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UNIVERSITY OF ALBERTA

ADULT CHILDREN OF ALCOHOLICS: A PERSONALITY PROFILE

BY

CLAUDIA MARGARET WIENS LORANGER

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF: MASTER OF EDUCATION

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THE UNDERSIGNED CERTIFY THAT THEY HAVE READ, AND RECOMMEND TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH FOR ACCEPTANCE, A THESIS ENTITLED ADULT CHILDREN OF ALCOHOLICS: A PERSONALITY PROFILE.
SUBMITTED BY CLAUDIA MARGARET WIENS LORANGER
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF EDUCATION IN COUNSELLING PSYCHOLOGY.

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Date: January 21,1991.

ABSTRACT

In this descriptive study, personality characteristics of a sample of 76 Adult Children of Alcoholics (ACOAs), 19 males and 57 females, were analyzed using the 12 scale Basic Personality Inventory (BPI) (Jackson, 1989). Questionnaires were computer scored and results compared to the BPI norm group. Individual T-scores were charted by hand and tabulated according to frequencies of occurrence of each subscale.

There was considerable individual variation among the BPI subscale scores. The means of seven subscale scores were in the upper average range (T=>58) when compared to the BPI norm group. Mean T-scores on the subscale of Persecutory Ideas were significantly higher than those of the norm group. Denial scores were not unusually elevated.

When subscale scores were compared to those expected from a general population, ACOAs were found to be over-represented at the clinical range (T-score >70) from 5-14 times. Altogether 59% of the sample was found to have one or more subscales at clinical levels. the greatest percentages occurred on the following scales: Persecutory Ideas (28% of sample), Depression (23%), Deviation (22%), Social Introversion (19.7%) and Anxiety (18.4%).

Although this sample may not have been completely representative of the greater population of ACOAs, it

demonstrated that, contrary to some long term studies, there may be legitimate cause for concern in the personality functioning of those who identify themselves as ACOAs when compared to the general population.

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I would also like to thank my husband and my three teen-aged children for their cooperation during this period of study.

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CHAPTER I

It has been estimated that one in eight American children may have parents with alcohol related problems (Woodside, 1988; Parker & Harford, 1987). In terms of treatment, it has also been estimated that only 5% of COAs ever receive treatment (Barnard & Spoentgen, 1987).

In the early seventies, various researchers suggested that children of alcoholics (COAs) may be at risk for problems such as substance abuse (including alcoholism), emotional problems such as depression and anxiety, disruptive and delinquent behaviors, hyperactivity, low self esteem and few coping strategies (Edwards & Zander, 1985). However, there remains much discussion among various researchers as to relative validity of these factors, an issue which has clouded COA research attempts.

In this chapter, an overview of literature related to COAs will be presented, including physiological and psychological risk factors. The scope of research related to Adult Children of Alcoholics (ACOAs) will be presented, and methodological issues and limitations of the study discussed. Further consideration of factors related to resiliency will be presented in Chapter II.

Risk Factors

Physiological Risks

Two clinical prenatal effects, Fetal Alcohol Effects (FAE), and the more serious Fetal Alcohol Syndrome (FAS) have been associated with maternal alcohol abuse. The resulting long term effects on COAs have been reported to range from reduced birth weight and developmental slowing, to mental retardation (Macdonald & Blume 1986). A third factor may relate to genetic makeup, as COAs were reported 4-5 times more likely than non COAs to become alcoholics (Cermack & Rosenfeld, 1987; Goodwin et al in Barnard & Spoentgen, 1986). Although the specific genetic markers are as yet unclear, two types of alcoholism have been identified: "male-limited", which occurs only in males and is strongly inheritable, and "milieu limited" which occurs in both sexes in both in mild and severe forms. The former was reported to be influenced by paternal alcoholism alone, and the latter influenced by alcoholism in both parents, as well as post-natal environmental factors. Although Macdonald and Blume (1986), suggest that family transmission of susceptibility may be involved in as many as 40% of reported cases of alcoholism, Wilson and Nagoshi (1988) noted that despite genetic risks, more than half of the individuals classified at risk would not develop

alcoholism, while 5-10% of individuals from non-alcoholic families would. They concluded that the tracking of genetic factors in the transmission of alcoholism was not entirely reliable without further longitudinal twin studies.

