male subject samples and on alcoholic fathers to the exclusion of alcoholic mothers and daughters. Alcoholism and women appears to only be addressed within the context of women being mothers and transmitting Fetal Alcohol Syndrome to their children. The effects of growing up female

and having an alcoholic parent are not as acknowledged in the research literature in contrast to males growing up with an alcoholic parent (El-Guebaly & Offord, 1976). It is apparent that alcoholism affects males and females -- and both daughters and sons -- and these elements need to be attended to in gender research. In this study, alcoholism's effects on daughters and sons will be examined, with special focus upon the impact of an alcoholic mother on her adolescent offspring.

Excessive alcoholic drinking in the home.

There have been a number of reports that problem-drinking among women has a later onset than among men and that women's excessive drinking is more confined to the home (Bromet & Moos, 1977; Orford & Keddie, 1985). Similarly, mothers were seen as engaging in problem drinking more regularly at home than were problem-drinking fathers (Werner, 1986; Wilson & Orford, 1978).

Temperament characteristics and coping skills.

Werner (1986) reported temperament characteristics or personality traits of COAs as possibly functioning as intervening variables in stressful alcoholic family systems.

The methods children characteristically use to cope with stress were also seen as instrumental in understanding alcoholic families (Ackerman, 1987; Clair & Genest, 1987).

Social Learning/Modeling and Gender Identification

Social learning and modeling.

"Except for elementary reflexes, people are not equipped with inborn repertoires for behavior. They must learn them" (Bandura, 1986, p.16.). According to social-learning theory, much of human behavior is acquired or learned in a meaningful

environment that is rife with social interactions with others (Rotter, 1954).

"It is a social learning theory because it stresses the fact that the major or basic modes of behaving are learned in social situations and are extricably fused with needs requiring for their satisfaction in the mediation of other people" (Rotter, 1954, p.84).

Most traditional views of social behavior have often suggested that person variables and environment variables operate independently to produce behavior. Albert Bandura (1986), one of the major social-learning theorists, instead, argued for reciprocal interactions among three interlocking sets of factors-- behavior, cognitive, and environmental influences (Bandura, 1986). He saw the influence of environmental and social events on the acquisition and regulation of behavior as largely determined by cognitive processes based on previous experiences. These cognitive processes help to determine what environmental influences are attended to, how they are perceived, whether they will be remembered, and how they might affect future action (Bandura, 1986). A person is viewed as "both the agent and the object of environmental influence" (Wilson & O'Leary, 1980, p.77) and has the capacity for self-directed behavior change.

Bandura (1986) asserted that an enormous amount of human learning involves modeling, observation, and imitation. In addition to motor acts, a variety of social responses, such as aggression, sex-typed behaviors, and emotional reactivity, among others, are observed and hence learned. Bandura defined acquisition, or learning of a response, as the first stage in observational learning. In order to learn a person must attend to, and accurately perceive, the important features of a model's behavior. Through

observation, a person acquires images and verbal representations (cognition) of a model's behavior. This behavior is then coded, organized, or rehearsed to facilitate storage in memory. Bandura noted that much human learning transpires without the customary reinforcement that operant and classical conditioning principles require. Therefore, it is not necessary for observational learning to be reinforced during the acquisition phase, nor is there a need to engage in any overt practice for observational learning to occur.

In stage two, performance of the modeled behavior by a learner, reinforcement is important in determining whether the behavior will occur. Individuals must be capable of initiating appropriate actions from stored symbolic representations and must be motivated to perform.

Bandura (1963) proposed that there are three major effects of modeling on observational learning. First, observational learning facilitates the acquisition and performance of new skills and behaviors. Second, behavior that has been acquired and performed, yet is under some form of inhibition (social or personal), can be affected by modeling following removal of imposed constraints, thereby increasing the level of performance of a behavior or further inhibiting the performance of a behavior. Third, observational learning can facilitate the performance of previously learned behaviors that, although under no constraints, are performed or only at a low rate.

According to Bandura (1986), models who possess prestige in the eyes of an observer are generally more likely to be emulated than low-prestige models. Social-learning theorists stress the importance of parents as models and reinforcement agents, especially for young children (Mischel, 1969). For a child, then, parents are crucial to

learning, partly because they are the most important people in a child's life. A growing child identifies with his or her parents and tries to imitate their behaviors.

There appear to be a number of factors involved in the issue of why children choose to imitate one adult rather than another. How available the model is, how similar the model is to the child (as perceived by the child), how nurturing the model is, and how powerful the model is are all possible factors involved in this process (Katz, 1979).

Modeling by one's same-sex parent is viewed as especially significant since Bandura (1986) and Mischel (1970) stressed the physical and social properties of parents and the nature of the reinforcement processes in a child's acquisition of sex roles and other characteristics. When children become adults, they are likely to follow the behavior patterns they acquired in childhood, either because new patterns were never learned or because the old patterns become rewarding in themselves (Sears, 1965).

As applied to families, social-learning theory views parents as controlling many of the contingencies influential in children who are acquiring and maintaining behavior patterns. Most abnormal behavior is acquired and maintained according to the same principles as normal behavior. Children growing up in dysfunctional family environments, where parents are modeling disturbed or unhealthy behaviors or communication patterns, can readily observe and learn these same behaviors and cognition without any overt reinforcement needed.

Gender identification.

Most theorists of identity argue that identity is a process whereby a child through imitation, modeling, identification, or introjection acquires traits, characteristics, and

values similar to a parent. In normal development, the boy is assumed to identify with the father and the girl with the mother. This results in the preference for and adoption of appropriate sex-role behaviors (Hetherington, 1965).

According to other researchers however, both daughters and sons make their earliest identifications with their mothers (Lynn, 1969). Similarly, social-learning theorists (Bandura, Ross & Ross, 1963; Mischel, 1966) and cognitive-development theorists (Kohlberg, 1966) assign a more significant role to mothers.

The impact of one's mother as the primary figure in the accomplishment of this psychosocial task (development of trust) has a special significance for the daughter. Mother is every daughter's first female role model. "Mother holds the power of punishment, of withholding love, of reinforcement and vicarious reinforcement, of status, and of similarity, all powerful factors in the identification process for a daughter" (Secord & Backman, 1964, p.117).

Magrab (1989) wrote:

As women, we carry our mothers with us in every breath, in every decision, in every success, and in every failure . . . As our first mirror of life in the world, mother serves as protector, guide, and interpreter through the maze of womanhood and our culture. Our first sense of self as an extension of mother, and the struggle for independence lies in the eternal conflict of this symbolic bond and the will toward oneness. Through this, mother stands as a lasting model and a touchstone in our lives (p.117).

Certainly, the present data argue strongly that the relationship with mother is

critical to a daughter's adjustment. What the impact of a relationship with an alcoholic mother is on daughter's adjustment is unknown. It is possible that having an alcoholic mother is more pathogenic for daughters, but less so for sons. A modeling interpretation would suggest that having a same-sexed role model who is inadequate or chronically dysfunctional will be more devastating for development than the same problems in the opposite-sex role model. Or, it could be that particular kinds of adjustment difficulties in daughters are more strongly linked with maternal alcoholism than are adjustment difficulties in sons. These interrelationships have not yet been explored, and, while the present data raise some provocative hypotheses, they provide little closure (Benson, 1980).

Research studies have suggested that a healthy relationship with the non-alcoholic parent may be a buffering factor that protects the child from the negative effects of parental alcoholism (Moos & Billings, 1982; Rutter, 1985). McCord (1988) also explored perceived esteem of the non-alcoholic spouse for the alcoholic spouse in terms of modeling for offspring. In this study, mothers who held their alcoholic spouses in high esteem were almost two times more likely to have alcoholic sons than mothers who did not hold their alcoholic spouses in high regard. Among those with non-alcoholic fathers, the rates for alcoholism were similar regardless of the mothers' levels of esteem for their spouses. These data, which are compatible with a modeling/imitation hypothesis of alcohol transmission, suggest that modeling effects are not simply based on level of parental consumption but on how highly an alcoholic model is valued by key family members.

Parental Alcoholism and Family Environment

Family interaction.

As more complex models of addiction have emerged, the role of the family of origin as a risk factor in developing and maintaining addictions has become more central (e.g., Bennett, Wolin, & Reiss 1988; Wampler, Fischer, Thomas & Lyness, 1993). Alcoholism in at least one parent has been well established as a risk factor for alcoholism and other problems in offspring (Leibman, White, & Nirenberg, 1986; West & Prinz, 1987). Families characterized as rigid-disengaged in the circumflex model seem more likely to produce offspring with addiction problems (Carneo, 1988; Friedman, Utada & Morrissey, 1987). Alcoholic families were seen as experiencing higher degrees of conflict, lower levels of family cohesion, expressiveness, intellectual-cultural orientation, and active-recreational orientation than non-alcoholic families (e.g., Benson & Heller, 1987; Callan & Jackson, 1986; Filstead, McElfresh & Anderson, 1981; Moos & Billings, 1982; Moos & Moos, 1984).

COAs living with an alcoholic parent may, through observational learning processes, acquire reliance upon the use of alcohol as a coping strategy (McLaughlin, Baer, Burnside & Pokorny, 1985). Chassin, Rogosch and Barrera (1991) noted that the impact of parental alcoholism is associated with general parental impairment and poor role-functioning which affects the quality of the family environment and the stability of a child's life. Such increased stress and disruption raise the risk for negative outcomes in a rather nonspecific way, so those all-negative outcomes were more likely.

Furthermore, since alcoholic adults often exhibit other types of inappropriate or

insufficient adjustment, it is possible that their children are at risk for acquiring a variety of nonalcoholic- related adaptation difficulties via this same general developmental mechanism; for example, inappropriate aggressiveness or social withdrawal. Thus, in order to develop an appropriate intervention and to examine the transmission of adjustment difficulties between alcoholic parents and their children, it is important that assessment processes examine whether a child's general adaptive approaches are related to those utilized by the parents (Dadds, 1987).

Secondly, parental alcoholism may result in modifications or distortions of the general environment in which a child or adolescent exists and develops (Chafetz, Blane, Hill, 1971; Clair & Genest, 1987; Moos & Billings, 1982; Moos & Moos, 1984). The parenting technique used by parents who drink may be, on average, less effective than the strategies used by parents who do not drink. For example, Peterson (1994) reported that parents who drink were less likely than non-drinking parents to monitor and articulate clear rules governing the behavior of their adolescent offspring. Altermann and Tarter (1983) also suggested that the development of alcohol and drug abuse and related problem behaviors in offspring of substance abusers may be attributed to the combined influence of psychological and genetic vulnerability, and may be exacerbated by the adverse social and environmental conditions in which these offspring are often reared.

However, parental alcoholism may be pervasively related to a host of less evident ecological risks to which children are exposed. For example, unpredictability, inconsistency, and tolerance of deviant behavior may characterize child-rearing activities, with deleterious consequences to the mental health of children (Miller & Jang, 1977).

Thus, it is important to develop an understanding of how parental alcoholism is related to specific aspects of a family environment in which children live. It is also critical to evaluate the extent to which a non-alcoholic parent compensates for the environmental risks contributed by an alcoholic parent (Bennett, Wolin & Reiss, 1988; Jacob, Favorini, Messel & Anderson, 1978). For example, the non-alcoholic parent may provide adequate nurturance and emotional support for the child to develop positive self-esteem, intercede on behalf of the child in altercations with the alcoholic parent, and/or assist the child in interpreting the inappropriate or nonsensical behaviors of the alcoholic parent.

According to Braithwaite and Devine (1993), family characteristics have featured significantly in other accounts of why some children are more resilient than others are. In Reich, Earles and Powell's (1988) study of the home environment of COAs with and without psychiatric diagnoses, the level of parent-child interaction, parent-child conflict, and exposure to parental drinking were important factors differentiating the groups. Overall, findings suggest that a divided family where children lack an intimate relationship with at least one parent, is a far more powerful predictor of serious maladjustment than alcoholism per se. These data are consistent with the casual pathway outlined by West and Prinz (1987) that an alcoholic parent disrupts family interaction that, in turn, causes child psychopathology. To further elaborate, alcohol dependency gives way to family disruption, that then leads to children distancing themselves from their families physically (the "lost child"), psychologically ("the clown"), and /or socially ("the acting-out child"). When a child's bond with the family is severed, the result is insecurity and lack of "psychological safety" which, in turn, gives risk to symptoms of

anxiety and depression in COAs.

According to a number of researchers (e.g., Rutter, 1985; Billings & Moos, 1983; Cooper, Pierce & Tidwell, 1995) it is important to adopt an integrative model that focuses on understanding the multiple predisposition and protecting factors that influence children's efforts at adaptation to stressful situations (e.g. parental alcoholism and its impact upon the family environment). Some factors to be considered in such an integrative model might be: (1) characteristics of stressor events, (2) characteristics of individual children involved, and (3) characteristics of social environments.

1. **Stressor events-factors:** This set of factors is concerned with the pervasiveness or magnitude of stressful events, the multiplicative effects of multiple stressors (Langner & Michael, 1963; Rutter, 1987) and clustered life events (Dohrenwend & Dohrenwend, 1977). In exploring the influence of this factor on an adolescent's life, it is critical to assess and identify the various realms of developmental experience, which are being modified by a parent's difficulties.

2. **Individual characteristics:** Recent studies of problem solving among children and adolescents indicate that the most adaptive individuals do not consistently apply the same approaches to different tasks or problems. Instead, they are able to recognize that a strategy useful in one context may be ineffective or maladaptive in another setting (Dodg, 1985; Spaniol & Jung, 1987).

3. **Social Environment:** Risk for children, in most cases, does not stem from a parent's illness itself, but from the associated psychosocial disturbance in the family as suggested by Billings and Moos (1983). In the inter-familial ecological context of

parents and siblings, research indicates that a critical element in raising resilient children is the presence of a responsive caretaker. Children need caretakers who support their efforts to develop self-regulation and autonomous functioning (Murphy & Moriarty, 1976; Werner, 1986). In situations where at least one non-alcoholic parent is available and able to promote autonomous and competent functioning, children may be less vulnerable to the negative consequences of a parent's alcoholism (Olson, Sprenklo, Russell, 1979). In a study by Cooper and associates (1995), low levels of support from one's female caretaker exacerbated the effects of drinking problems on adolescent offspring alcohol use, whereas, higher levels of support buffered these effects.

Pattison (1977) noted that the existence of social-support networks provide a cushioning effect for individuals confronted with a variety of stresses. The size, quality, and degree of reciprocity in personal support systems are variables correlated with mental-health status. It has repeatedly been observed that many children who are living under conditions of family dysfunction or stress and yet involved with a "significant other" outside the nuclear family, appear to be relatively well-protected from negative adjustment outcomes (Kauffman, Grunebaum, Cohler & Gamer, 1979; Werner & Smith, 1983; Wilson & Orford, 1978).

Statement of the Problem

The original research questions were: (a) Is there a significant difference between daughters of alcoholics and sons of alcoholics on measures of self-esteem, depression, drinking behavior, and perceptions of family environment? (b) Is there an interaction between gender of parent and gender of offspring on measures of self-esteem, depression,

drinking behavior and perception of one's family environment? (c) Is there less family disruption and greater mental health in families whose members report a high degree of intact family rituals and closeness, regardless of a parent being identified as alcoholic? (f) Can there be "healthy" families and family members despite the fact that there is an identified alcoholic parent in the family?

Because of the difficulty in recruiting sufficient numbers of respondents, the results of this study, unfortunately, could not be examined with multivariate statistical analysis. As a result, this study did not yield results involving interaction between variables. In particular, the question regarding impact of gender was not assessed, and only correlations between the study's variables were available. The following hypotheses were reformulated, with dissertation-committee approval, in respect to the study's sampling limitations:

Revised Hypotheses

Identified alcoholic parents.

In the present study, it was predicted that:

H1. For identified alcoholic parents, a low level of intact family rituals in families of origin will be:

- (a) Positively related to low self-esteem
- (b) Positively related to depression
- (c) Positively related to family disruption in their current families,
- (c) Positively related to a low level of intact family rituals in their current families.

H2. For identified alcoholic parents, family disruption in families of origin will be:

- (a) Positively related to low self-esteem,
- (b) Positively related to depression,
- (c) Positively related to family disruption in their current families,
- (d) Positively related to lower levels of intact family rituals in their current families.

Spouses.

H3. For spouses of identified alcoholics, family disruption in families of origin will be:

- (a) Positively related to low self-esteem
- (b) Positively related to depression
- (c) Positively related to family disruption in their current families,
- (d) Positively related to lower levels of intact family rituals in their current families.

H4. For spouses, a low level of intact family rituals in families of origin will be:

- (a) Positively related to low self-esteem.
- (b) Positively related to depression.
- (c) Positively related to family disruption in their current families,
- (d) Positively related to lower levels of intact family rituals in their current families.

Adolescents.

H5. Daughters and sons of alcoholic mothers will report (as compared to daughters and sons of alcoholic fathers);

- (a) Significantly higher scores on depression,
- (b) Higher scores on disruptive family environment,
- (c) Lower self-esteem scores,
- (d) Increased drinking behavior,
- (e) Lower levels of family rituals

H6. Daughters of alcoholic mothers, as a subgroup, will report:

- (a) The highest scores on depression,
 - (b) The highest scores on disruptive family environment,
 - (c) The lowest scores on self-esteem
- as compared to all other subgroups (daughters of alcoholic fathers, sons of alcoholic mothers or fathers)

H7. For adolescent offspring of identified alcoholics, family disruption will be:

- (a) Positively related to low self-esteem
- (b) Positively related to depression
- (c) Positively related to drinking behaviors,

suggesting a relationship between family environment and resiliency.

H8. For adolescent offspring of an identified alcoholic parent, high level of family rituals/closeness will be:

- (a) Positively related to self-esteem

- (b) Inversely related to depression
- (c) Inversely related to drinking behaviors
- (d) Inversely related to family disruption,

suggesting a possible role of family rituals/closeness in “buffering” the impact of alcoholism in the family.

Alcoholic Parents, Spouses and their adolescent children.

H9. Adolescents and their same- gender alcoholic parents will demonstrate a similar and statistically significant relationship on measures of self-esteem, drinking behavior and depression.

- (a) Alcoholic fathers and their sons will show relationships between reported measures of self-esteem, drinking behavior and depression.
- (b) Alcoholic mothers and their daughters will show relationships between reported measures of self-esteem, drinking behavior, and depression.

H10. In families where the adolescent respondent, identified alcoholic parent and identified non-alcoholic parent all report low levels of family disruption and a high level of intact family rituals/closeness, there will be:

- (a) Higher scores on self-esteem,
- (b) Lower scores on depression,
- (c) Lower drinking behavior among adolescent respondents.

Variables

The independent variables are adolescent offspring (male and female) of alcoholic parents (mothers and fathers). The dependent variables are depression, self-esteem, drinking behavior, perceived family functioning, and perception of family rituals and closeness.

Definition of Terms

For the purposes of this study, the essential terms were defined conceptually and operationally as follows:

1. Adolescent offspring of alcoholics were conceptually defined as individuals between the ages of 12 and 18 who have at least one biological, alcoholic parent. The identified alcoholic parent was diagnosed as having alcoholism by a psychiatrist and was also currently involved in outpatient treatment for this problem. The second parent, or "spouse" of the identified alcoholic parent, was also the biological parent of the adolescent respondent. Spouse respondents were selected for the study based purely on their status as the married spouses of identified alcoholics, and may or may not have or had a problem with alcohol.

2. Similarly, identified alcoholic parents needed to have at least one biological child living at home between 12 and 18 years old who agreed to participate in this study. This child was defined as being the "adolescent respondent" in this study.

3. Depression was conceptually defined as an alteration in mood that included sadness, loneliness, and apathy. Depression was also characterized by a negative self-concept with self-reproaches and self-blame as well as activity level changes, either

retardation or agitation (Beck, 1967). Operationally, a respondent's level of depression was seen as his/her total score along the continuum of all possible scores using the Beck Depression Inventory (BDI) (Beck, 1967).

4. Self-esteem was conceptually defined as a positive or negative attitude towards one's self with high self-esteem reflecting that a person sees one as "good enough" and a person worthy of respect (Rosenberg, 1965). Self-esteem was operationally defined as the score on the Rosenberg Self-Esteem Scale (Rosenberg, 1965). The Rosenberg Self-Esteem Scale was used as a continuous scale in this study.

5. Family functioning was conceptually defined as the perception adolescent offspring or their alcoholic parents have of their current family units and/or families of origin in terms of overall family competence or disruption. Operationally, family environment was defined as the score on the Self-Report Family Inventory (SFI) constructed by Beavers & Hampson (1990). The Self-Report Family Inventory was used as a continuous scale in this study.

6. Drinking Behavior was conceptually defined as the self-reported drinking pattern, of the adolescent and adult respondents. Operationally, drinking behavior was measured by the Michigan Alcoholism Screening Test (MAST) (Selzer, Vinokur & van Rooijen, 1975). The Michigan Alcoholism Screening Test was used as a continuous score in this study rather than using it to define "alcoholic" versus "non-alcoholic" respondents. It was seen as potentially more useful to compare degree of drinking behavior among respondents rather than to create dichotomous respondent groups.

7. Family rituals were defined as family celebrations, vacations, and

holidays which are maintained by a family and contribute to a sense of closeness and stability as a family unit. Operationally, the perception of family rituals and family closeness was defined by responses to several self-report questions regarding these family events, replicating the questionnaire of Braithwaite & Devine (1993) and based on the theories of Bennett, Wolin, & Reis (1988).

Significance of the Study

Little is known of the statistical association between alcoholism in parental background (a risk factor, presumably) and development of later psychopathology in children, and even less is known of the variables that mediate this process (if they indeed exist). Available literature in this area is often complex. Numerous methodological flaws and hypotheses in the research literature allow for little confidence in drawing conclusions or in generalizing to other studies.

This study was significant in that it explored parental alcoholism as a risk factor in the development of children's psychopathology while exploring possible intervening variables that could potentially buffer an adolescent's experience of growing up in an alcoholic family. The study sought to address some of the questions related to identifying which adolescents might be more at risk when growing up with an alcoholic parent and also identifying factors that support resiliency and healthy mental health.

The study also explored how individuals with a history of alcoholism transmission in their family systems might present differently in terms of depression, self-esteem, and alcoholic behaviors, in contrast to family systems where alcoholism is not seen in other generations. By exploring the family-of-origin experiences of the alcoholic

parents and their spouses, the study was able to ascertain whether intergenerational relationships existed that could impact present parenting skills, the establishment of family environments, and the presence or absence of family rituals in respondents' present families.

A basis premise of this study was the possibility that alcoholism, per se, might be nearly irrelevant in understanding the degree of stress occurring in each child's life. Instead, the prediction of vulnerability to psychological distress based on risks defined only in terms of parental alcohol abuse was seen as overlooking processes that appeared to be critically important. The experiences of an adolescent in a family setting and relationships with not only an alcoholic parent but with both parents, as well as in a larger sense, the adolescent's parents' experiences with their parents, could all contribute to an understanding of the family environment and risk versus buffering factors.

Results of this study added to understanding more about adolescent COAs and their relationships in alcoholic family systems. The study contributed new ideas regarding the identification of adolescent children of alcoholics who may be more at risk and possibly in need of early intervention and attention by treating professionals. The study also explored the intergenerational transmission of alcoholism from grandparent to parent to child in respect to family competence, perceived level of closeness between family members, and presence or absence of family rituals. Lastly, the results of the study contributed to the under-researched area of alcoholism and women, with particular emphasis on the role of alcoholic mothers and their adolescents -- research not addressed previously in the literature and yet of prime importance to the field.

CHAPTER II

Review of the Literature

Weakness of the COA Literature

As suggested in Chapter One, because of serious methodological inadequacies of the empirical literature regarding offspring of alcoholics, few definite conclusions are possible. In this chapter, weaknesses in sampling, in defining alcoholism, in providing adequate controls and objective instrumentation, and problems with gender bias will be highlighted in the context of an overview of the relevant literature.

Problems in sampling.

In a review of 27 studies conducted by Windle & Searles (1990), sampling problems were abundant. Many studies had sample sizes that were small and unrepresentative. For example, 18 studies were based on samples of fewer than 100 children. In addition, much research has been based on select populations such as college students, juvenile delinquents and children in treatment. These cannot be accurately generalized to the population at large.

In a survey of the previous research on children of alcoholics, especially adolescent children of alcoholics, there appear to be two prevalent methods for obtaining samples for study. The first is by examining populations of children already in trouble or already in treatment. The second method, also widely used, assesses children whose parents are already in treatment for alcoholism.

The generalization of research findings using these two methods of sampling seems hazardous since it is known that most alcoholics are not in treatment, nor are most children of alcoholics part of a clinically-defined group. In general sampling COAs who are themselves in treatment will tend to overestimate psychopathology among COAs (Tarter, et al., 1984). One can speculate on the ways in which the offspring of alcoholics-in-treatment might differ from the children of their untreated counterparts. The former group may have more seriously ill parents. That is, alcoholics in treatment might show greater symptomatology or longer duration of the drinking problem, so as to have found their way into treatment through legal necessity or medical imperative. Alcoholism might, among alcoholics-in-treatment, be confounded with socioeconomic bias associated with samples drawn from treatment facilities, with the "downward social drift" phenomenon said to characterize some alcoholics, or with additional effects attributable to higher family disruption rates (e.g., because of incarceration or higher rates of divorce or desertion).

A third method, less widely used, samples children from a general population and identifies those considered to be "at risk" on the basis of parental alcoholism. This last-considered method does not eliminate sampling bias entirely because of introducing other methodological problems such as defining alcoholism.

Of special note, when alcoholic mothers and their offspring are studied, it is important to determine the extent to which active alcoholism or heavy drinking was present during pregnancy. If possible, in an effort to exclude those research participants likely to have had significant prenatal exposure to alcohol or to place those research participants in a separate group for analysis (or to employ some other method of statistical control).

Research participants with excessive prenatal exposure may exhibit cognitive or behavioral dysfunction attributable to teratogenic effects of alcohol which will seriously complicate interpretation of obtained data (Sher, 1991).

Problems in defining alcoholism.

The validity as well as the reliability of much of the existing research on the offspring of alcoholics is affected by the absence of an objective, precise, operational definition for alcoholism. A few studies examining children use the subjective term "parent with alcohol problems" or parent who is a "heavy drinker" rather than quantify the extent to which a parent is an alcoholic (Blane, 1977).

In general, early alcohol research was founded on alcohol-use status of the parent from clinical records, from interviews with the children themselves, or from inferences by persons of varying sophistication in the alcohol-abuse area. An early study by Kammeier (1971), for example, relied on the subjective judgements of two high school guidance counselors to determine parents' alcoholism status.

In part, this dilemma may reflect conceptual confusion about the nature of "alcoholism" and the way in which alcohol abuse may or may not be viewed as a symptom of other, underlying pathology that predates and explains the alcohol abuse. Very few researchers have attempted to discriminate a primary from a secondary alcoholic, and even fewer studies of alcoholics' children have considered this distinction. There is some evidence supporting greater heritability among male offspring for the more severe, early onset form of alcoholism, called Type 2 alcoholism (Cloninger, 1987). Type 2 alcoholism has been associated with a more extensive family history of alcoholism, suggesting that having

multiple relatives with alcoholism (at least the paternal bloodline) is associated with greater genetic risk than having one alcoholic relative (Cloninger, 1987).

An implicit difficulty in arriving at even a working definition of alcoholism as a unitary construct (e.g., in terms of onset, course and outcome) persists in spite of the lack of empirical support for such a position (Pattison, Sobel & Sobel, 1977). Alcoholism has been better described as a "final common pathway" (Chafetz, Blane & Hill, 1971) with those labeled as alcoholic sharing little other than the fact that they "drink too much." Thus the problem in defining alcoholism raises theoretical issues that would be problematic for the most rigorous of methodologies; nevertheless, most researchers have not attempted to define alcoholism in a reliable way.

To paraphrase Mark Keller (1976), the problem in alcohol research is not the absence of a convincing definition, but the presence of too many. Even if one were able to assess the presence of a process called "alcoholism" carefully and to measure it reliably, one would be confronted with the reality that the affected individuals are far more different than alike. Specifically, many persons, with many different kinds of pre-morbid and concurrent difficulties, for a variety of reasons (none of which may be necessary, though each is sufficient in an individual case) begin drinking excessively.

Problems with adequate controls.

In what has since become a landmark study, Cork (1969) contacted a large number of alcoholics who were in treatment or who had formerly been in treatment and found 62 sets of parents (with 115 children) who were willing to participate. Cork herself interviewed each child, had each child complete a questionnaire, and on these bases estimated the degree of

emotional damage each child manifested. Eight percent were described as "slightly damaged," 49% as "fairly seriously damaged," and 43 % as "very seriously damaged."

While this study appears to be rich sources of hypotheses about the impact of parental alcoholism on children, it also illustrates most of the methodological problems discussed, particularly those involving the validity of the data. Because the investigator interviewed the children herself, and because no control group was used, her evaluation of the children's psychosocial functioning (upon which her global "damage" ratings depended) was hardly independent of her knowledge of his or her status as the child of alcoholics. Similarly, many studies of alcoholics' children lack an adequate comparison population (e.g., Aronson, 1963; Cork, 1969; Haberman, 1966; McLachlan, 1985; Nylander, 1963) and /or the evaluator is not blind to the hypotheses under investigation.

An additional problem exists in determining just what an adequate control group for comparison with children of alcoholics might be. Children of alcoholics are usually simply compared with children of non-alcoholics, if they are indeed compared with anyone and usually these respondents are in treatment (e.g., Chafetz, et al., 1971; Fine, Yudin, Holmes & Heinemann, 1976). It is unclear whether this kind of simplistic dichotomy is appropriate, or whether a great deal more might be learned about the unique impact of parental alcoholism by including children of parents with other kinds of chronic illness or psychiatric disorders.

Problems with objective instrumentation.

Frequently in the literature, the nature of the impact of a parent's alcoholism on a child or adolescent's development is inquired about in a relatively unstructured way.

Clinical, observational interviews are often used and no attempt is made to quantify data.

This results in a lack of replicability (e.g. Cork, 1969). When some attempt is made to use measures such as questionnaires or problem checklists, the instruments used are frequently unreliable, and no statistical techniques are employed to determine the possible significance of the data. For example, in much of the research prior to the mid-1970's, information about children's adjustment was obtained from even more dubious sources than children's unstructured accounts or from similar reports from parents. For example, school records or counselor's impressions have frequently been used. Objective, empirically adequate measures of psychopathology have rarely been relied on to determine the adjustment status of alcoholics' children.

A further problem related to measurement exists in that no two studies utilize the same behavior rating scale or self-report measure. Some investigators utilize their own measures or use established but inappropriate measures designed for non-institutionalized samples of COAs, according to a review by Blane (1977).

Problems with gender bias.

Until slightly more than ten years ago, the issue of female alcoholism was seldom addressed in clinical or research literature (Nixon, 1993). Despite this phenomenon, six million women or 6% of the adult female population are alcohol abusers or alcohol-dependent (as compared to 12.1 million men or 14% of the adult male population) (NIAA, 1985). Although the male-to-female alcoholism rate appears to be 2:1 (NIAA, 1985), the ratio does not carry over to the prevalence of women in treatment programs. Within Alcoholics Anonymous, the male to female ratio is 3:1 (NCA, 1990). Women constitute less

that 20% of all clients within alcoholism treatment, nationally; hence, a significant gender disparity exists between prevalence of the problem and access to or utilization of care (Beckman & Amaro, 1984). Mothers who were also alcoholics, have also bore 3,700 to 7,400 babies in the United States with Fetal Alcohol Syndrome and an additional 11,000 to 18,500 babies with Fetal Alcohol Effects (Children of Alcoholics Foundation, 1998).

Despite the prevalence of female alcoholics, they are underrepresented in the treatment population, according to Ackerman (1990) because: (1) there are few facilities geared to the needs of women, (2) women alcoholics are less visible because they are less likely to work outside the home, and (3) women alcoholics are both ignored and protected by families and physicians because of the greater stigma associated with the heavy alcohol use by women.

Bergh (1991) noted that women are also underrepresented in addiction treatment because of sex-role stereotypes and lack of financial resources. While family and friends are frequently the motivators and proponents for men to get treatment, those same groups have actually been shown to deter women from getting help (Beckman & Amaro, 1984). Working women tend to be occupationally segregated in jobs that are low-paying, and they are also less likely to be recipients of healthcare insurance that could offset the costs of treatment.

Women's responsibilities as primary caretakers for children also serve to deter their access to treatment services. Many women may fear losing their children through family-court action if they admit to an addiction problem. Provisions for the care of one's dependent children must be arranged if a woman is to enter treatment. If she does not have family or other social-network resources to assist her and if a treatment center has no provisions for

assisting women with childcare needs, entry into a treatment program maybe precluded (Bergh, 1991).

In addition to the problems created by the manner in which the sample is collected, the samples of children of alcoholics reported on have been largely male (Windle & Searles, 1990). As El-Guebaly and Offord (1976) remarked in their review article on the offspring of alcoholics, " the effects of parental alcoholism on females are often neglected. Daughters of alcoholics receive much less attention than sons despite the fact that as future wives and mothers their impact is as important as that of their male counterparts" (p.363). Implicit in this statement is the myth so often found in this literature and in clinical circles as well: namely, that only men can become alcoholic and that only fathers can exert a negative impact because of their alcoholism. The implication is also that daughters of alcoholics should be studied primarily because of their influence on their husbands and children, not because of their own potential to develop alcoholism or other problems. Such attitudes, which seem to view alcoholism as a fundamentally male problem, may be partly responsible or the inattention to the impact of parental alcoholism on daughters.

One of the limitations of previous research is that studies have neglected to make a distinction between paternal and maternal alcoholism in respect to their potential impact on the family environment and possible modeling effects. In addition, most studies have identified the father as the alcoholic parent and have given little or no attention to the mother as the alcoholic parent, with the exception of those studies that have investigated "fetal alcohol syndrome" -- the impact of maternal drinking on the developing fetus in the womb.

Only one study, to date, has specifically looked at what difference it may make in

the family environment as to which parent is identified as alcoholic. In this study, conducted by Berkowitz and Perkins (1988), it was suggested that the most serious impaired adolescents were sons of alcoholic mothers.

Although cited in a review of the literature in an article by Hibbard (1993) and frequently mentioned in studies as a variable to address in future studies, no research has been forthcoming in the area of alcoholic parent/adolescent child gender identification. Of significant note, recent research in the field continues to deny and/or minimize the impact of female alcoholism in the family environment. A study by Sher (1993) with only a sampling of children of male alcoholics noted that the possible sample size for children of maternal alcoholics was "too small" for inclusion to his study. Similarly, Donald, Dunne and Raphael (1993), in their research on young women with alcoholic parents, indicated that:

Fathers' consumption was used to categorize the sample rather than mothers' consumption because previous research [see Cotton, 1979, for review] indicated that fathers' drinking has more influence on children's drinking than mother's drinking and because we found very few women in this sample who reported high drinking (p.962).

One wonders whether or not these researchers had reviewed articles beyond 1979 indicating the need to address maternal alcoholism. A study by Cooper, Peirce and Tidwell (1995) did include gender of alcoholic parent when examining the mediating effects of demographic and familial factors on adolescent offspring. Unfortunately, 97% of the families studied were headed by only one parent (the mother). Results from this study might have been confounded by the stress inherent in single-parent families and not just the

alcoholism.

Little recognition is given to the fact that, even more frequently than men, women alcoholics report a history of alcohol abuse in their families of origin and in their nuclear families as well. Wall (1937) discovered that 28% of the female alcoholics studied had an alcoholic parent. Sherfey (1955) found family histories of alcoholism among 68 % of the female alcoholics she studied in comparison with 41% of the male sample. Lisansky (1957) noted that 44% of her female alcoholic sample, in contrast with 35% of her male sample, had parents who abused alcohol. Wood and Duffy (1966) reported a majority (51%) of the alcoholic women they studied to have had alcoholic fathers. Corrigan (1980) in his study of women in alcoholism treatment found that 61% of respondents had a relative with a drinking problem and 40% had an alcoholic parent. A study by Gomberg and Lisansky (1984) linked women's alcoholism to the disease's prevalence in their mothers, rather than in their fathers.

Problems with generalization to adult psychopathology.

As Wilson and Orford (1978) pointed out, a major problem in drawing any conclusions, however tentative, about children of alcoholics is that a wide age range is covered. It is difficult, for example, to compare findings about newborns with fetal alcohol syndrome with data about adolescent delinquency problems.

Given the methodological problems already discussed, there appear to be several particular categories of problems for adolescent children of alcoholics who are reported frequently in both the longitudinal studies and when clinical populations of adolescents in treatment are studied retrospectively for a history of parental alcoholism. These problems

and illnesses include juvenile delinquency (MacKay, 1961, 1963), hyperactivity (Cantwell, 1972), victims of child abuse (Mainard, et al, 1971; Young, 1964); anorexia nervosa (Halmi & Loney, 1973), and drug abuse (Judd & Mandell, 1972; Lidberg, 1970).

A more salient question than the nature of the problems shown by offspring of alcoholics while they are children concerns their eventual adult adjustments. Even the most often corroborated problems these children are thought to experience (i.e., emotional disturbance and antisocial behavior) shed little light on the nature and extent of the difficulties these children will experience in maturity.

Problems with research focus: Casualties or copers?

Much of the evidence in supporting the premise that offspring of alcoholics are at long-term risk has come from the retrospectively reconstructed family histories of adults who are already receiving treatment for alcohol problems. Few existing long-term studies of offspring of known problem drinkers have been conducted (Miller & Jang, 1977; Rydelius, 1981). Hypotheses and unproven claims about COAs are frequently quoted in articles such as the one by Whitfield (1980) in the Maryland State Medical Journal in which it is stated that: "Although unproven, they (COAs) probably have a higher incidence of depression, functional (psychosomatic) illness, and difficulty relating to the opposite sex. It has been estimated that 80% of all adolescent suicides may be COAs" (p.2).