Psychological Risks

Russel, Henderson and Blume (1985) noted that COAs may be at risk for familial transmission of psychiatric and physical disorders associated with alcoholism, such as depression, sociopathy and hyperactivity. Socially, COA's have also been reported to be at higher risk for marrying an alcoholic than non-COA's (Cermack & Rosenfeld, 1987; Woodside, 1988).

The effect of family environment has also received considerable attention in COA research. In summarizing their findings about alcoholic family environments, Macdonald and Blume (1986) stated that they were often reported to be chaotic, unstable, lacking consistency and emotional support. However, Goodman (1987) has argued that similar family dysfunction could occur for a variety of reasons, and dysfunction attributed to alcoholic families could take place under different circumstances of parental illness as well.

Adult Children of Alcoholics (ACOAs)

Early longitudinal studies which followed COAs into adulthood, such as the observations of Woititz (1984) and her observations of the long term effects of being an COA, have helped to popularize a secondary movement, that of Adult Children of Alcoholics (ACOAs). For the purposes of this research, the term ACOA shall refer to individuals who grew up in a home where one or both parents were considered by the adult children to have had problems related to alcohol abuse.

In general, it may be most important to note that ACOA's should not be classified as one homogeneous group, for as individuals, all ACOAs may not have had the same experiences, nor been affected in the same way (Barnard & Spoentgen,1986; Goodman,1987). Further, experiences of ACOAs may not have necessarily been negative, and ACOA adults may not as a rule be maladjusted and in need of counselling (Goodman 1987; El-Guebaly, 1982; Werner,1986). However, there may be positive factors in being identified as an ACOA, such as: (a) a warning of their tendency toward alcoholism or other addictive behaviors, (b) an identification of ACOA issues in a contextual frame of reference, (c) the possibility of providing assistance through self-help groups and materials, and (d) the opportunity to provide identity,

support and learning through the network of self help groups (Goodman, 1987). Although help for COAs can be beneficial in terms of understanding their experience in terms of parental illness, coping with their own emotions, and encouraging the development of a social support system, Goodman (1987) also cited the dangers of ACOA identification. He cautioned that ACOA "checklists" may closely resemble a checklist of broader mental health complaints rather than specifically related concerns. In addition he suggested that common descriptors of ACOAs may not necessarily be associated with childhood, but with a more recent cause.

Methodological Issues

The nature of the interaction of a child with the environment remains fundamental to the study of children, and the ability to study adults who were products of alcoholic environments has been further complicated by the numbers of variables involved, and the necessary time frames for study. In addition, much of the early research has been criticized for lacking in rigorous methodology. Jacob, Favorini, Meisel and Anderson (1978) analyzed methodological issues in research related to the alcoholic's spouse husband and children. After considering the results of 16 studies, they concluded that there was modest to moderate support for the view

that COA's exhibit significant difficulties in psychological, social and family functioning. However, they also found that many studies had methodological problems such as small samples, lack of control groups (or inconclusive control groups, such as psychiatrically disturbed families), and unmatched variables (such as religion, social status and family size). In addition, they reported that conclusions were made based on indirect reports or subjective interviews, terms were ill defined and the whole issue of the child interacting within a family system was ignored.

Similarly, Wilson and Orford (1978), in comparing family relationships of 11 families to those presented in the literature, commented on the apparent lack of an underlying theoretical concept to guide COA research, and cited the large variety of samples and methods used, which made it difficult, if not impossible, to compare findings.

This lack of rigor continues to be mentioned in literature reviews (Drake & Vaillant, 1988; Woodside, 1988), suggesting that it may still be a problem. Recently Blane (1988) suggested that there was a need for further COA research in areas such as objective verification of COA characteristics described in early studies (including distribution and clinical

significance); more study on family functioning; and an evaluation of existing COA programs. In addition, Woodside (1988) indicated that the use of more objective research measures might assist in providing additional data necessary for funding of preventative strategy programs for high risk individuals.

Scope of the Study

The author of the current study sought to explore personality characteristics of Adult Children of Alcoholics (ACOAs) using a standardized objective measure, the Basic Personality Inventory (BPI) (Jackson,1989). It is hoped that the results of this investigation may contribute to a fund of knowledge related to ACOAs that is based on objective data.