Researchers studying the children of alcoholics almost universally assume that the children will in some manner be casualties of the parental drinking problem. The task then becomes one of finding the "defects" and pathology in this population. In an often-quoted and seldom challenged passage, Fox (1962) wrote: "Of all of the illnesses that

affect family life, none is more devastating than that of alcoholism" (p.38). In the empirical literature as well as the clinical circles, the notion of great and lasting damage is implicit.

A study by Cork (1969) was one of the first studies to suggest the probability of psychological disturbance among COAs and one of the few studies of any kind, that includes data on the drinking behaviors of COAs. In this study, Cork interviewed 115 children of alcoholics, aged 10 to 16, asking them questions about their family lives and the affects of their parents upon them. Cork concluded that over 90% of the sample lacked self-confidence, felt rejected by their parents, and expressed that their parents' behavior was "unpredictable." Over 50% were "constantly angry" with their parents, anxious and defiant toward authority, and felt that they had too many responsibilities at home. Numerous methodological problems aside, how might this contrast with a "normal" group of adolescents? Unfortunately, studies like this one have been the cornerstone of the research on children of alcoholics.

In a descriptive and exploratory study by Chafetz, Blane and Hill (1971) comparing two groups of children on personal and familial characteristics with the two groups differing only in terms of presence or absence of parental alcoholism, the authors cited "distinct and deleterious social consequences" (p.102) in being a COA. However, it is essential to note the serious methodological problems in this study, which make this conclusion questionable. First, the sample was composed of children in treatment at a child guidance center, and all of the participants had psychiatric diagnoses. This makes generalization to the children of alcoholic population at large impossible without a non-

institutionalized sample involved. Secondly, the author's conclusion is brought into question because it is also not clear whether these "consequences" result from the alcoholism of the parents or from the higher incidence of family instability, or other factors.

In 1979, an article in Newsweek from May 28, 1979 (Brown, 1979) went even further in claiming that even children of alcoholics who appear to be doing well initially are in for trouble. A kind of "sleeping effect" will eventually surface in the adult lives of the "copers" who have had to struggle too long and too hard to maintain the appearance of adequate or even superior adjustment. Dr. Stephanie Brown, Associate Director of the Stanford Medical Center Alcohol Clinic, was quoted in this article as claiming that: "There is an entire population of children who grew up looking so good, acting so perfect, and achieving so much. Then, in their 20's and 30's, things begin to fall apart. My research shows that more than half of them will turn to alcohol and perpetuate the problem from generation to generation."(p. 82)

Yet it is known that some children with alcoholic parents (in fact, probably most) do not develop serious psychopathologies or at least are not treated for their problems (El-Guebaly & Offord, 1977). A number of fairly recent studies have indicated that long-term risks to offspring may have been exaggerated (Benson, 1980; Clair & Genest, 1987; Knop, Teasdale, Schulsinger, & Goodwin, 1985; Werner, 1986). While one would not wish to minimize the anguish that may be involved in growing up in such a setting, the case for a permanent deficit in coping ability created by being the son or daughter of an alcoholic parent has not yet been reliably proven.

Another closely-related assumption affecting research concerns damage not only to children in an alcoholic's family, but the belief that alcoholism is also always maladaptive for the functioning of a marriage or larger family system. There is, however, growing empirical support for an interactional model of chronic alcoholism (e.g. Berenson, 1976; Janzen, 1977; Steinglass, 1976) in which alcohol abuse is seen as "an adaptive response to specific intrafamilial issues and is retained to provide interactional continuity" (Wolin, Steinglass, Sendroff, Davis & Berenson, 1975, p.654). This model features systems analysis of the contingencies which maintain abusive drinking, and implies strongly that, in some cases, the alcoholism itself may result from familial dysfunction rather than precede and presumably cause it (e.g., Steinglass, Weiner & Mendelson, 1971). This view involves exploring the contributions that alcohol abuse may make toward greater health and integration and is sensitive to the adaptive consequences that drinking may have for some family members or for the family system as a whole. Several studies employing process analysis of family interaction during experimentally manipulated intoxication suggest that, when drinking, an alcoholic may be more likely to engage in behaviors positively valued by one's family, such as increased ability or willingness to express tender feelings or appropriate assertiveness (Weiner, Tamerin & Steinglass, 1971).

The whole concept of being "at risk" for the development of anything is a very complex one. However, it appears that regardless of what process is being studied (with a few exceptions), more offspring survive rather than succumb to the ill effects of parental pathologies. A number of studies have begun to explore this idea of focusing on offspring

invulnerability rather than pathology, including early studies by Anthony (1974) as well as Murphy and Moriarty (1976). Anthony (1974) described these paradoxes associated with risk and vulnerability eloquently:

Two children from the same stock, the same womb, the same propitious or unpropitious environment may end quite differently with one falling psychologically ill and the other apparently blossoming. A superchild may come out of the ghetto and a sad and sorry child from the well-to-do suburbs. Why and how? By what mysterious process of psychological selection is the one destroyed and the other preserved." (Anthony, 1974, p.533)

Similarly, Hindmen and Small (1984) made the following comment:

Certainly, not all COAs become alcoholic in adulthood and not all develop major problems. In fact, there may be "benefits" to children who grow up in a family where the alcoholic member is recovering. Research needs to look at the so-called "invulnerables," the people at risk who don't develop any problems. We need to find out how many of these there are and why they escape problems. (p.4)

" Risk" in relation to alcoholism research.

An analysis of the risk to which a child has been exposed on the basis of parental alcoholism is complex and challenging. It may be that the risk for adolescent COAs does not stem from a parent's disease itself, but from the associated psychosocial disturbance in the family, as suggested by Billings and Moos (1983). The context in which problem drinking develops, the interaction with the general family climate, the age of the child during the time the drinking problem was most critical, as well as the duration and

severity of the drinking-related problems may all need to be considered (Wilson & Orford, 1978). According to Wilson and Orford (1978):

An 8-year old girl living with a parent since infancy and an 18-year old boy living with a parent whose alcoholism is of recent onset are both children of alcoholic parents, but the impact must be expected to be quite different (p.140).

Two theories are outlined by Su and associates (1997) that might explain parental influences on the possible resulting pathology and adjustment among adolescents. The first theory involves social-learning theory, as previously discussed in Chapter One and the second is called "stress-coping theory". This theory is based on the proposition that parental psychopathology (substance use, depression, etc.) increases an offspring's risk of experiencing other family stressors. This further assumes that family stressors are associated with substance-abusing parents or a parent and their family functioning, which in turn leads to negative outcomes in children (Seilhamer & Jacob, 1990; West & Prinz, 1987).

An important consideration to the analysis of a COA's risk is the non-alcoholic spouse's degree of health or pathology and the possible "compensation" or buffering he/she can provide to potential negative consequences of an alcoholic parent. Social support was seen as a key variable in moderating the relationship between life stress and a host of negative outcomes in studies conducted by Barnes & Farrell (1995), Booz-Allen & Hamilton, Inc. (1974), Caplan (1981), Cohen & Wills (1985), Dean & Lin (1977), and House & Kahn (1985).

According to Moos and Billings (1982), it is essential that researchers and clinicians

take into account the variety of parental and family variables often related to children's levels of health functioning. They advocate that in addition to the extent of alcohol consumption and drinking problems, the emotional, physical, and occupational functioning of both parents and their methods of coping with stress need to be defined because they provide incremental information in predicting their children's emotional health. Characteristics of the family system, such as the occurrence of undesirable life change events and dimensions of the family environment, were also seen as significant predictors of children's emotional symptoms.

Other related areas of consideration might be either the presence of possible support outside the immediate family which is available to children of alcoholics and the specific personality characteristics of individual children growing up in alcoholic families (Windle, 1990). Critical studies of the COA literature (Blane, 1977; El-Guebaly & Offord, 1977; Seilhamer & Jacob, 1990) have pointed to the need to focus on factors such as age and gender of the child, family structure, poverty, and other measures of interfamilial stress or conflict. Werner (1986) is among those researchers advocating that research regarding gender of the parent with a drinking problem be explored and is also among those suggesting that the outcome may be worse when mothers have drinking problems. Miller and Jang (1977) have espoused studying the interaction of the child's gender and that of the parent with a drinking problem, suggesting a worst outcome when the parent of the same gender has a drinking problem. With the multitude of possible variables, one wonders about the likelihood of uncovering a main effect for parental alcoholism on children's development at all.

From studies of children's psychological status when experiencing parental psychosis, it has been apparent that biological factors interact with environmental factors to influence developmental outcomes (Anthony, 1987). Anthony proposed three possible outcomes for children:

1. Group One: Children who have a very high probability of negative developmental consequences. These children would experience both an intrinsic predisposition to adjustment difficulties and also a high-risk environment.
2. Group Two: The majority of children. These children experience intrinsic vulnerability within a protective environment. These children would experience a moderate risk environment and some adjustment difficulties.
3. Group Three: Children experiencing an absence of vulnerability yet living within a high-risk environment.

Groups Two and Three may be quite likely to avoid psychological impairment, as long as they remain protected in one or the other domain. In an analogous fashion, adolescent children exposed to parental alcoholism may be categorized along these dual continua of intrinsic vulnerability and environmental risk to more accurately anticipate and predict the probability of adjustment difficulties among specific sub-populations. Thus, it would be essential to clarify the factors that relate to the vulnerability and risk continuum (Begun & Zweben, 1990). Barrera, Li and Chassin (1993) stressed a distinction between "exposure to stress" and "vulnerability to stress" as essential in studying the possible effects of parental alcoholism within a family.

In summary, it appears that the adoption of a process-oriented developmental theory

to explore the myriad of influences upon a specific area of development and to include attention to diverse populations as well as variability in developmental outcomes is important in understanding "risk" for adolescent COAs.

Adolescent Drinking Behavior

Frequency of use and age of onset.

Alcohol use among adolescents is a major public health problem in the United States because of its prevalence and association with a host of health and social problems. Alcohol usage has remained at a stable and relatively high level since 1975 with 93% of high school seniors stating usage "at some time in their lives"(Addictions, 1998). The statistics vary, yet best estimates indicate that there could be more than 4 million American alcoholics under the age of eighteen. Early experimentation with alcohol is a risk factor for subsequent alcohol and drug abuse (Gruber, DiClemente, Anderson, & Lodico, 1996; Hawkins, Graham, Maguin, Abbott, Hill & Catalano, 1997), motor vehicle crashes (National Highway Traffic Safety Administration, 1990), and juvenile violent crime (Dawkins, 1997). Drugs or alcohol abuse has been found to be a contributory factor in over 50 % of motor vehicle accidents involving teens (Parrish, 1994). Youth who begin drinking at age 13 are twice as likely to become alcoholics as youth who began drinking at age 17 and five times more likely than those who begin at age 21 (Grant & Dawson, 1998). In addition, national trend data show that male adolescents report drinking more frequently and more intensely (measured by binge drinking and drunkenness) than do females (Johnson, O'Malley, & Bachman, 1995).

In at least two recent studies with large samples, it has been reliably

demonstrated, both statistically and clinically, that significant elevations in alcohol and drug use exist among COA adolescents both in early adolescence (Chassin, Rogosch & Barrera, 1991) and in late adolescence (Sher, Walitzer, Woors & Brent, 1991). Some researchers are reporting an earlier age of onset and higher frequency of drinking among the adolescent offspring of alcoholics as compared to the adolescent offspring of non-alcoholics (e.g., Chassin, Barrera, Molino, Pillow & Curran, 1993; Herjanic, Herjanic, Penick, Tomelleri & Armbruster, 1997; McCaul, Turkan, Suikis & Bigelow, 1990; Sher, 1991) while others have failed to find any effect of parental alcoholism on adolescent drinking behavior (e.g. Alterman, Searles & Hall, 1989; Knop et al., 1985). It may be that parental alcoholism is more predictive of adolescent drinking problems than quantity—frequency of alcohol use (e.g. Pandina & Johnson, 1990; West & Prinz, 1987).

Relationship of alcohol use and family history of alcoholism.

Alcoholism has long been considered by clinicians and researchers to be a familial disorder. In a review of 39 studies, the rates of alcoholism were substantially higher in relatives of alcoholics than in relatives of non-alcoholics, even when the non-alcoholic were psychiatric patients (Cotton, 1979). In a study conducted by Werner (1999), 38% of Americans stated that they had a family member with alcoholism. Regardless of the nature of the population studied, it was found that alcoholics were more likely to have a mother, father, or more distant relative who was an alcoholic (Clapper, et al. 1994; Werner, 1999). In two-thirds of the studies of alcoholics reviewed by Blacker (1966), at least 25% of alcoholics sampled had fathers who were also alcoholics. In a study of alcoholics by Lisanky (1957), approximately one-half of the women and one third of the

male alcoholics came from families in which at least one parent was an alcoholic. Nine percent of the siblings of male alcoholics as compared to 24% of the siblings of female alcoholics were also reported to be alcoholics. Barnes and Welte (1990) reported that if either parent was a heavy drinker, as opposed to an abstainer, adolescents were much more likely to be heavy drinkers themselves. In a study by Orford and Velleman (1991) involving one hundred and sixty-nine offspring of alcoholics, aged 16-35, it was found that women who had a positive relationship with an alcoholic father were at greater risk for alcohol or drug abuse.

Brook, Whiteman, Gordon, & Cohen (1986), McGue, Sharma & Benson (1996), and Rowe & Gulley (1992) also investigated the relationship between sibling alcohol use and adolescent involvement, indicating that the magnitude of this relationship appears to be stronger than that observed with parental alcohol use.

Gender differences and drinking behaviors in families.

In a study by Wall (1973), 51% of female alcoholics had one or more relatives in the preceding generations who were problem drinkers. More recently, higher rates of alcoholism have been observed in families of females rather than male alcoholics (Jackson & Connor, 1953; Jones, 1971; Rathod & Thompson, 1971; Russell, Henderson & Blume, 1985; Winokur & Clayton, 1967,1968; Winokur, et al., 1970). The finding that female alcoholics are more likely than male alcoholics to come from families in which pathological drinking occurred would seem to indicate that women are more vulnerable than men to the impact of familial alcoholism. Ongoing research observations continue to indicate that the incidence of alcoholism women is increasing (Russell, et al., 1985).

Schukit (1994) examined the family histories of women having primary alcoholism or primary affective disorder. They discovered that rates of alcoholism and affective disorder were similar in the relatives of both groups of women--the male relatives tended to be alcoholics, and the female relatives tended to have the same primary disease as the patient. For example, alcoholism was seen significantly more often in first-degree female relatives of primary alcoholics while affective disorder was seen significantly more often in female relatives whose primary disease was affective disorder.

Genetic transmission of alcoholism: The biological factor

Many studies in the alcoholism field focus on the genetic, intergenerational transmission of alcoholism. Schuckit (1982; 1983; 1985; 1994) proposed that both genetic heterogeneity and environmental influences combine in an unknown manner, placing some people at high risk and others not at risk for developing alcohol abuse or dependence. In

high-risk individuals Schuckit described a decreased response to alcohol as a genetic factor (Johnson, O'Malley & Bachman, 1995).

Cloninger (1987) pointed to characteristics of two categories of male alcoholics: "Type I" alcoholics and "Type II" alcoholics. Type I alcoholics were described as having greater genetic loading and tended to display an earlier onset. Type II alcoholics were described as likely having environmental pressures and experiencing a later onset of alcoholic drinking.

Robert Cloninger (1997) later proposed that alcoholism could be caused by "inherited personality traits". Cloninger suggested that genotypes of alcoholics, when present at childhood, could predict, with an 80 percent accuracy rate, who was going to develop alcoholism later in life. He further suggested that the personality traits signaling a person had the tendency to become an alcoholic were "anxiety, shyness, pessimism, impulsiveness, and aloofness" (Cloninger, 1997, p.411).

Fetal alcohol syndrome.

Despite the fact that women's drinking rates have remained relatively constant since the 1960's (Larkby & Day, 1997), the rate of drinking during pregnancy appears to be increasing. For example, the Behavioral Risk Factor Surveillance System reported that among pregnant women, the rate of drinking increased from 12.4 percent in 1991 to 16.3 percent in 1995 and that the rate of frequent drinking was four times higher in 1995 than in 1991, increasing from 0.8 percent in 1991 to 3.5 percent in 1995 (Center for Disease Control and Prevention, 1997). These patterns are in contrast to the publicized awareness of the dangers of fetal alcohol exposure. Initially identified in the late 1960's,

the dangers of fetal alcohol exposure were outlined in a 1981 U. S. Surgeon General 's health advisory recommending that women who are pregnant or planning a pregnancy should not drink alcohol, and then this advisory was repeated in 1990 and 1995 (Larkby & Day, 1997). Similarly, since 1983, the American Medical Association has recommended that physicians advise women against drinking during pregnancy because of the potential dangers of alcohol consumption to a fetus (Waterson & Murray-Lyon, 1990).

Pregnant alcoholic women risk the health of their offspring in multiple ways. First, the physical consequences of alcohol in the mother (e.g., falls or malnutrition) may independently affect the developing fetus (Larkby & Day, 1997). Secondly, genetic vulnerability to alcohol in the fetus may increase the effects of prenatal exposure (Larkby & Day, 1997). Thirdly, the lifestyle of an alcoholic parent may lead to negative consequences to the fetus, the pregnancy, and the developing child (Larkby & Day, 1997). Of significance, research by Jackson (1997) suggested that, even though a mother may not be labeled an "alcoholic", her child may not be spared the effects of parental alcohol exposure. Research conducted by Jacobson and Jacobson (1994) has detected prenatal alcohol effects at moderate levels of alcohol consumption (i.e., between 3.5 and 7.0 ounces of absolute alcohol or the equivalent of 7 to 14 standard drinks per week).

Lastly, researchers have learned that prenatal alcohol exposure can have devastating effects on the developing fetus and that these effects can be viewed as falling along a continuum (Mattison & Riley, 1995). At the farthest end of the continuum are perinatal death and "fetal alcohol syndrome" (FAS). Jones and Smith (1973) coined the

term "fetal alcohol syndrome" to describe children who had a specific and visually recognizable pattern of characteristics. A FAS diagnosis is made when an alcohol-exposed infant exhibits pre- or postnatal growth deficiency (i.e., craniofacial anomalies) and some central nervous system dysfunction (Mattison & Riley, 1995; Cordero, Floyd, Martin, Davis & Hymbaugh, 1994). The diagnosis of FAS identifies only a relatively small proportion of children prenatally affected by alcohol (Connor & Streissguth, 1996). According to the National Institute on Alcohol Abuse (1990), fetal alcohol syndrome occurs at an estimated prevalence of 1-3/1,000 live births. Fetal alcohol syndrome is the leading cause of mental retardation in children (Black, 1993) and can be described as a birth defect that causes significant lifetime disabilities (Abel, 1990; Cordero et al., 1994). But unlike many other birth defects, FAS, which is caused by maternal alcohol use during pregnancy, is preventable (Cordero et al., 1994).