Results of this study may also provide a foundation for further objective personality research in the areas of resiliency to stressful situations. Lastly, this study may also assist in developing a base for comparison of the effects of long term childhood stress in other areas, such as chronic parental illness.

Limitations of the Study

The sample of individuals who participated in this study were volunteers who were generally aware of their ACOA status and its personal implications. The majority of the participants had been involved in some form of therapeutic intervention, either personal counselling or attending a workshop. As such, this sample is not necessarily representative of the total population of ACOAs, and so interpretation of the results may be limited.

In addition, data for the study was based on a written questionnaire, without personal interview, and thus may have pre-selected those individuals who had time or interest in completing the written form.

The BPI and the Short Michigan Alcohol Screening Test (SMAST) were used as screening devices rather than diagnostic measures. Thus any elevated individual scores may not necessarily indicate personality or drinking problems without further investigation. Conclusions about personality characteristics were made on a group rather than individual basis.

Family environment factors were not assessed, due to the length of the BPI and lack of a reliable appropriate measure. Some compensation for this was made in the inclusion of open-ended questions as to the

effects of the alcoholic parent on the individual, but it was left to the respondent to indicate specific situations such as abuse or violence. Similarly, the type of behavior of the alcoholic parent was not analyzed, nor was the potential effect of subsequent rehabilitation efforts noted, apart from voluntary comments. In addition, the effect of life events such as current marital or employment status, which could act as mediating factors in ACOA coping styles were also not included.

Other potential mediating factors, such as the effect of ACOA support group membership, were not explored, nor were the various group parameters such as structured versus self-help group support. For the purposes of this study, various forms of ACOA groups, such as structured support groups, time-limited ACOA courses or on-going self-help groups were not differentiated.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

In the following chapter, background literature relevant to the study of personality characteristics of ACOAs is presented.

In an attempt to describe individuals from alcoholic families, Woititz (1984) published thirteen personality characterizations that were based on her clinical observations of 500 COAs. These items included the following: "guessing at what normal is", having difficulty following through a project to completion, judging oneself harshly without mercy, having difficulty with intimate relationships, constantly seeking approval and affirmation, being super responsible or super irresponsible, extremely loyal even if not required, and locking oneself into a situation without considering the alternatives.

In contrast, it has also been suggested that some ACOA's may compensate by becoming overachievers, who maintain an "appearance of survival" while hiding their problems (Booz-Allen & Hamilton, 1974 in Black, Bucky & Wilder-Padilla, 1986). However, the publication of clinical judgements unsubstantiated by objective data has made it difficult to determine if these descriptions do

in fact describe ACOAs, and under what circumstances they may apply.

ACOA Personality Factors

In a recent review of ACOA literature, Black et al. (1986) compared adults from alcoholic and non-alcoholic families. They reported less utilization of interpersonal resources as a child, significantly more family disruptions, characterized by a higher divorce rate and premature parental and sibling death, more reported emotional and psychological problems in adulthood, and more experience of physical and sexual abuse as children. Further consequences were reported to be an increased rate of becoming alcoholic and marrying an alcoholic.

In addition to these findings, Cermack and Rosenfeld (1987) have used their clinical observations to suggest that ACOA's may suffer from Post-Traumatic Stress Disorder, and may experience feelings similar to individuals who had been physically abused.

Parker and Harford (1987) analyzed data from a household survey and reported that parental drinking, in combination with a low occupational status, placed both sons and daughters at elevated risk for alcohol related problems. Their study also confirmed the earlier findings of Goodwin, Schulsinger, Knop, Mednick and Guze (1977) in

which it was reported that parental alcohol abuse may affect adult daughters of alcoholics in terms of depression. In a subsequent study, Parker and Harford (1988) further suggested that having parents as alcohol abusers placed sons at risk for dependent problem drinking (drinking with a loss of control), and both sons and daughters at risk for divorce or separation, as well as daughters at risk for depressive symptomatology.

Berkowitz and Perkins (1988) hypothesized that the effect of being an ACOA might be gender specific, and using selected parts of short form personality inventories such as the Self Identification Form, the Interpersonal Orientations Form, and the "other-directedness" scale of the Self Monitoring Scale they found that females with alcoholic fathers were significantly different from their peers on measures of Self Depreciation, while males with alcoholic fathers were significantly different on measures of Independence/Autonomy. However, the authors also reported both male and female ACOAs to be similar to their peers on six out of eight personality measures: Impulsiveness, Lack of tension, Other-directedness, Directiveness, Need for social support, and Sociability.