According to Black (1993), when a mother drinks heavily, the chances that her baby will have FAS are 30 to 40 percent. Black continues:

If mothers drinks during the first trimester of pregnancy, the baby's structure—mainly internal organs and the brain—might be damaged; in the second (if the mother doesn't miscarry), size and intelligence are most affected; in the third, intelligence is most at risk from the mother's drinking. (p. 55)

Children with fetal alcohol syndrome often have a smaller-than-expected brain size and a smaller head (Mattison & Riley, 1995) as well as reduction of the size of the cerebellum and the structures involved in the sense of smell. Ventricles may be enlarged, small, or absent (Mattison & Riley, 1995). Typically, children with FAS are mentally

retarded, with an average IQ of about 70 (Mattison & Riley, 1995). Specific cognitive deficits have been reported in several domains, including language, attention, verbal learning, and memory (Mattison & Riley, 1995).

In an article published by the National Education Association, Stephanie Weiss described children with FAS or FAE (Fetal Alcohol Effects) as tending to be hyperactive and distractible, having attention deficits, speech problems, and learning difficulties. Arithmetic, reading, and spelling deficits are very characteristic of these children. Ms. Weiss went on to further describe FAS children as tending to be impulsive, as having difficulty in appreciating consequences and in responding to subtle social cues. In general, they have poor social skills. According to Streissguth, Aase & Clarren (1991), as children with FAS mature, they demonstrate increasingly poor socialization and communication skills and commonly experience problems with alcohol and drug abuse and antisocial behavior.

In a 14-year longitudinal study by Baer and colleagues (1998) regarding prenatal alcohol exposure and family history of alcoholism on the etiology of adolescent alcohol problems, it was reported that prenatal alcohol exposure was more predictive of adolescent alcohol use and its negative consequences than was family history of alcohol problems. Prenatal exposure returned a significant predictive effect even after adjustment for family history and other prenatal and environment covariates (Baer, Barr, Bookstein, Sampson & Streissguth, 1998).

One of the first published studies concerning prenatal alcohol exposure on alcohol consumption among adolescent offspring was conducted by Griesler and Kandel (1998).

Results from this study suggested an increased vulnerability among female offspring to the deleterious effects of gestational alcohol exposure. The study reported that maternal drinking during pregnancy, particularly continuous moderate to heavy consumption, had a significant positive effect on adolescent daughters' current drinking, but a slight negative effect on sons' life time drinking (Griesler & Kandel, 1998). Maternal drinking during pregnancy was found to be associated with elevated rates of current drinking among female adolescent offspring (Griesler & Kandel, 1998).

The terms "fetal alcohol effects" (FAE) and "prenatal exposure to alcohol" (PEA) are sometimes used to describe people who do not exhibit all the features required for a diagnosis of FAS but for whom physical or behavioral problems are ascribed to prenatal alcohol exposure (Mattison & Riley, 1995; Connor & Streissguth, 1996). It is estimated that in the United States each year, one in 300 children are born with fetal alcohol effects (Black, 1993). A new category of prenatal alcohol exposure has been suggested by the Institute of Medicine (IOM) that would replace FAE (Connor & Streissguth, 1996). This classification, referred to as 'alcohol-related neurodevelopmental disorder' (ARND), is focused specifically on brain dysfunction in the presence of significant prenatal alcohol exposure (Connor & Streissguth, 1996).

Relationship between parental drinking patterns and adolescent consumption.

Much literature documents the relationship between parental drinking patterns and the level of alcohol consumption of adolescent children (e.g., Adler & Lotecka, 1973; Akers, 1968; Bacon & Jones, 1968; Barnes, 1977; Forslund & Gustafson, 1980; Fox, 1968; Greenley, et al., 1970; Johnson & Leff, 1999; McDermott, 1984; McLachlan, 1985;

NIAAAA, 1975; Prendergust & Schaefer, 1974; Rachal, et al., 1975, 1980; Roosa, 1988; Smart & Fejer, 1972; Stras & Bacon, 1953; Zhang, et al 1998; Zucker, 1976). In addition, all longitudinal studies involving investigating the relationship between parents' and children's substance use have led to the conclusion that, for both sexes, use of alcohol or drugs by parents increases the chances of use by children (Cahalan, 1969; Chassin et al., 1993; Johnson & Leff, 1997; Kandel, 1985; Margulies, 1977; McLaughlin, et al., 1985; Robins, 1966; Swain, 1991; Webb et al., 1991; Windle, 1997; Zucker & De Voe, 1973). Despite the belief that problem drinking is more prevalent among adolescent COAs than among the offspring of moderate drinkers or abstainers, the reason for this relationship has not yet been ascertained. Hereditarian explanations have gained some support, but they are to varying degrees confounded with learning (Goodwin, 1976; 1979a; 1979b; 1985).

Maddox (1966) noted that the first experience of alcohol is most likely to be in the home where parents serve as role models for alcohol use. Jessor (1968) reported parents' drinking behavior to be the best single predictor of the initial stage of adolescent alcohol use. Coombs and Dickerson (1981) found that the substance abuse behavior of both mother and father influenced their children's substance abuse behaviors. A minimum of one-third of children of alcoholics is expected to abuse alcohol according to Miller and Jang (1977). Children of alcoholics are also twice as likely to develop alcohol-related problems than children of non-alcoholics (Bosma, 1975; Goodwin, Schulsinger, Knop, Mednick & Guze, 1977). Not only are adolescents of alcoholic parents more likely to report heavy drinking themselves (Barnes, 1977; Templer, Ruff & Ayers, 1974) but

studies of alcoholics have shown that more severe symptoms and an earlier onset of alcohol use was positively related to a family history of alcoholism (Penick, 1978). Reich (1988) demonstrated strong cohort effects in age of onset of alcoholism, with more- recently born cohorts of both males and females demonstrating an earlier onset age of onset. This trend was particularly marked for females. Fox (1962) indicated that children might learn from alcoholic parents that drinking is an effective means of avoiding responsibility or punishment or of coping with stress.

Rouse (1973) examined the effect of fathers' drinking on a random sample of adolescents aged 15-21 years old who were living at home. The 186 adolescents in this study (87 males and 99 females) and their fathers were interviewed to determine whether or not a father's level of drinking behavior (abstaining, moderate drinking, heavy drinking) impacted the child's level of stress and anxiety, degree of expressed anger, and coping activities used to relieve depression and anxiety. Despite the methodological problems in this study, particularly in respect to questionable validity and reliability of the instruments, the study's implication that children of heavy drinking fathers drink alcohol significantly more at home is noteworthy.

In a study by Zhang, Welte, and Wieczorek (1998) regarding peer and parental influences on male adolescent drinking, the researchers found that parents and peers affect adolescent alcohol behavior both through their own drinking and also through their alcohol-related attitudes. The researchers also discovered that parental alcohol-related attitudes were more important than parental drinking, while peer drinking was more critical than peer alcohol-related attitudes. Peers were seen as having a more important overall influence on

male adolescent drinking than parents (Zhang, Welte, & Wieczorel, 1998).

According to research conducted by Lewinsohn and associates (1993) a stress and negative affect regulation model provides a plausible theoretical explanation for increased risk for substance abuse among adolescent COAs. Laboratory data suggest that young adult COAs derive greater stress response dampening benefits of alcohol use than do non-COA peers (Lewinsohn, Hops, Roberts, Seeley & Andrews, 1993). The presence of parental alcoholism is also associated with elevated levels of environmental stress among adolescent offspring, according to Roosa and colleagues (1988). Therefore, in following, if COAs experience elevated stress levels and if they experience greater stress response dampening effects of alcoholism, it would stand to reason that a stress and negative affect reduction mechanism may underlie the COA risk for alcohol substance use and abuse (Lewinsohn et al., 1993). Similarly, Fox (1962) suggested that children might learn from an alcoholic parent that drinking is an effective means of avoiding responsibility or punishment or of coping with stress.

Adolescent drinking behaviors, self-esteem, and levels of depression appear to be linked in the recent literature concerning adolescent COAs. Kaplan (1980) suggested that adolescents who suffered negative self-evaluations were more likely to seek out deviant peer networks as a way of repairing damaged self-esteem. Thus stress and negative affect may raise risk in early adolescent drug use not only through self-medication motives but also by increasing the likelihood of associations with a drug-use-promoting peer group.

In contrast to the vast majority of literature, a Canadian study by McLachlan (1985) reported no significant differences between adolescent COAs and normal controls

regarding drinking behavior. In this study, adolescent children of actively drinking alcoholic parents (COAs) showed the highest rate of abstinence (39% versus 30% for the control group). In addition, the control group (non-COA) had the highest rate of drinking--at least four times a month--and the children of recovered alcoholic parents, the lowest rate (41% versus 23%, respectfully). Data from this study, unlike other studies reviewed, voice the possibility that adolescent children of alcoholics have a lower prevalence and frequency of alcohol use than other adolescents.

The impact of gender on adolescent drinking behavior.

According to several studies, the gender of an adolescent and also of a drinking parent appear to be influential in the drinking practices of adolescents, but the conclusions differ. Parental use of alcohol is recognized as one of the most important factors in an adolescent's early use of alcohol and subsequent drinking patterns (Adler & Loteka, 1973; Alexander, 1975; Forslund & Gustafson, 1970; Johnson & Leff, 1997; Lassey & Carlson, 1980; Mandell & Ginzburg, 1976). A 20-year longitudinal study of children of alcoholics by Miller and Jang (1977) indicated that the negative impact of an alcoholic mother is significantly greater than that of an alcoholic father. The role of "social agent" primarily assumed by mothers evokes a more negative affect when that mother is also alcoholic. Forslund and Gustafson (1980) reported that whether or not a mother drank affected both the sons and daughters' drinking behavior. In contrast, they found that father's drinking affected daughters only, not sons, and then to a lesser degree than mother's drinking.

Cork (1969) found that children tend to be more disturbed by maternal rather than

paternal drinking, again supporting the possible serious influences of alcoholic mothers upon their offspring. In a study conducted by Smart and Fejer (1972) mothers' substance abuse was more closely related to the children's use than was fathers' use. The odds of greater alcohol use among children reporting moderate drinking by their mothers was over twice that of children who reported their mother as abstaining. Perceived heavy alcohol use by mother was associated with seven times the odds of greater alcohol use in early adolescents as compared to six times the odds for heavy-drinking fathers.

Studies by Greenley (1970) and Zucker (1976) contributed to the observation that parental influence affects adolescent daughters more than the drinking behavior of their sons. In work conducted by Widseth and Mayer (1971) and Zucker and Devoe (1975), heavy drinking by girls was related specifically to drinking by their mothers. This finding can be partly explained by the process of modeling by the same-sex parent, suggesting that a mother's parenting role is perhaps more crucial in determining the drinking-behavior patterns of her daughter. Barnes (1977) also reported that daughters of alcoholic parents drank somewhat more heavily than the daughters of non-alcoholic parents. Ensminger (1982) found that family closeness was more important than peer relationships in determining lowered substance use in girls whereas peer relationships were more important determinants for boys. A meta-analysis of the relationships between sex-of-parent and sex-of-offspring on the transmission of alcoholism (Pollock, Schider, Gabrielli & Goodwin, 1987) indicated that, across family studies, paternal alcoholism is associated with increased rates of alcoholism in both sons and daughters and maternal alcoholism is associated only with increased rates of alcoholism among daughters. A

study of 169, 16 to 35- year-old offspring of alcoholics conducted by Orford and Velleman (1991) demonstrated that female respondents who had a positive relationship with an alcoholic father were at greater risk for alcohol or drug use.

In an investigation of the recollections of young adult offspring of alcoholic parents, Velleman and Orford (1990) discovered that offspring of alcoholic mothers recalled significantly more negative childhood experiences than children of alcoholic fathers despite the fact that the onset of maternal drinking problems was estimated to be on average four years later than similar paternal problems. Mothers were significantly more likely to have drunk regularly at home according to their offspring. This lends support to the view that maternal problem drinking may have a greater impact upon children because of the greater involvement of mothers in childcare roles (e.g. Werner, 1986).

Despite a word of caution given by Biddle and associates (1980) regarding parental influence on drinking behavior of adolescent daughters because of their finding that parental norms affect the drinking of younger adolescents (13-14) and older adolescents (17-18) but not middle adolescents (15-16), the vast majority of literature fully supports a correlation between parental influence and drinking behavior among adolescents of all ages. In addition, daughters appear to be more strongly influenced by parental practices, regardless of peer-pressure level (Forsland & Gustafson, 1980). Alcoholic parents may not only provide models for drinking and access to alcoholic beverages, but they may also be impaired in their abilities to monitor their children's behaviors (Dishion, 1988).

Summary: Drinking behavior.

In the research concerning adolescents of alcoholic parents, there is strong support for the finding that parental drinking behaviors have an effect on adolescent drinking behaviors, possibly because of the interplay between genetics, modeling, and environmental factors. Exposure to Fetal Alcohol Syndrome or Fetal Alcohol Effects may be the first and primary way that an alcohol-drinking parent impacts a COA. The impact of gender of alcoholic parent and gender of adolescent as it relates to modeling of drinking behaviors remains debated in the research literature.

Self-Esteem and Adolescent Children of Alcoholics

One task of early and middle adolescence is to achieve a new and positive sense of self in response to the many changes that occur at that age and, hence, develop a positive self-esteem (Aklous, 1978). Adolescent self-esteem and self-image are important concepts to focus on because of the key role they play in the development of adolescent psychosocial disturbances and the fact that self-esteem is strongly influenced by family environment (Killeen & Forehand, 1998; Rosenberg, 1985; Tomori, 1994). Numerous studies have shown that adolescent self-esteem is positively associated with supportive family characteristics (Allen et al., 1994; Killeen & Forehand, 1998; Tomori, 1994).

Development of self-esteem in females.

Of particular note in the research literature and of significance to this study is the development of self-esteem of female adolescents. Results from several studies imply that girls' self-concepts change during early adolescence in two ways. (1) They experience

greater disruption of self-concept than do males, and (2) they become more concerned about interpersonal aspects of their lives and physical experiences (Gunn & Peterson, 1975).

Feminist theoreticians perceive women as psychologically defined through their relationships (Berzoff, 1989; Miller, 1976; Gilligan, 1983). Women's connections with others promote psychological growth. Gilligan (1982), in her development of women's distinctive psychology, noted women's greater orientation toward relationships and interdependence. The achieving of autonomy is accomplished through a connection with others. Miller (1976) described women's senses of self as "organized around being able to make and then maintain affiliations and relationships" (p. 83). The need for connection may be of initial importance in understanding an adolescent girl's relationships and self-esteem development.

A study of early adolescent girls conducted by Rosenberg and Simmons (1975) noted that adolescent girls reported greater anxiety than their male counterparts, worrying more about what people thought of them, cared more about being well-liked, and frequently felt "self-conscious." In addition, adolescent girls were more likely than boys to cope with anxiety-provoking situations by being compliant or by avoiding negative reactions (Gunn & Peterson, 1975). Similarly, studies by Workman and Beer (1989), Kling and associates (1999), and Scheier and colleagues (2000) also indicated that male adolescents reported higher levels of self-esteem than females.

Adolescent girls have also been reported to have greater insecurity about social status. In one study (Savin-Williams, 1979), female and male campers 12-14 years of age were asked to estimate their sociometric rankings by other campers. Boys were

significantly more likely than girls to be accurate in estimating their own rankings by other campers; girls were likely to underestimate their own rankings.

Self-esteem and its relationship to adolescents' depression and drinking behaviors.

In recent years, researchers have investigated the role of self-esteem as a possible antecedent of alcohol and drug use among adolescents (Abernathy et al., 1995; Vega et al., 1996; Wills, 1994).

In a study conducted by Workman and Beer (1989) involving the self-esteem, depression, and alcohol dependency among high-school students, adolescents, as a group, displayed "mild depression". Self-esteem scores correlated significantly and negatively with depression, and depression scores correlated significantly and positively with alcohol dependency. Notably, boys tended to have higher mean self-esteem scores and higher alcohol dependency scores than their female peers. Adolescent drinking behaviors, self-esteem, and levels of depression appear to be linked in the recent literature concerning adolescent COAs. Kaplan (1980) suggested that adolescents who suffered negative self-evaluations were more likely to seek out deviant peer networks as a way of repairing damaged self-esteem. Thus stress and negative affect may raise risk in early adolescent drug use not only through self-medication motives but also by increasing the likelihood of associations with a drug-use-promoting peer group.

Despite promising theoretical arguments, empirical evidence for a role of low self-esteem in promoting alcohol or drug use is "inconclusive" according to Scheier and associates in their recent article on self-esteem and adolescent alcohol use (2000). Scheier noted that cross-sectional studies have provided evidence for an association between self-

esteem and alcohol use. These studies are hampered, however, by the inability to infer causation from correlational data (Crump, et al., 1997; Young & Werch, 1990; Scheier et al., 2000).

Self-esteem of adolescent COAs in the research literature.

Although poor self-esteem is frequently cited in the clinical and research literature (e.g., Berkowitz & Perkins, 1988; El-Guebaly and Offord, 1977; Hughes, 1977; Jones, 1971; Roosa, 1986; Russell et al., 1985; Tomori, 1994; Tweed & Ryff, 1991; Woititz, 1983) as being part of the children-of-alcoholic profile, the research is consistently full of methodological problems in this area. Instead of clear conceptualizations of this variable, self-esteem is given vague and undefined meanings. Instruments are used that are frequently inappropriate or of questionable validity. Frequently studies include the use of subjective observational data in making an assessment about a child's self-esteem. For example, in a study by Barnes (1977) it was suggested that COAs are likely to have problems in developing well-integrated "self-images." Research cited by Booz-Allen and Hamilton (1974) indicated that a lack of "self-confidence" existed in almost one-third of the children interviewed in their study. Yet another example of the subjective use of assessing self-esteem is found in a study by Cork (1969) who reported that over 90% of a sample of 115 middle- and upper-class children of alcoholic parents, aged 10-16 years of age, expressed a lack of self-confidence and feelings of being unloved and rejected by one or more parents.

In a fairly well-designed longitudinal study by Werner (1986) of children of alcoholic parents raised on the island of Kauai, Hawaii, self-esteem was measured using

several sub-scales of the California Psychological Inventory (CPI) and interview ratings. Hughes (1977) refreshingly measured self-esteem of adolescent children of alcoholics using the Rosenberg Self-Esteem Scale. Adolescent children of alcoholics suffered from lower self-esteem more than non-COA adolescents.

Two studies—both dissertations—used the Piers-Harris Children's Self-Concept Scale to measure self-esteem or self-concept. O'Gorman (1975) reported that adolescents from problem-drinking homes had significantly poorer self-concepts than adolescents from non-drinking problem homes. Baraga (1978) noted that COAs had lower scores on the Piers-Harris Children's Self-Concept Scale. A regression analysis showed parental alcoholism to be predictive of low self-concept in children. Years of separation from the alcoholic parent, larger number of siblings, and membership in Alateen tended to improve children's self-esteem. However, the total years of parental alcoholism did not add to lower self-esteem scores, nor did the parents' total years of recent sobriety tend to repair poor self-concepts in their children.

In a study involving 54 adolescent COAs and 54 normal controls conducted by the McLachlan group (1985) no significant intergroup differences were found in school performance, alcohol/drug use, or on any measure of personality disturbance, with the exception that adolescent COAs had significantly lower self-esteem than did controls. Of note, adolescent children of recovered alcoholic fathers demonstrated the lowest self-esteem and, surprisingly, children of recovered alcoholic mothers had the highest self-esteem—even higher than the normal control—again, suggesting the focal role of the alcoholic mother.

Donald, Dunne, and Raphael (1993), investigating young adult daughters of alcoholic

fathers, found that daughters of high-drinking fathers reported significantly poorer self-esteem and greater depression than normal controls. Similarly, Tweed and Ryff (1991) also noted that adolescents had difficulty with issues of self-esteem, depression, ego control, and experienced feelings of guilt.

In light of the literature regarding self-esteem of adolescent COAs, it is essential that the variable "self-esteem" be clearly defined and measured by an appropriate instrument in this study.

Depression and Adolescents

The study of depression among adolescents is an important area of exploration, yet, depressive symptoms among adolescents often remain undetected by those most responsible for adolescents when parents and teachers often fail to notice manifest signals (Graham et al., 1976; Offer & Schanert-Reichel, 1992; Rutter, Grahano, Chadwick & Yule, 1976). Many reports indicate that first episodes of depressive symptoms often occur before adulthood (Kandel & Davies, 1986). Early episodes of depression problems seem to increase the likelihood of future episodes (Holsen, Kraft & Vitterso, 2000). Furthermore, according to Lewinsohn and colleagues (1993), depression in adolescence may predict future adjustment problems in the areas of marriage, dropping out of school, unemployment status, involvement in drugs, delinquent behavior, being arrested, being convicted of a crime, and being in a car accident.

Recent theoretical work in developmental psychology suggests that the etiological pathway to adolescent depressive symptoms and substance use may be gender-specific. These differences may be the results of different vulnerabilities between males and females

to interpersonal depressive experiences—experiences that often stem from negative life events involving the self and/or others (Hops, 1995; Leadbeater, Blatt & Quinlan, 1995). Depressive vulnerability theorists posit that adolescents with higher level of interpersonal or self-control vulnerability have heightened reactivity to stresses involving others or themselves. Research shows that females are more likely than males to demonstrate interpersonal depressive vulnerabilities (Baron & Joly, 1988; Campbell et al., 1992; Su et al., 1997). For example, in a study by Baron and associates (1993) examining gender differences in the expression of depressive symptoms among adolescents, data supported the theory that female adolescents had greater depressive symptoms than their male counterparts. The mean BDI score for the adolescent group as a whole was 9.39 ($SD=8.08$). When separating out females from male adolescents, females had a BDI mean score of 10.66 ($SD=9.07$), which indicates “mild depression” and male adolescents a mean score of 7.16 ($SD=5.33$) which signifies no notable depressive symptoms. This difference between gender groups was significant at the .01 level (Baron, 1993).

Literature also suggests that female adolescents appear to be more sensitive than male adolescents to parental influences are (Kandel, 1985) and that the family is a more salient context for female adolescents’ adjustment than for male adolescents (Johnson et al., 1995; Su et al., 1997). Therefore, one would expect girls to be more sensitive to parental psychopathology and negative life events and thereby more susceptible to depression. In contrast, studies conducted by Noahn-Hoeksema (1991), Reinherz and associates (1993) and Kandel and Davies (1986) reported different results. These studies indicated that boys tended to experience about the same or slightly higher levels of

depressive symptoms than girls in early adolescence (between age 11 and age 13 years), but by age 13-14 years, there was a change and girls reported more depressive symptoms than boys did.

Most of the methodologically sound studies with adolescents and depression are sparse. Unlike the literature on the variable "self-esteem," the literature on depression frequently does not define the concept and frequently does not indicate how depression is measured or assessed. Yet, "depression" and "depressive tendencies" are frequently cited in the literature of adolescent COAs (e.g., Clair & Genest, 1987; Fine, et al., 1976; Goodwin, Schulsinger, Knop, Mednick & Guze, 1977; Herjanic, Herjanic, Penick, Tomelleri & Armbruster, 1977; Roosa, 1986; Tweed & Ryff, 1991; Whalen, 1952; Woititz, 1983).

The empirical literature concerning depression and adolescent COAs.

Among the 400 adult children of alcoholics studied by Black (1986), 45% of the ACOAs identified depression as a major problem in their lives compared to only 23% of the controls. Unfortunately, criteria for "depression" were not specified in this study, nor was the control group defined. In research conducted by Merikangas and associates (1985) on the familial transmission of depression and alcoholism (1985), consistently higher rates of both alcoholism and depression than would be expected in the general population were found among the offspring of alcoholic parents.

Findings from the Danish adoption studies conducted by Goodwin (1976) regarding the rate of depression of daughters of alcoholics showed that non-adopted daughters of alcoholics (predominately fathers), raised at home, had a higher rate of depressive

symptomatology. A lower rate of depression was observed among adopted daughters who were not raised with their biological parents.

An earlier study by Whalen (1953) also suggested that a depressive tendency in adolescent children of alcoholics exist. COAs in his study were withdrawn, rebellious and exhibited more disturbed social and psychological behavior than non-COAs.

Herjanic's study (1977) demonstrated that, although no differences were found between COAs and non-COAs in the 6-12 age range, children of alcoholic teenagers were found to exhibit more deviant behavior and were two times more likely to receive a psychiatric diagnosis than controls, thus suggesting the possibility that some COAs were diagnosed with depression.

Results from a study by Rouse (1973) indicated that children of heavy-drinking fathers used fewer different coping methods and were more likely to forget, smoke, and engage in solitary activities in dealing with their stress. Perhaps of no surprise, these same children reported a significantly higher rate of depression than the children of moderate-drinking parents or abstaining parents (Rouse, 1973).

Children, aged 4-12 of alcoholic fathers in Sweden were found to exhibit "emotional disturbance" (Nylander, 1960, p.172) more often than a control group of children without alcoholic parents. Based upon a mental and physical examination, 29% of the COAs suffered depression and anxiety, as compared with 5% of the matched controls. Again, the criteria of depression were not given, and the examination that assessed depression was not described sufficiently.

Chassin and associates (1993) investigated adolescent substance use and

discovered that having an alcoholic mother was significantly associated with heightened emotionality in adolescents as well as higher levels of negative affect. In a study reported by Bush, Ballard & Fremouw (1995), children of alcoholics were compared to children of non-alcoholic parents on measures of depression, self-esteem, and attributional style. Adult children of alcoholics were more likely than children of non-alcoholic parents to have a depressive attributional style, in that they perceived failure as more internal, stable and global (Bush et al., 1995).

Data from the National Institute of Mental Health Catchment Area Program (Christie, Burke, Rae, Boyd & Locke, 1988) provided evidence that adolescent offspring with an early onset of a major depressive disorder or anxiety disorder had a twofold risk of later drug abuse or dependence. Further, it appears that onset of depression almost always precedes substance abuse, thus supporting the role of depression as a risk factor for subsequent abuse in adolescence (Deykin, Levy, & Wells, 1987). In a study conducted by Van Hassett and associates (1993), research findings suggested that mild to moderate levels of depression was evident in both male and female adolescent substance abusers. These data are consonant with prior research attesting to the considerable prevalence of affective disorder in substance abusing adolescents and young adults (e.g., Deykin et al., 1987; Kashani et al., 1985).

Family Rituals and the Transmission of Alcoholism in Families

Bennett, Wolin & Reiss (1988) have observed that family rituals represent a core of a theoretical model explaining alcohol transmission in families. Family rituals can be viewed as the symbolic forms of communication among family members. These forms have specific meaning, a repetitive nature, and the capacity to provide families with

stability during crises and stresses (Schuck & Bucy, 1997). Family rituals can strengthen and maintain attachment and bonding among family members, produce and reproduce a family's culture or sense of identity, and socialize family members in how to conduct social relations (Baxter & Clark, 1996).

Bennett and associates (1988) identified three types of family rituals. The first type of ritual is related to "ceremonies and celebrations" and includes national and religious holidays and special family events like weddings and funerals. The second type of ritual involves "traditions." Regularly observed family events such as birthdays and vacations exemplify this type of ritual. The third type of ritual is comprised of "patterned routines" and involves the daily and weekly activities of living such as meals and weekend activities. Through their special meanings and repetitive natures, all three of these types of rituals can contribute significantly to the establishment and preservation of a family's collective sense of itself, which we will call the "family identity" (Bennett et al., 1988).

According to this theoretical model, family rituals offer an especially good window through which to view the family and to assess the relative impact of alcoholism upon family life. In families whose rituals were consistently subsumed by alcoholism ("subsumptive families"), there is evidence of a significantly greater incidence of intergenerational continuity of alcoholism than in those families who had kept their rituals distinct from the alcohol-abuse behavior ("distinctive families") (Bennett, et al., 1988; Wolin, Bennett, Noonan & Teitelbaum, 1980).

According to Johnson and Leff (1997) maintaining family rituals during periods

of heavy parental drinking results in fewer transmittable cases of alcoholism compared with families who alter their rituals. In addition, Roberts (1988) has proposed that rigidly ritualized symptoms such as binge drinking, alcoholic drinking, and drug abuse often appear in families lacking more meaningful rituals.

Many adult offspring of alcoholic parents have reported that the problem-drinking parent's unreliability and tendency to upset or fail to join in with family activities during childhood was one of the most negative effects upon the family. Studies have consistently demonstrated that adolescents who report higher levels of family conflicts also report more alcohol use (Baer, Garnezy, McLaughlin, Pokorny & Wernick, 1987; Webb & Baer, 1995). A related measure of family functioning, family cohesiveness has also been shown to be related to substance use (Baer et al., 1987; Webb & Baer, 1995). According to Johnson and Leff (1999) the stability of rituals in alcoholic families during childhood and adolescent appear to influence later alcoholism. Thus, those families showing more stability also evidence less alcoholism in adult COAs (Johnson & Leff, 1997).

Conversely, a study by Hussong and Chassin (1997) reported that adolescents with high family organization and either very low or very high levels of behavioral coping were less likely to initiate substance abuse. This study also suggested that highly organized families and behavioral coping efforts might deter substance use initiation (Hussong & Chassin, 1997). Results from a study by Su and associates (1997) implied that family cohesion played a dominant role in mediating the stress related to parental substance abuse. In another study, alcoholic families characterized by a lack of

disruptions in ceremonies and celebrations, traditions, and patterned routines tended to produce fewer alcoholic offspring (Bennett, Wolin & Reiss, 1988; Wolin, 1979; Wolin, Bennett, Noonan & Teitelbaum, 1980).

A study by Tomori (1994) indicated that adolescents from alcoholic group, held negative views of their families and experiences and a high degree of uncertainty about their roles in the families. As a group, adolescent children of alcoholic parents reported significantly lower levels of family rituals than non-COAs (Fiese, 1993). The degree and importance of family rituals were related to a perceived feeling of family solidarity, and for adolescents, the development of a strong self-identity (Fiese, 1993).

Review of the Literature: Summary

Despite the numerous methodological errors in the literature which limit the interpretation of findings, previous research involving alcoholic parents and their adolescent offspring supports a relationship between mental-health variables, family functioning, and resiliency of offspring, yet does not specifically address how these variables are related. Gender of parent and gender of adolescent, drinking behaviors, self-esteem, depression, family functioning, and family rituals all appear to be variables in need of more exploration in respect to the research questions regarding risk and resiliency of adolescents growing up with an alcoholic parent.

CHAPTER III

Methodology and Procedures

Respondents

The respondents in this study consisted of two different generational groups-- adolescents and their biological parents (identified alcoholic parent and his or her non-alcoholic spouse). The adolescent group, which is further subdivided into female and male groups, was aged 12-18 and living at home with their alcoholic mother or father. Identified alcoholic parent respondents in this study were being treated for alcoholism at several outpatient community mental health agencies, and were similarly subdivided into male and female subgroups.

The spouse of the identified alcoholic parent (and other biological parent of the adolescent respondent) completed the "family trio" of respondents. This group of respondents was also subdivided into male and female subgroups.

Thirty-seven families (two parents and one adolescent) agreed to fully participate in this study.

Subject Selection

Each new adult admission with a diagnosed alcoholism problem at one of the eight outpatient mental-health centers participating in this study were screened by registration staff in order to determine if patient was married and had a biological adolescent child (aged 12-18 years old) living at home. In addition, recovering alcoholic

parents who were currently in alcoholism treatment/recovery and attending recovery/aftercare groups were also "flagged" for screening and potential participation in this study. Families who consisted of two identified alcoholic parents, according to outpatient registration information, were not included as respondents in this study.

Identified alcoholic patients meeting research criteria were given written information regarding the study and met with the researcher to answer any questions they might have had about the protocol. After agreeing to participate in the study, the identified alcoholic patient completed a consent form and was given the study materials. If the identified alcoholic spouse was also present at the outpatient session (for family therapy), he or she was also met with, given a consent form to be completed, and then given study materials. If the spouse was not present at the session, a consent form and study materials were sent home with the alcoholic respondent in a sealed, confidential envelope. Each identified alcoholic respondent was also given a packet of information for his or her adolescent child, including an Adolescent Assent Form and study materials. Parents were requested to explain the study to their adolescent child and, if desired, to contact the researcher if they or their child had any questions about the study or study protocol.

All potential respondents were instructed to return the completed consent forms and study materials in the sealed envelopes to the outpatient registrar or researcher at the next outpatient session, or to mail the materials in the pre-addressed, pre-stamped envelope contained in each of the packets to the researcher's post office box. For purposes of confidentiality and to aid in collating family responses, a family identification number and also a member identification letter identified packets. For

example, the first family "trio" of respondents were identified as "1A" (identified alcoholic parent), "1S" (spouse), and "1C" (adolescent).

According to study protocol, parental respondents with more than one adolescent child would give consent for the eldest child to participate. Among the families sampled in this study, none of the parental respondents reported having more than one biological adolescent child living with them, so all available adolescents were included in this study.

Procedure

Parent respondents.

Each alcoholic and spouse respondent completed five paper-and-pencil instruments: The Beck Depression Inventory, the Michigan Alcoholism Screening Test, Rosenberg Self-Esteem Scale, two copies of the Self-Report Family Inventory, and several questions regarding parent/child closeness and presence/absence of family rituals in the current family and family-of-origin. The first copy of the Self-Report Family Inventory was completed as it pertained to one's family-of-origin and the second in respect to one's current family. Respondents were encouraged to discuss any concerns possibly brought up by the instruments with one's treatment team, alcohol counseling group, or family support group.

Each parental respondent was asked a number of demographic questions including age, gender, respondent's self-description of his/her own ethnicity, religion, date of last drink, family addiction/alcoholism history, if applicable, and occupation and household income range.

Adolescent respondents.

Respondents completed a series of paper-and-pencil instruments including Beck

Depression Inventory, Michigan Alcoholism Screening Test, Rosenberg Self-Esteem Scale, several questions regarding parent/child closeness and presence/absence of family rituals, and the Self-Report Family Inventory. Demographic information such as age, gender, family addictions/alcoholism history and self-reported ethnicity were also obtained.

Instruments/Assessments

Beck Depression Inventory.

The Beck Depression Inventory (BDI) was used in this study to measure the self-reported depth of depression an individual might be experiencing. The BDI consists of 21 items, each describing a symptom and rating it on level of severity. With increasing depression, the number of symptoms increases and there is a step-like progression in the frequency of depression symptoms from non-depressed, to mildly depressed, to moderately depressed, to severely depressed. According to Beck (1967), the more depressed an individual is, the more intense a particular symptom is likely to be.

Each of the 21 items describes a specific behavioral manifestation of depression and consists of a graded series of four self-evaluative statements. These statements are ranked to reflect the range of severity of the symptom, from neutral to maximal severity. Numerical values for 0 to 3 are assigned to each statement to indicate the degree of severity. (See Appendix 2).

This study used the cut-off scores ranges for the BDI which have been used in the literature for non-psychiatric populations (Lightfoot & Oliver, 1985; Oliver & Simmons, 1984; Brumberry & Oliver, 1978):

0 - 9 Non-depressed

10-15	Mildly depressed
16-23	Moderately Depressed
24+	Severely Depressed

Beck (1967) reported two methods for evaluating the internal consistency of the BDI. In the first method, the protocols of 200 consecutive cases of outpatient and inpatient psychiatric subjects were administered the BDI and analyzed by comparing the score for each of the 21 symptom categories with the total score for each individual. The second method of evaluating internal consistency involved the determination of split-half reliability. The BDI results from 97 outpatients and inpatients were selected for this analysis. Both methods demonstrated sufficient reliability for the Beck Depression Inventory ($r=.92$) (1967). A reliability analysis of the data for this study yielded a reliability coefficient of .82.

Beck (1967) used a two-dimensional test-retest method to estimate the stability of the BDI. The BDI was administered at two different times to a group of 38 patients. At each administration, a psychiatrist made a clinical estimate of the depth of depression. The time interval between the two tests varied from two to six weeks. Results indicated that changes in the total scores on the BDI tended to parallel changes in the clinical ratings of the depth of depression, suggesting a consistent relationship of the instrument to the patient's clinical state.

An indirect measure of inter-rater reliability was also performed by Beck (1967). In this method, each of the scores obtained by each of the interviewers was plotted against the clinical ratings. A very high degree of consistency among the interviewers was plotted against the clinical ratings. A very high degree of consistency among the

interviewers was observed for the mean scores obtained at each level of depression. Curves of the distribution of BDI scores plotted against the depth-of-depression scores were notably similar, indicating a high degree of correspondence among those who administered the inventory. In addition, the BDI discriminates well between anxiety and depression (Beck, 1972).

Concurrent validity was evaluated by demonstrating how well the Depression Inventory corresponded to other measures of depression, such as clinical evaluation and scores on other psychometric tests of depression. A significant relationship between the Beck and the Hamilton Rating Scale for Depression has been demonstrated by Schwab, Bialow, and Holzer (1967) and also between the BDI and Lubin's (1965) Depression Adjective Checklist, which is used to measure transient depressive mood. Reynolds and Gould (1981) reported a significant correlation between the BDI and the Self-Rating Depression Scale developed by Zung (1974) and the University of Los Angeles (UCLA) Loneliness Scale (Russell, Peplau, Ferguson, 1978).

The Rosenberg Self-Esteem Scale (RSE).

The Rosenberg Self-Esteem Scale (RSE) (Rosenberg, 1965) is a ten-item instrument employed to determine the feelings of satisfaction a person has about her or himself which reflects the relationship between current self-image and ideal self-image.

Items are phrased in a positive or negative direction to discourage response bias. Each item is rated on a four-point Likert scale ranging from "strongly agree" (1) to "strongly disagree" (4). Scores are obtained through a two-step process. The first step is to reverse the scoring for negatively phrased items (items 2, 5, 6, 8, and 9), so responses are consistent with positively phrased items. Second, responses to all items are then

scored according to Guttman scale. This procedure yields a total score ranging between 10 and 40 and is the most frequently used in the literature (e.g., Dobson, Goudy, Keity & Powers, 1979; Ward, 1977; Yancy, Rigsby & McCarthy, 1972).

Two studies examining test-retest reliability of the RSE are frequently cited in the literature. Silber and Tippett (1965) obtained a two-week test-retest reliability coefficient of .85 for college students (n=28). Also utilizing a college sample (n=590), Rosenberg (1979), reported a slightly higher two-week test-retest reliability coefficient of .88.

A reliability analysis of this study's data yielded a reliability coefficient of .91.

Previous studies have demonstrated reliability and the convergent and divergent validity of this construct (Kohut, 1977; Rosenberg, 1985).

Rosenberg (1965) argued that it is commonly observed that depression accompanies low self-esteem. Rosenberg hypothesized that people with measurably low self-esteem should appear more depressed to outside observers. In a study by Rosenberg (1965), using normal volunteer subjects, a significant (.05 level) association between a subject's self-esteem and the likelihood that he or she will appear depressed to nurses was reported.

Rosenberg (1965) further concluded that not only are people with low self-esteem scores more likely to appear depressed to others, but also they are, as expected, more likely to express feelings of unhappiness, gloom, and discouragement. Results from Rosenberg's (1965) New York study based on a sample of 5,024 high school juniors and seniors from ten high schools in New York State indicate a very strong and consistent relationship between self-esteem and a Guttman scale of "depressive affect." Rosenberg concluded that only 4% of those students with the highest self-esteem scores, but 80% of

those students with the lowest self-esteem scores, were "highly depressed."

A study of 44 college students by Silber and Tippett (1965) provided evidence of the convergent validity of the RSE. Using the RSE, the Kelly Repertory Test (differences between self and ideal self based on 20 bipolar dimensions), the Health Self-Esteem questionnaire (a sum of 20 items dealing with self and social ideal discrepancy), as well as a psychiatrist's rating, the study was intended to measure two traits-- global self-esteem and stability of self-concept. High convergent validity were reported between the RSE and the other instruments (Kelly Repertory Test, $r = .67$; Health Self-Image Questionnaire, $r = .83$; psychiatrist's rating, $r = .56$) (Silber and Tippett, 1965).

Michigan Alcoholism Screening Test.

The Michigan Alcoholism Screening Test (MAST) (Selzer, 1971) was designed principally "to provide a consistent, quantifiable, structured interview instrument for the detection of alcoholism that could be rapidly administered by non-professional as well as professional personnel" (Selzer, 1971, p. 1654) (Appendix E). According to Hedlund and Vieweg's (1984) comprehensive review of this test, the MAST has been used with many different respondent groups and ages, including alcoholics and non-alcoholics, psychiatric and medical patients and college students.

The MAST was developed by Selzer (1971) as a questionnaire to be individually administered by an interviewer. It contains 25 direct, "face-valid" questions about the respondent's drinking behaviors and any associated problems. All MAST items require a simple yes/no response, and the total test can be completed within 10-15 minutes.

Individual items are assigned scores of 0, 1, 2 or 5 points if answered in a significant direction. Individual response scores are summed to obtain a total MAST score. A total

score of three points or less is considered "non-alcoholic," a total score of 4 points is considered "suggestive of alcoholism," and a total score of 5 or more points is considered to reflect alcoholism (Selzer, 1971).

Internal consistency estimates for the MAST is reported as having alpha coefficient ranging from .83 to .95 (Hedlund & Vieweg, 1984). Zung (1982), for example, reported alpha co-efficient of .88 and .83 for two samples of DWI (drinking while intoxicated) offenders (both $n=100$) and Selzer (1971) calculated an internal consistency co-efficient of .83 for an alcoholic sample ($n=228$), .87 for a non-alcoholic sample ($n=293$), and .85 average for the total sample ($n=521$).

Two studies provided information concerning test-retest reliability. Zung (1982), using a psychiatric inpatient sample ($n=120$), reported a MAST total score reliability co-efficient of .97 for a one-day test-retest interval, .86 for a two-day interval, and .85 for a three-day interval. Skinner and Sheu (1979), with a sample of 91 acute psychiatric admission, obtained a reliability co-efficient of .84 for an average of 4.8 month test-retest interval.

A number of studies have investigated the ability of the MAST to differentiate alcoholics from other patient and non-patient groups (e.g., Selzer, 1971; Moore, 1972, 1971; Zung, 1980, 1982; Favazza & Pires, 1974; Benussi, 1982). Selzer (1971) reported that MAST scores of five or more identified 98% of his alcoholic group and the score of four or less correctly classified 95% of his control group. Pottenger, McKernon and Patrie (1978) reported that the MAST correctly identified inpatient alcoholics very near 100 %, and outpatient alcoholics, near 97%. Other studies indicate an overall range of reported MAST sensitivity, i.e., its accuracy in identifying diagnosed alcoholics, at 79%

to 100% (Hedlund & Vieweg, 1984).

The use of the MAST to correctly identify non-alcoholics appears to be less accurate, with MAST specificity ranging from 36% to 95%, as reported in a number of studies reviewed by Hedlund & Vieweg (1984). Despite the fact that false positive errors (the MAST incorrectly identifying a non-alcoholic as an alcoholic) are considerably more frequent than false negative ones (Hedlund & Vieweg, 1984), the MAST appeared to be an adequate instrument for use in this study.

In the actual study, a number of problems were apparent with the MAST. It appeared to give a high number of potentially "false positive" alcoholism scores and put more respondents in the "alcoholic" category than cited by previous researchers. Following an individual item analysis, item #9 ("Have you ever attended a meeting of Alcoholic Anonymous?") and item #11 ("Has drinking ever created problems with your family?") were removed, without a problem to the test's reliability. Many of the respondents had attended an Alcoholic Anonymous meeting, even if they never drank and many respondents responded with a "yes" to #11, which needed to be more specific about whose drinking was creating the problems in the family. In addition, item #1 (Do you feel you are a normal drinker?) was also seen as potentially misleading to the respondents who wrote in on the top of their inventory, "I don't drink" and circled "no" to this statement. Respondents with this write-in were re-coded to yes" to discourage the "false positive" bias of this statement.

Self-Report Family Inventory.

The Self-Report Family Inventory (SFI), designed by W. Robert Beavers and Robert B. Hampson (1990), is a 36-item questionnaire that, like other self-report scales, can be

used as a reasonable screening device to identify potential dysfunction in a family system. This inventory is heralded for its ability to assess a family member's view of overall family competence in a generally reliable, quick, and relatively unobtrusive way—the higher the score, the more perceived dysfunction in the family. In order to arrive at a total score for each respondent, several items on the scale were recoded to appropriately reflect this “dysfunctional continuum. SFI scores, like family functioning, are best described on a continuum, rather than as discrete types. Less competent SFI scores ($x > 3$, raw scores 57 or above), can be viewed as suggestive of a less competent family (Beavers & Hampson, 1990). In less competent families, more stereotyping in family ratings is observed with fewer differences between parents and adolescents scores and higher pairwise correlation occur among family members' ratings. Conversely, low scores on the SFI indicate healthy family relatedness and effective communication, suggesting a low level of family disruption.

Family rituals and family closeness.

Six family rituals and family closeness questions used by Braithwaite and Devine in their 1993 study were also used in this study to measure the degree of intact rituals and family connectiveness in one's present family, as perceived by the adolescent and parent respondents (See Appendix). Scores ranged from six to 18 with higher scores indicative of “intact rituals and family closeness” and lower scores indicative of “rare or infrequent family rituals and lack of family closeness”. In the current study, parent respondents also answered a set of similar questions regarding family rituals and perceived closeness in their families of origin (five questions; scores range five to 15) (See Appendix).

Design and Statistical Analyses

The study's original design included using multivariate statistical analysis to

explore between-group effects. However, because of sampling difficulties, the study could not reach sufficient sample size for this type of analysis. As a result, the study's hypotheses were tested using the following statistical analyses:

1. Descriptives and frequencies were calculated for all variables.
2. Paired t-Tests were performed:
 - a) Comparing identified alcoholic parent data and adolescent child data
 - b) Comparing spouse data and adolescent child data
 - c) Comparing identified alcoholic parent data and spouse data.
3. Independent Sample t-Tests were performed:
 - a) With data from adolescent girls and adolescent boys of alcoholic mothers,
 - b) With data from adolescent girls and adolescent boys of alcoholic fathers,
 - c) Between gender of alcoholic parent and adolescent girls,
 - d) Between gender of alcoholic parent and adolescent boys.
4. Pearson Correlations were calculated between:
 - a) Variables of family functioning, depression, self-esteem, family rituals and drinking behaviors among adolescent respondents,
 - b) Variables of present family functioning, family-of-origin functioning, depression, self-esteem, present family rituals, family-of-origin rituals, and drinking behaviors among identified alcoholic parent respondents
 - c) Variables of present family functioning, family-of-origin functioning, depression, self-esteem, present family rituals, family-of-origin rituals,

and drinking behaviors among spouse respondents.

5. **Post-hoc Analyses were computed using :**
 - a) **Regression.** Adolescent depression was the dependent variable and predictor variables were gender of adolescent, age of adolescent, present family ritual score (computed by averaging mean of adolescent, alcoholic parent and spouse present ritual scores), spouse family-of-origin rituals, alcoholic parent family-of-origin rituals, alcoholic parent depression scores, and spouse depression scores.
 - b) **Regression.** Dependent variable was adolescent drinking behavior and predictor variables were gender of adolescent, age of adolescent, alcoholic parent family-of-origin disruption score, spouse family-of-origin disruption score, new present family disruption score (computed by taking the average of adolescent, spouse and alcoholic parent present family disruption score), spouse drinking behavior, and alcoholic drinking behavior.
 - c) **Regression.** Dependent variable was adolescent rituals and predictor variables were gender of adolescent and age of adolescent, spouse family-of-origin family disruption score, alcoholic parent family-of-origin family disruption score, new, averaged present family disruption score, spouse drinking behavior, alcoholic parent drinking behavior.

Power analysis.

When this study was first proposed incorporating multivariate statistical analyses, an analysis of power was performed to determine the minimum number

of respondents needed to achieve sufficient statistical power. It was anticipated that the effect size (ES) of adolescents and parents would be of "medium size", i.e., that $R^2 = .25$. Using Cohen's Table of Power of the F test on means (Cohen, 1987, p.315-316) with a $u = k-1 = 3$, and given the standardized means of the populations of adolescents in the four groups (alcoholic mothers and sons, alcoholic mothers and daughters, alcoholic fathers and sons, alcoholic fathers and daughters) equal to .25, the probability that F will meet $\alpha = .05$ criterion in respondents per cell would yield .85. As a result of Cohen's (1987) and Lipsey's (1990) suggestion that .80 be a desirable minimum of 44 subjects per cell would assure adequate power and a goal of 50 subjects per cell was proposed for this study. Having equal numbered groups would also be ideal in the goal of maintaining "good" statistical power. However, as mentioned previously, the study did not attain the projected number of respondents needed to satisfy requirements for this type of analysis, even after one year of concentrated respondent recruitment at eight outpatient sites. As a result, this altered the statistical tests which could be performed (correlational tests, t-tests) on the available data.

CHAPTER IV

Results

Identified Alcoholic Parent Respondents

Summary of demographic data.

Thirty-seven alcoholic parents participated in this study. The respondents ranged in age from 32 to 62 years of age with a mean age of 43 ($SD = 6.37$). Approximately 62% of the identified alcoholic parents in this study were male ($n = 23$) (see Table 1).

Overall, identified alcoholic parents, as well as their spouses, appeared to be a homogeneous group, tending to be of European background (76%), having a Catholic, Protestant or "Christian" background (83%), and a mean family income of \$66,000 to \$75,000 (see Table 1 and Table 2).

Drinking behavior scores, as reflected by the Michigan Alcoholism Screening Test (MAST), ranged from 0 to 44. The mean drinking behavior score among the identified alcoholic parents was 20.17 ($SD = 10.82$), indicating severe drinking behaviors (See Figure 1). Sixty-five percent of the identified alcoholic parents sampled reported having had a drink "during the past week," and only 8 % reported abstaining from drinking for more than years (see Table 3). Eighty-nine percent of identified alcoholic parents also reported a family addictions/alcoholism history. Seventeen of the 33 alcoholic parent respondents (nine females, eight males) who completed this question in

Table 1

Summary of Demographic Data for Identified Alcoholic Parent Respondents (n=37)

	Frequency	Percentage
Gender		
Female	14	37.8
Male	23	62.2
Family Income		
Below \$15,000	1	2.7
\$16,000-\$25,000	1	2.7
\$26,000-\$35,000	2	5.4
\$36,000-\$45,000	6	16.2
\$46,000-\$55,000	7	18.9
\$56,000-\$65,000	1	2.7
\$66,000-\$75,000	6	16.2
\$76,000 and up	12	32.4
Not Sure	1	2.7
Ethnic Background		
European	28	75.7
Asian	1	2.7
African	2	5.4
Hispanic	4	10.8
Other	2	5.4

Table 2

Self-Reported Religious Affiliation and Occupation among Identified Alcoholics and Their Spouses

Religion	Frequency of Response (n=74)			
	Identified Alcoholic		Spouse	
	N	%	N	%
Protestant	7	18.9	9	24.3
Catholic	15	40.5	13	35.1
Fund/ Pent	6	16.2	5	13.5
Jewish	4	10.8	4	10.8
Other	4	10.8	5	13.5
None	1	2.7	1	2.7
Occupation				
Profess/Tech	14	37.8	11	29.7
Business	4	10.8	5	13.5
Clerical/Sales	4	10.8	5	13.5
Craftsmen	6	16.2	4	10.8
Operatives	7	18.9	4	10.8
Unskilled	1	2.7	1	2.7
Homemaker	1	2.7	6	16.2
Student	0	0	0	0

Table 3

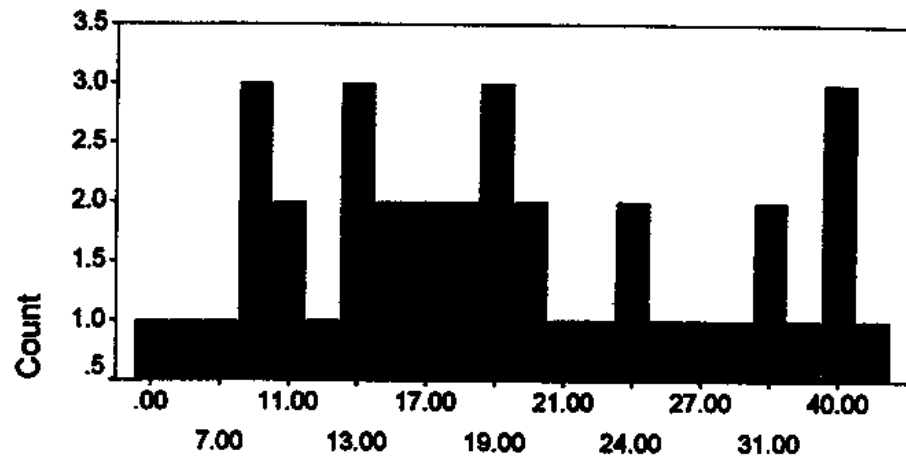
Date of Last Alcoholic Drink for Identified Alcoholic Parents (n=37)

Date	Frequency	Percentage
One week or less	24	64.9
Within the Month	5	13.5
Within the Past Three Months	4	10.8
Within the Past Six Months	1	2.7
Longer than a Year	3	8.1

Figure 1

Michigan Alcoholism Screening Test Scores:

Identified Alcoholic Parents (n = 37)



new mast score omitting items 9&11

the study indicated "self" as the identified family member with an addictions/alcoholism history. Overall, identified alcoholic parent respondents tended to identify male family members as having addictions/alcoholism histories including twenty-two percent who identified their fathers as alcoholic (see Table 4).

Of special note, items #9 and #11 were removed from the total MAST scores following analysis of results showing that these items failed to discriminate in this sample, leading to more "false positive" drinking behavior scores. The New MAST was found to have sufficient reliability without these two items.

Bivariate Relationships for Alcoholic Parents

Relationship between depression and self-esteem.

Among alcoholic parents, a significant inverse correlation was found for depression scores, as measured by the Beck Depression Inventory and self-esteem scores, as measured by the Rosenberg Self-Esteem Inventory ($r = -.57, p < .01$). As depression scores increased (greater depression), self-esteem scores decreased (lower self-esteem). These findings support the premise that there is a correlation between self-esteem and depression specific to alcoholic parents.

Relationship of family disruption in alcoholic parents' families of origin with depression, self-esteem, and drinking behaviors.

A bivariate correlation approached significance between family disruption in alcoholic parents' families of origin and depression ($r = .28, p < .10$) (see Table 5). The results suggest that as a depression score increases, family disruption score for family-of-origin may also increase.

Table 4

Family Addictions/Alcoholism History as Reported by Identified Alcoholics (n=37)

Response	Frequency	Percentage
Yes	33	89.2
No	2	5.4
No Response	2	5.4

Identified Family Member*

Family Member	Frequency	Percentage
Self	17	45.9
Mother	1	2.7
Father	6	21.6
Child	1	2.7
Uncle	1	2.7
Aunt	2	5.4
Brother	1	2.7
Grandfather	3	8.1
No Response	3	8.1

Note. Table does not sum to 100% because not all respondents identified a family member while other respondents identified more than one family member.

Table 5

Identified Alcoholic Parent Respondents: Relationship between Independent Variables
(Listwise n=37)

Variables	1	2	3	4	5	6	7
1. Depression	1.00						
2. Self-Esteem	-.53***	1.00					
3. Drinking Behaviors	.30*	.25	1.00				
4. Family Disruption- Family of Origin	.28*	.15	-.24	1.00			
5. Family Disruption- Present Family	.05	.02	.09	.12	1.00		
6. Family-of-origin Rituals	-.07	.18	-.37**	-.36**	-.01	1.00	
7. Present Family Rituals	-.20	-.06	-.02	.02	-.29**	.09	1.00

* $p < .10$, two-tailed. ** $p < .05$, two-tailed. *** $p < .01$, two-tailed.

It was hypothesized that family disruption in alcoholic parents' families-of-origin would be inversely related to self-esteem and positively correlated with drinking behaviors. Data from this study did not find significant relationships between family disruption for family-of-origin and self-esteem. Given a greater sample size, a possible relationship may be found between family disruption for family-of-origin and drinking behaviors ($r = .28, p < .10$) (see Table 5). These findings suggest that the perceived level of family disruption in the alcoholic parent's family-of-origin may be related to his/her level of drinking behaviors as an adult with greater family-of-origin disruption related to increased drinking.

Relationship of family disruption in alcoholic parents' families of origin with family rituals (family-of-origin and present family) and present family disruption.

Family disruption in alcoholic parents' families of origin was hypothesized as being correlated with family disruption in respondents' current families. The results did not support the hypothesis.

An inverse correlation was also found between level of family disruption for family-of-origin and level of family rituals for family-of-origin, such that high disruption in respondents' family-of-origin was related to low family-of-origin rituals ($r = -.36, p < .05$) (see Table 5).

Relationship between family-of-origin rituals with depression, self-esteem and drinking behaviors.

It was hypothesized that identified alcoholic parents with a low level of intact family rituals in their families of origin would also experience lower self-esteem and

increased depression. The data did not support a relationship between level of family-of-origin rituals and self-esteem or family-of-origin rituals and depression. A significant inverse correlation was found between family-of-origin rituals and drinking behaviors ($r = -.37, p < .05$), indicating that as level of family-of-origin rituals decreased, drinking behavior increased among alcoholic respondents. This data suggest that alcoholic parents' current drinking behaviors may be related to the level of family rituals they perceived growing up, such that respondents with greater intact family rituals also exhibit less drinking behaviors.

Summary.

The majority of identified alcoholic parents in this study tended to be male and to have a positive family history for addictions/alcoholism. The data suggest that there is a relationship between alcoholic parents' family-of-origin experience regarding perceived family disruption and level of family rituals and the level of rituals/closeness and family disruption in the present families of these alcoholic parents. The data also suggest that respondents' current alcoholic drinking behavior may be related to the level of family rituals and closeness in family-of-origin as well as the level of perceived family disruption in family-of-origin.

Spouse Respondents

Summary of Demographic Data.

Spouse of identified alcoholic parents ($n = 37$) had a more limited age range than the identified alcoholic sample, ranging in age from thirty years old to fifty-four years of age, with a mean of forty-two years ($SD = 6.02$). Similar to the identified alcoholic sample, respondents were predominantly "Christian", of European descent and from a

higher than average socio-economic level (see Table 2). In contrast to the identified alcoholic group, 62% of the spouse respondents were female. Twenty-four percent of the spouse respondents reported having "had a drink during the past week " and 19% of the respondents reported that they "never" drank alcohol (see Table 6). Spouse respondents reported MAST scores with a mean of 5.46 and a standard deviation of 6.84, indicating that, on average, spouses of alcoholics were "social" instead of alcoholic drinkers (See Figure 2). In examining the data retrospectively, the possibility exists that there may be spouse respondents who were "alcoholic" (as many as ten percent of the sample), but are not identified as such or receiving treatment for this problem.

Seventy-three percent of the spouse respondents reported a positive family history for addictions/alcoholism (see Table 7). No spouses identified themselves as having a personal addictions/alcoholism history, despite the aforementioned high drinking behavior scores among this "non-alcoholic" group. "Grandfathers" were the most frequently cited family member who had an addictions/alcoholism history (38% of respondents), followed by "father" (24%) and "mother" (8%). "Brother" and "sister" were both reported by 5% of the respondents (see Table 7).

Bivariate Relationships between Variables of Interest

Relationship between depression and self-esteem.

Similar to the identified alcoholic parent sample, a very strong inverse correlation was seen between depression scores and self-esteem in that as depression increased, self-esteem decreased ($r = -.75, p < .01$) (see Table 8).

Table 6

Date of Last Alcoholic Drink for Spouses of Alcoholics (n=37)

Date	Frequency	Percentage
One Week or Less	9	24.3
Within the Month	7	18.9
Within Past Three Months	8	21.6
Within Past Six Months	3	8.1
Longer Than a Year	3	8.1
Never	7	18.9

Table 7

Family Addictions/Alcoholism History as Reported by Spouses of Alcoholics (n =37)

History of Addictions/Alcoholism?	Frequency	Percentage
Yes	27	73.0
No	10	27.0

Identified Family Member*

Family Member	Frequency	Percentage
Self	0	0
Mother	3	8.1
Father	9	24.3
Brother	2	5.4
Sister	2	5.4
Grandfather	14	37.8

Note. Table does not sum to 100% due to the fact that not every respondent identified a family member and some respondents identified more than one.

Table 8

Spouses of Alcoholics: Relationships between Independent Variables (n=36 Listwise)

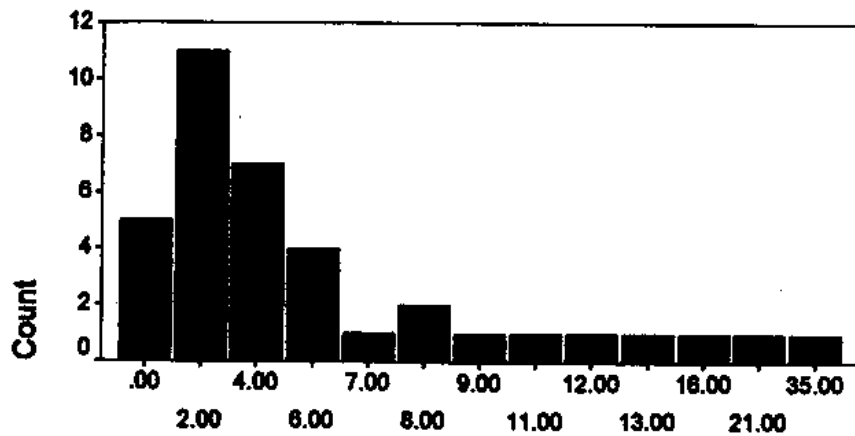
Variables	1	2	3	4	5	6	7
1. Depression	1.00						
2. Self-Esteem	-.75**	1.00					
3. Drinking Behaviors	.13	.00	1.00				
4. Family Disruption Family-of-origin	.28*	.25	.01	1.00			
5. Family Disruption— Present Family	.23	.30*	.10	.20	1.00		
6. Family-of-origin Rituals	-.24	-.13	-.06	-.48**	-.39**	1.00	
7 Present Family Rituals	-.11	-.18	.03	-.20	-.57***	.43***	1.00

* $p < .10$, two-tailed. ** $p < .05$, two-tailed. *** $p < .01$, two-tailed.

Figure 2

Michigan Alcoholism Screening Test

Spouses of Alcoholics (n = 37)



spouse - new mast score omitting items 9&11

Relationship of family disruption in spouses' families of origin and depression, self-esteem, and drinking behaviors.

Although the data did not support a relationship between family disruption and self-esteem or family disruption and drinking behaviors among spouses of alcoholics a possible correlation may be found with a larger sample size between family-of-origin disruption and depression ($r = .28, p < .10$)(see Table 8). This tendency towards significance suggests that increased levels of family disruption in one's family-of-origin may be related to depression among spouses of alcoholics.

Relationship between family disruption and family rituals (family-of-origin and present family).

A significant inverse correlation was reported for family disruption in respondents' family-of-origin and the family-of-origin rituals ($r = -.48, p < .01$) (see Table 8). The data suggests that as scores of family disruption in respondents' family-of-origin increase, family rituals in family-of-origin decrease. Similarly, a significant relationship was found between present family disruption and respondents' family-of-origin rituals ($r = -.39, p < .05$) (see Table 8). The data suggests that increased present family disruption scores are related to decreased scores of family-of-origin rituals. Spouses' level of rituals in their families of origin also appear to be significantly correlated to the rituals in their present families ($r = .43, p < .01$) (see Table 8). All of these findings, together, demonstrate the important interplay between family rituals and family disruption among spouse respondents and suggest that this group of respondents may be transmitting or establishing family rituals among the next generation.

Summary.

In contrast to the identified alcoholic parent sample, the spouse respondent group was 62 % female. It was also clear from the data that this group of respondents could not be labeled as "non-alcoholic parents. Given the scores on the MAST regarding Regarding drinking behavior of this respondent group, it appears that a number of spouses may also have or have had a drinking problem even though they are not, for the purposes of this study, the "identified alcoholic parents". As a result, the spouses' drinking behaviors also will be evaluated in considering adolescent outcome.

Data from this study showed a direct correlation between one's family-of-origin perception regarding rituals and family disruption and respondents' current families' experience of these variables. In addition, spouses were also more apt to report higher depression scores when there was a higher level of family disruption in their families of origin. These findings suggest that spouses of identified alcoholic may be instrumental in transmitting the healthy sense of family rituals and closeness and aid in minimizing family disruption in their current families—but only if they, personally have experienced these aspects while growing up. Conversely, spouses who experienced low levels of family rituals in their family-of-origin may contribute to low levels of rituals in current families, perhaps exacerbating family disruption.

Adolescent Respondents

Summary of demographic data.

Adolescent respondents (n =37) were fairly equally divided into male (n=18) (49%) and female (n=19) (51%) groups with a mean age of fifteen years of age $SD=2.03$ (see Table 9). The mean MAST score for this adolescent sample was 5.27

Table 9

Summary of Demographic Data for Adolescent Respondents (n=37)

Age (Years)	Frequency	Percentage
12	5	13.5
13	6	16.2
14	5	13.5
15	4	10.8
16	6	16.2
17	6	16.2
18	5	13.5
Gender		
Female	19	51.4
Male	18	48.6

($SD = 7.44$) and median was 2.0 indicating low level of drinking (See Figure 3). Twenty-seven percent of adolescents reported having had their last drink "one week or less." Thirty-five percent of adolescents reported that they had "never" drunk alcohol (see Table 10). Eighty percent of all adolescent respondents indicated that they had a family history of addictions/alcoholism. Of all of the adolescents who identified family members as alcoholic, twenty-seven percent wrote in that "mom" was the identified alcoholic parent (which is approximately the amount of female identified alcoholic parents). Forty-three percent of adolescents wrote in that "dad" was the identified alcoholic parent (while 62 % of the alcoholic respondents in the sample were male). and Nineteen percent indicated that there was no history of alcoholism in the family (see Table 11).

As compared to the alcoholic parent and spouse groups, the adolescent group reported the largest ranges of scores on several of the variables of interest (See Table 12). Mean scores on the Beck Depression Inventory (BDI) appeared to have some variation between those of alcoholic parents ($M=11.24$) and scores of spouses of alcoholics ($M=11.24$). On average, the adolescent group of respondents reported a moderate level of depression ($M = 11.97$) (see Table 12). Adolescents reported a mean score of 110.78 ($SD = 11.92$), approximately ten points or one standard deviation higher than the present family disruption scores for the spouse group ($M = 99.49$, $SD = 11.38$) (see Table 12). The report of level of family disruption was different from both identified alcoholics and spouses. Adolescents' scores concerning family rituals were similar to the two parent groups, reporting a mean score of 13.14 ($SD = 3.04$).

Table 10

Date of Last Drink for Adolescent Respondents (n=36)

Date	Frequency	Percentage
One Week or less	10	27.0
Within a Month	3	8.1
Within the Past Three Months	5	13.5
Within the Past Six Months	0	0
Within a Year	2	5.4
Longer Than a Year	3	8.1
Never	13	35.1

Table 11

Family Addictions/Alcoholism History as Reported by Adolescent Respondents (n=35)

History of Addictions/Alcoholism?	Frequency	Percentage
Yes	28	75.7
No	7	18.9

Identified Family Member*

Family Member	Frequency	Percentage
Self	0	0
Mother	10	27.0
Father	16	3.2
Uncle	2	5.4
Sibling	1	2.7

Note. Table does not sum to 100% because some respondents did not identify a family Member while other respondents identified more than one family member.

Table 12

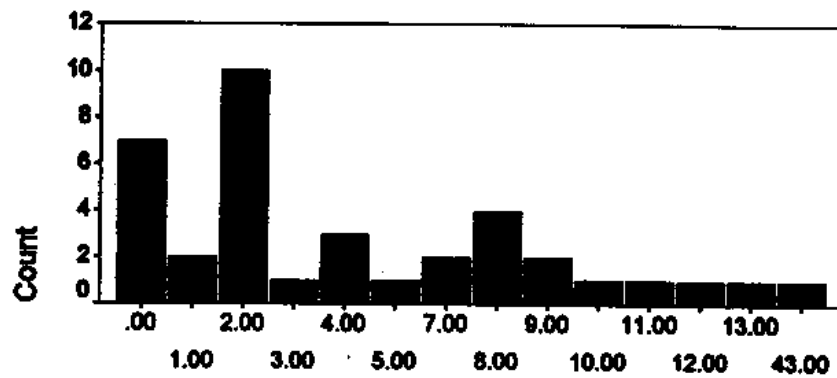
Descriptive Summary of Variables of Interest

	Alcoholic Parent (n=37)			Spouse (n=37)			Adolescent (n=37)		
	M	SD	MIN MAX	M	SD	MIN MAX	M	SD	MIN MAX
Depression	11.24	9.52	0 29.00	9.03	9.69	0 32.00	11.97	11.41	0 41.00
Self-Esteem	23.35	5.54	13.00 34.00	21.81	6.01	13.00 38.00	24.41	5.16	12.00 37.00
Drinking Behaviors	20.16	10.67	0 44.00	5.78	6.82	0 35.00	5.27	7.44	0 43.00
Family Disruption—									
Family of Origin/	99.58	20.19	53.00 149.00	92.92	20.02	45.00 147.00	110.78	11.92	83.00 135.00
Family Disruption—									
Parent Present Fam	101.53	12.15	79.00 128.00	99.49	11.38	72.00 126.00	—	—	—
Rituals									
Family of Origin	12.62	2.45	8.00 18.00	13.95	2.66	6.00 18.00	13.12	3.04	6.00 19.00
Rituals									
Parent Present Fam	12.86	2.15	8.00 15.00	13.57	1.77	9.00 15.00	—	—	—

Figure 3

Michigan Alcoholism Screening Test for Adolescents of Alcoholic parents

N = 37



adolescent-new mast score omitting items 9&11

MAST scores omitting items 9 & 11

Bivariate Relationships between Variables of Interest

Relationship between depression and self-esteem.

A strong correlation was found between scores on the Beck Depression Inventory and the Rosenberg Self-Esteem Scale among adolescents sampled ($r = .77, p < .01$), such that as depression scores increased, the Rosenberg scores decreased, indicating low self-esteem.

Relationships of family disruption with depression, self-esteem, drinking behaviors, and family rituals.

It was hypothesized that family disruption would be inversely related to self-esteem and positively related to depression and drinking behaviors among adolescent offspring of identified alcoholics. These hypotheses were not supported by the findings in this study (see Table 13). However, a significant inverse correlation was found between family disruption, as measured by Beavers, and adolescents' reports of family rituals/closeness ($r = -.44, p < .01$) (see Table 13) such that the higher the Beaver Score, (the greater the family disruption), the lower the family ritual/closeness score.

Relationships of family rituals with measures of depression, self-esteem, and drinking behaviors.

It was hypothesized that family rituals/closeness would be positively related to self-esteem and inversely related to depression and drinking behaviors. A significant correlation was found between total rituals/closeness in the family and level of depression ($r = .35, p < .05$) (see Table 13) indicating that adolescents with high perceived rituals experienced fewer depressive symptoms. A significant relationship was also found between rituals/closeness in the family and scores on the Rosenberg Self-Esteem Scale

Table 13

Adolescents of Alcoholic Parents: Relationships between Independent Variables

(n=37)

Variables	1	2	3	4	5
1. Depression	1.00				
2. Self-Esteem	-.77**	1.00			
3. Drinking Behaviors	.10	.12	1.00		
4. Family Disruption	.14	.08	-.09	1.00	
5. Family Rituals	-.35**	-.37	.04	-.44**	1.00

Note. Present Family Rituals and Family-of-origin Family Rituals are the same for Adolescent Respondents.

* $p < .10$, two-tailed. ** $p < .05$, two-tailed. *** $p < .01$.

self-esteem (see Table 13). Family rituals were not significantly related to drinking behaviors in the current study

Perceived mental health, behavior, and family functioning among adolescents by gender of adolescent and gender of alcoholic parent.

A 2 x 2 between-subjects analysis of variance was performed on the five dependent adolescent variables: depression, self-esteem, drinking behaviors, family disruption, and present family rituals. Independent variables were gender of identified alcoholic parent (male and female), gender of adolescent (male and female), and the interaction of gender of alcoholic parent by gender of adolescent. SPSS MANOVA was used for this analysis. Gender of adolescent emerged as significant in predicting total family rituals. Post hoc analyses showed that female adolescents reported the greatest amount of perceived family rituals in their families, regardless of the gender of their alcoholic parent ($M = 15.00$, $SD = 2.60$) (see Tables 14, 15).

In addition, it was hypothesized that daughters of alcoholic mothers, as a subgroup, would report the highest scores on depression and family disruption and the lowest scores on self-esteem, as compared to all other subgroups (daughters of alcoholic fathers, sons of alcoholic mothers, sons of alcoholic fathers). These analyses did not reach statistical significance in this study (see Tables 14 and 15). In addition, it was hypothesized that daughters of alcoholic mothers, as a subgroup, would report the highest scores on depression and family disruption and the lowest scores on self-esteem, as compared to all other subgroups (daughters of alcoholic fathers, sons of alcoholic mothers, sons of alcoholic fathers). These analyses did not reach statistical significance in this study (see Tables 14 and 15). Adolescents who reported a high level of family

Table 14

Perceived Mental Health, Behavior, and Family Functioning among Male and Female Adolescents of Alcoholic Mothers

		Independent t- Test				
		n=14				
Adolescent Gender		N	Mean	SD	df	t
Depression	Female	7	10.43	12.12		
	Male	7	15.00	9.26	12	-.79
Self-Esteem	Female	7	23.14	4.63		
	Male	7	25.29	5.02	12	-.83
Drinking Behaviors	Female	7	4.86	4.45		
	Male	7	4.14	2.91	12	.35
Family Disruption	Female	7	108.14	16.96		
	Male	7	114.71	10.44	12	-.87
Family Rituals	Female	7	15.00	2.31		
	Male	7	11.86	2.67	12	2.35**

** $p < .05$, two-tailed.

Table 15

Perceived Mental Health, Behavior, and Family Functioning among Male and Female Adolescents of Alcoholic Fathers

Independent Samples t Test

n=23

	Adolescent Gender	N	Mean	SD	df	t
Depression	Female	12	11.50	11.10		
	Male	11	11.55	13.60	21	-.01
Self-Esteem	Female	12	24.00	3.77		
	Male	11	25.09	7.05	21	-.47
Drinking Behaviors	Female	12	6.67	12.04	21	.50
Family Disruption	Female	12	112.50	10.10		
	Male	11	108.09	11.62	21	.97
Family Rituals	Female	12	14.00	3.38		
	Male	11	11.82	2.60	21	1.72*

* $p < .10$, two-tailed.

Rituals/closeness at home also were found to have high self-esteem and less depression symptoms. No significant differences regarding the measures were found among adolescents based on whether they had a mother or a father as an alcoholic parent. The data does, however, suggest that adolescent boys may be experiencing the most stress as a result of being raised in an alcoholic family, with lower levels of reported self-esteem, higher depression, greater perceived family disruption, and less reported family rituals than adolescent girls, irregardless of gender of alcoholic parent.

Post-Hoc Multivariate Analyses

Regression: Predicting Adolescent Drinking Behaviors

A hierarchical regression analysis was employed to evaluate the relationship between several theoretical models in the prediction of adolescent drinking behavior, the dependent variable. Analysis was performed using SPSS REGRESSION. Based on findings from a review of the literature, the following independent variables were evaluated as potentially significant and thus were included in the model: age and gender of adolescent, average family disruption score, drinking scores for alcoholic and drinking scores for spouse. The average family disruption score was computed using data from identified alcoholic parents, spouses and adolescents. This variable was seen as most representative of the "true" family disruption score for the families sampled.

None of the predictor variables identified in this model achieved statistical significance in predicting adolescent drinking.

Regression: Predicting Adolescent Depression

Hierarchical regression was employed to determine if "family rituals" and the

depression scores of parents were predictors in determining adolescent depression, controlling for gender and age of adolescent. Analysis was performed using SPSS REGRESSION. Three family ritual variables were entered into the equation: family-of-origin rituals for spouse, family-of-origin rituals for alcoholic, and mean present family rituals. The mean present family ritual variable was computed, averaging present family ritual scores for identified alcoholic parents, spouses, and adolescents. Based on the review of the literature, these variables were all seen as potential predictors in determining adolescent depression.

The variables were entered into the model on three steps. First, adolescent gender and age were evaluated and only explained 1% of the variance of adolescent depression. Next, all of the family rituals were entered into the equation. This step made a significant contribution to the model, explaining 19 % of the variance of adolescent depression ($F=.095$). With this group, spouse family-of-origin family rituals, as reported by the spouse, is the only significant coefficient ($B = -1.418, p < .05$). The final step of the model evaluates the mental health status of both parents entered, and was not significant. However, total family-of-origin family rituals for spouse only approached significance ($B = -1.235, p < .15$).

Regression: Predicting Adolescent Self-Esteem

Hierarchical regression was employed to determine if family rituals scores, family disruption scores or parental drinking scores predicted adolescent self-esteem, controlling for age and gender of adolescent. Analysis was performed using SPSS REGRESSION. Mean family ritual score were computed using the means of alcoholic parent, spouse and adolescent. Mean family disruption scores were computed in a similar method.

The variables were entered into the model in four steps, based on hypotheses by the researcher regarding possible contributions to the model. First, adolescent gender and age were entered. They explained 11% of the variance of adolescent self-esteem ($F=4.5$, $p < .05$). Next, the mean family ritual scores were entered into the equation. This step also made a significant contribution to the model, explaining 9% of the variance of adolescent self-esteem ($B = -.874$, $p < .10$). Mean family disruption scores were added to the equation in step three. This variable explained 0% of the variance. Spouses' drinking behavior scores and identified alcoholic parent drinking scores were then entered in step four. Twenty-one percent of the variance was explained in this step, with the alcoholic parent being the significant coefficient ($B = .24$, $p < .01$).

Summary

Among adolescent children of alcoholic parents there was a significant correlation found between level of family disruption and family rituals/closeness such that, the more adolescent respondents reported perceived family disruption to be present in their families, the lower the level of perceived family rituals/closeness reported. In families where the adolescent respondents perceived they had greater degrees of family rituals/closeness, the healthier the family.

Adolescents who reported a high level of family rituals/closeness at home also were found to have high self-esteem and less depression symptoms. No significant differences regarding the measures were found among adolescents based on whether they had a mother or a father as an alcoholic parent. The data does, however, suggest that adolescent boys may be experiencing the most stress as a result of being raised in an alcoholic family, with lower levels of reported self-esteem, higher depression, greater

perceived family disruption, and less reported family rituals than adolescent girls, regardless of gender of alcoholic parent.

CHAPTER V

Discussion

Although this study did not have the necessary number of respondents in order to assure adequate statistical power for the original hypotheses, the study results do suggest several possible trends in respect to adolescents raised in a home with an alcoholic parent. A discussion regarding study results, study limitations, and implications for further exploration are included in this chapter.

Summary of Results

Among the identified alcoholic parent respondents, 90% reported having at least one family member who had a drinking problem, while 73% of their spouses reported having at least one family member who had a drinking problem. The data also suggested a "family-of-origin" transmission of perceived family disruption and level of family rituals among alcoholic and spouse respondents, such that what was felt and experienced as a child growing up in the family was also similarly experienced in respondents' current families, as adults. Parent respondents reported similar levels of family disruption and level of intact family rituals/closeness in their current families as they did in their families-of-origin. The powerful impact of one's family-of-origin was also found in the data implying that alcoholic respondents' current alcoholic drinking may also be related to the level of family rituals and closeness as well as the perceived family disruption in their families-of-origin. Spouse respondents also reported higher depression scores when there was a higher level of family disruption in their families-of-origin.

A significant correlation was found among adolescent respondents between level of family disruption and family rituals/closeness, the more adolescent respondents reported perceived family disruption, the lower the level of perceived family rituals/closeness seemed to be. Adolescent respondents who reported higher levels of family rituals/closeness at home were also found to have high self-esteem and less depressive symptoms. Gender of adolescent emerged as significant in predicting family rituals in that female adolescents reported the greatest amount of perceived family rituals in their families, regardless of the gender of their alcoholic parent. Using a hierarchical regression analysis to predict adolescent depression, "family rituals" were seen as the factor that most contributed to the model, which explained 19 % of the variance of adolescent depression. Similarly, in a hierarchical regression analysis to predict adolescent self-esteem, "family rituals," again, was seen as an important contributor, explaining 9% of the variance of adolescent self-esteem.

The drinking behavior scores of alcoholic parents were also noted to be very contributory to level of adolescent self-esteem, with 21% of the variance explained by the addition of this factor in the model. Different from what was hypothesized, it appeared that boys—rather than girls—might be experiencing the most negative "side-effects" from being raised in an alcoholic family, regardless of gender of alcoholic parent. Adolescent boys in this study, as a group, reported lower levels of self-esteem, higher depression, greater family disruption, and less family rituals/closeness than their female counterparts.

Interpretation of Results

Awareness of Study Limitations.

Any and all of the results in this study need to be examined carefully and cautiously in respect to the many limitations inherent in it, including sample size, sampling bias, measurement concerns, and potential intervening variables that were not able to be addressed within the scope of this pilot study:

1. Sample Size. Although a power analysis recommended that 200 families be included in the study (fifty families in each cell: alcoholic mothers and daughters, alcoholic mothers and sons, alcoholic fathers and daughters, alcoholic fathers and sons) there were only 37 families who completed all of the study materials within a ten month recruitment period. The study protocol required that both parents and their adolescent child complete questionnaires in order to be included in the study. There were many families who were unable to have all three members complete the required study materials, and, in many cases, only the alcoholic parent filled out his/her study materials with the necessary follow-through. This incomplete data was not included in the study and only "family trios" were the respondents in this study. Unfortunately, the need for completed study information by three persons, within in one family, resulted in a smaller sample size than what would have been ideal and resulted in a less reliable statistical analysis.

2. Sampling Bias. In addition to the sampling bias that sample size, alone, could present, this investigator was concerned about the possibility that the respondents, as a group, could be biased in several ways. First, the respondent group consisted of alcoholic parents (and their families) who were in outpatient treatment for substance

abuse and were attending individual, group, and/or Twelve Step programs. The investigator questions whether this population of alcoholics could possibly be different from alcoholics not identifying themselves as "alcoholics" and still actively drinking or even those alcoholics who only attend Twelve-Step Programs and are not involved in the behavioral healthcare system. Also, it is possible that the phase of recovery that the alcoholic respondent was in could have had an impact on the study and the sampling. For example, would the responses from an alcoholic in early recovery differ from the responses of someone with six months sobriety, or one year or more?

Another potential sampling bias came from the fact that respondents in this study were representative of alcoholic families--but not each and every alcoholic family. All respondents in this study were married, living in intact families, and had a biological adolescent child. Among the many alcoholic parents initially identified for this study, the majority of parents did not fit this profile--they were single or divorced parents, sometimes raising their adolescent child alone--therefore, they did not fit the subject criteria.

The study could also be seen as having a potential adolescent sampling bias. If there was more than one adolescent in the family and the parents had chosen the respondent that would have "most likely" cooperated and participated in the study, a bias could have resulted.

Trends and Results Approaching Statistical Significance.

The major question regarding the results continues to be "what if?"--what if the sample size had been bigger, if more questions had been asked, if the study could have included more variables. It is noteworthy that so a few of the analyses of the data

yielded significant results on such a small sample size. There also appeared to be several intriguing trends and movement "towards significance" among the variables studied. Given a more sizeable sample size, statistically significant correlations between family disruption in both alcoholic parents' families-of-origin and spouses' families-of-origin with depression ($r = .28, p < .10$) might be expected. A relationship between alcoholic parents' perceived family disruption in families-of-origin and current drinking behaviors might also be potentially significant ($r = .28, p < .10$).

Theoretical Implications of Results

According to Bandura (1977), an enormous amount of human learning involves modeling, observation, and imitation. For a child, then, parents are crucial to learning, partly because they are the most important people in a child's life and serve as models and reinforcement agents within the context of the family unit. The emergence of a powerful and influential peer group around the time of adolescence is certainly an intervening factor when looking at the influence of the family system on adolescent respondents and one factor that was not addressed within the scope of this study.

The study also focused on the role of gender identification in respect to modeling and identification. Most social-learning and cognitive-development theorists (Bandura & Walters, 1963; Kohlberg, 1966; Mischel, 1966) assign a more significant role to mothers for both sons and daughters early development. As the child develops, same-gender identification takes on a more dominant role, with boys identifying with fathers, and girls with mothers. From these perspectives, this investigator hypothesized that maternal drinking would have a greater negative effect on adolescents, especially

daughters, and, in general, adolescents would be more apt to model behaviors of their same-gender parents.

The results from this study differed from the theory and hypotheses. Adolescents in this study did not appear to have similar scores to their same-gender parents (regardless of whether he or she was alcoholic or not). Adolescents who had a same-gender, alcoholic parent did not fare any worse or better on measures of self-esteem, depression, or drinking behaviors. In contrast, the data suggested that adolescent boys might be experiencing the most stress as result of being raised in an alcoholic family. Adolescent boys were found to have lower levels of reported self-esteem, higher depression, greater perceived family disruption, and fewer reported family rituals than adolescent girls, regardless of the gender of an alcoholic parent. Female adolescents also reported the greatest amount of perceived family rituals in their families regardless of the gender of the alcoholic parent. This indicates that adolescent boys lacked the feelings of closeness, stability, and structure in their families compared to adolescent girls.

Concerning the apparent resiliency of adolescent girls in comparison to boys in this study, this investigator raises several "red flags." Although the current study supports the longitudinal research (birth to age 18) by Werner (1986) that female adolescents were the more resilient offspring of alcoholics, some previous studies have suggested that daughters of alcoholics do not begin to show negative effects of being raised in an alcoholic family until later in life (e.g. Ackerman, 1989, 1990). According to Jones (1968, 1977), alcoholic men tend to have been rebellious, impulsive, and under-controlled as adolescents, while alcoholic women were more submissive, withdrawn, or "problem-free" adolescents. Perhaps, what the data are showing is a "sleeper effect" for

adolescent females in comparison to males, and what appear to be like resiliency may only be the seeds of "co-dependency." Many women, for example, do not develop alcoholic drinking behaviors until they reach the ages of 35 to 49 (Bergh, 1991; Schliebner, 1994; Wilsnack, et al., 1984). Many women with a family history of alcoholism also develop depression later in life (Helzer & Prybeck, 1988; Windle & Miller, 1989) or have both alcoholism and severe depression together (Barnes, 1977; Brown & Schuckit, 1988).

From a different perspective, Williams & Smith (1993) found that family closeness was more important than peer relationships in determining later substance use among women, whereas peer relationships were seen as more important determinants for males. Perhaps the female adolescents, who are in the minority and do not have the higher scores on family rituals/closeness are the ones most at risk from a disruptive family system.

This investigator wonders if the evolution within families in respect to changing parental roles--dual-career parents, more active "fathering" roles, and a more equal division of parenting tasks, for example--have influenced and will continue to impact the theory of same-gender modeling and identification. Perhaps the once primary and significant role of "mother" will be replaced with having either parent be the primary role model or with the emergence of "co-role models." In following up on this research study, it would be more valuable to see which parent the adolescent feels closest to, spends the most time with, and considers the primary caretaker, if applicable.

The study also highlighted the concept of family rituals and family functioning as they related to families with an alcoholic parent and ultimately, as they were implicated

in the transmission of alcoholism. According to Wolin and associates (1980) and Bennett et al (1988), family rituals and family cohesiveness were useful ways to assess the relative impact of alcoholism upon family life. Alcoholic families that were able to experience family rituals despite a parent's drinking and to create a sense of family identity have shown a significantly less incidence of intergenerational continuity of alcoholism than those families whose rituals were subsumed by alcoholism (Bennett, et al., 1988; Wolin et al., 1980). Similarly, adolescents raised in families with a high degree of organization and coping were less likely to initiate substance use (Hussong & Chassin, 1997).

In the present study, the importance of family rituals and family cohesiveness was also supported by the data. Results from a number of statistical analyses in this study pointed to the relationship between family rituals and adolescent respondents' self-esteem, depression and drinking behaviors--and across all respondent groupings. Family rituals were also seen as related to higher self-esteem, lower depression and lower levels of drinking behaviors among adolescent respondents. Study results also suggested that adolescent respondents who reported greater perceived family disruption in their families, also experienced lower levels of perceived rituals/closeness.

Comparison to Previous Research Findings

Drinking behavior.

This investigation only partially supported other research studies. Cork (1969), Smart and Fejer (1972), and Werner (1986) reported that adolescents were more negatively impacted by maternal rather than paternal drinking. In the current study, there were no significant differences regarding gender of alcoholic parent. Greenley (1970)

and Zucker (1976) observed that parental influence affects adolescent daughters' drinking more than the drinking behavior of their sons. Widseth and Mayer (1971) and Zucker and Devoe (1975) noted a significant relationship between heavy drinking by girls and alcoholic drinking by mothers. Again, there were no gender differences reported in this study related to gender of alcoholic parent and that of the adolescent respondents regarding drinking behaviors. There was also not a significance difference between adolescent boys and girls in respect to amount of reported drinking behaviors.

Self-esteem.

Many of the previously cited studies regarding the variable "self-esteem" have indicated that adolescents of alcoholic parents have low self-esteem (Barnes, 1977; Berkowitz & Perkins, 1988; Booz-Allen & Hamilton, 1974; Donald, Dunne & Raphael (1993); El-Guebaly & Offord, 1977; Hughes, 1977; Jones, 1971; McLachlan, 1985; Roosa, 1986; Russell et al., 1985; Woititz, 1983). Because the current study did not use a control group of adolescents with two non-alcoholic parents, comparisons to these studies are difficult. Adolescent respondents in this study did, as a group, report the highest self-esteem among respondent groups (more than alcoholic parents and spouses).

Family rituals.

Of all of the variables explored in this study, the variable "family rituals" appeared to have the greatest significance in this study.

In regard to self-esteem and family rituals, adolescents in this study who reported higher levels of family rituals/closeness also reported higher levels of self-esteem and lower levels of depression. This finding also supports the theoretic and clinical work of Bennett et al (1988), Wolin (1979, 1980, 1990) and the more recent work of Hounig and

Chassin (1997) concerning adolescent and family functioning. Like the studies previously cited, the current research showed the significance of family rituals and family functioning on the mental health of all adolescent respondents, but especially adolescent boys. This finding is particularly interesting since this researcher has never seen this gender difference reported in the literature.

Depression.

On average, the adolescent respondents reported a level of depression that Beck (1976) calls a "mild mood disturbance" ($M = 11.97$) and was not significantly different from the levels of the parent groups. In contrast, many previous studies have reported significant depression in adolescent respondents, especially adolescent daughters (Donald et al., 1993; Goodwin, 1977; Kandel, 1985; Kaplan, 1980; Merikangas et al., 1985; Woititz, 1983). Adolescent boys reported greater depression than adolescent girls in the current study--a novel find.

Practical Implications of Results

The present study's data suggest, in part, that the quality of the family environment, as perceived by the adolescent child, is an essential ingredient to healthy individual functioning. The supportive and consistent relationships with one or more parents appears to influence the essential adjustment and mental health functioning of that developing child--regardless of the gender of parent or gender of adolescent and, most importantly, regardless of whether that adolescent has an alcoholic parent or a non-alcoholic parent. The primary contribution of this study may well lie in the implication that it is not the alcoholic drinking in the family that causes adolescents difficulty while growing up--it is the quality of the environment and relationships that the parents either

seek to maintain or let fall to the wayside--that primarily determines the overall health of the family system.

Based on his genetic research, Rose (1996) hypothesized that genetic effects were more powerful once one began to drink, but environmental effects were more influential in predicting abstinence. "The choice to use and begin use is not genetic, but more influenced by their family and school environment" (Rose, 1996, p.9).

Because we currently can do little to change the genetic risk for alcoholism or drug abuse among children of substance abusers, changing the family or peer social environmental risk is the most feasible approach to reducing the overall risk. In following, it stands to reason that the focus of alcoholism recovery needs to be more than abstinence and focusing on the alcoholic alone. The spotlight needs to be in amending the family environment and improving the relationships, so that everyone benefits. Practical suggestions might include marital counseling, family therapy, and groups like effective parenting or communication workshops, "Life Skills" groups like anger management, self-esteem enhancement, or assertiveness training for the parents.

A program described in an article by Emshoff and Price (1999) is an example of such an intervention. Called "Strengthening Families Program" (SFP), this program is a family intervention that has been shown to reduce risk factors, increase resilience, and decrease alcohol, tobacco, and drug use among elementary school children of substance abusers, across many different cultural groups (Kumpfer, 1999; National Association for Children of Alcoholics, 1998). The major challenge of the program is to support high-risk COAs or COSAs (Children of Substance Abusers) to not begin use by changing their family and social environments (Kumpfer, 1999). The basic intervention of SFP consists

of a sixteen-week, behavioral parent training program and social-skills training for the children, as well as a family relationship enhancement program (Emshoff & Price, 1999). Each weekly SFP session meets for two-to-three hours per session.

Suggestions for Future Research

Future research is needed to:

1. Control for intervening variables that potentially impacts adolescents.

Investigating the impact of peer group influence versus family environment/parental influence as well as other significant persons in an adolescent's life would add to the literature. It would also be beneficial for future research to clearly define how long and during which ages the adolescent respondents had been living with an alcoholic parent. It would stand to reason that length of time exposed as well as the age of the adolescent at the onset of parental drinking might be potential intervening variables. Birth order of the adolescent respondent might also have some impact as an intervening variable and could be addressed in future studies.

2. Investigate the potential impact of alcoholism in "non-intact" families (e.g., single-parent, step-parents, etc.) in comparison to "intact" families.

3. Replicate the current study but collect more specific data regarding family history of substance abuse, mental health/psychiatric history, and significant medical history of all respondents. The marital functioning/satisfaction levels of parent respondents would also be beneficial in gaining a clearer picture of the family environment. Gathering more data regarding comorbid illnesses such as mood disorders, anxiety disorders, or psychotic disorders of both parents would also contribute to the literature. In addition, it would be useful in future research to control for possible fetal

alcohol syndrome or fetal alcohol effects by inquiring whether or not alcoholic mother respondents had been drinking or using any other drugs/substances while the adolescent respondent was a fetus or being breast-fed as an infant. Respondents with significant pre-natal exposure to alcohol most likely would represent a totally different group of "children of alcoholics" than children without this exposure.

4. Conduct more longitudinal studies that follow children of alcoholic parents through adolescence and adulthood, including their experience of parenting. This would be a major contribution to the literature.

5. Conduct/ replicate research with a variety of alcoholic populations for a broader perspective on the functioning of alcoholic families and the potential impact of parental alcoholism on adolescents. For example, would a sample of families with a parent who attends AA only, differ from families who have a parents who is a "rehab graduates" or a family with an alcoholic parent who has legal issues attributable to drinking (e.g. loss of driver's license).

6. Conduct a study that also takes into consideration coping mechanisms of respondents, sibling/birth order, and the presence/absence of mediating relationships outside of the family, e.g. coach, teachers, mentors.

In summary, families who have an alcoholic parent can either be "alcoholic families" who subsume to all the possible problems that drinking problems can lead to (e.g., communication problems, marital stress, divorce, abuse) or be in a loving, supportive family of individuals who may have problems and possibly alcoholic behaviors, but are still functioning families.

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