Similarly, Pliscia-Pikus, Long-Suter, and Wilson (1988) examined 44 ACOA's in comparison to 92 controls

with regards to achievement, well being, intelligence and stress reaction, using three scales from the California Psychological Inventory (CPI), and Factor B for Intelligence from the Sixteen Personality Factor Questionnaire (16PF). They found that ACOAs with high well being scored higher on achievement scales than the controls, and were above average for national norms as well. ACOAs with low well being scored lower than the controls and were higher in their response to stress.

From these articles it has appeared that researchers are as yet unclear as to the fundamental effects of being ACOA. It has also been difficult to ascertain validity of ACOA claims, as they have been based either on clinical observations alone, or selected subscales from standardized tests. By using an objective measure in the current study, the author hopes to be able to clarify some of the findings reported.

Resiliency

Garmezy (1974) was one of the earliest researchers to note that some children in high risk situations, such as having parents with chronic mental conditions, emerged relatively unscathed, and demonstrated unusual competence in managing their situations. That is, they appeared "resilient" in spite of their surroundings. Garmetzy concluded that there were six criteria for competence:

effectiveness in work, play and love; healthy expectancies and the belief in "good" outcomes; feelings of personal worthiness and a sense of control over one's environment; self discipline in the ability to delay gratification; control and regulation of impulsive drives; and the ability to think abstractly and to be flexible in finding solutions to a problem.

Similarly, the findings of longitudinal studies such as those of Werner (1986), and Drake and Vaillant (1988) have suggested that ACOAs as a group may emerge relatively free of negative experiences, despite coming from an alcoholic home.

Werner (1986) followed 700 children, including 49 COAs, and reported that over half of the COAs did not demonstrate any problems. Based on interviews with the COAs at age 18, Werner concluded that girls were more resilient than boys, and an alcoholic mother was more damaging than an alcoholic father. However, as Stark (1987) commented, the differential effect of an alcoholic mother may also be related to the potential development of Fetal Alcohol Syndrome. Werner identified intervening variables in successful functioning as related to characteristics of temperament, communication skills, self concept and locus of control, as well as experiencing fewer stressful events in the family during

the first two years of life.

Beardslee, Son and Vaillant (1986) compared functioning of ACOA and non-ACOA men in terms of alcohol outcomes through the assessment of records of a 40 year longitudinal study. They concluded that the degree of exposure to parental alcoholism in childhood was independently related to the development of alcoholism in adulthood, and that the main effects were limited to the relatively small group of men who developed alcoholism themselves. It was concluded that ACOAs may possess considerable resiliency despite their experiences with alcoholic parents.

Coping Styles

Two of the more recent studies have focused on coping styles of ACOAs. Barnard and Spoentgen (1986) studied the variations between two groups of college-aged COAs, those seeking treatment through an educational or supportive group, and those not seeking treatment. They found that despite a greater degree of parental loss, COAs not seeking treatment were more similar than different from non-COAs. Using the Personal Orientation Inventory, the authors also unexpectedly found that COAs demonstrated higher scores on the test measuring capacity for intimate contact than non-COAs. However, of the total

COA group, those seeking treatment scored significantly lower on psychological functioning than the non-treatment COAs, experienced the greatest amount of parental loss, and had fewer financial resources than either of the other two groups. Despite this evidence, the authors also noted that most of the COAs in their sample demonstrated a normal level of psychological functioning. The authors commented that previous research may have been biased toward treatment populations.

Coping Strategies

Wilson and Orford (1978) reported that COAs of alcoholic fathers tended to resort to solitary activities such as smoking and trying to forget, while non-COAs coped with stress by talking with friends and relatives, eating, and church related activities. Other solutions frequently mentioned by COAs were: attempting to ignore provocative remarks, avoiding potential clashes, withdrawing, leaving home.

Cork and Genest (1987) studied the moderator variables and coping strategies related to adjustment of offspring of alcoholic fathers of a largely female college sample. They found that while ACOAs came from more dysfunctional families than the control group, and reported to be more prone to depression, many adult children were functioning at or above the non-ACOA group,

and did not differ in their perceptions of self esteem. In coping strategies, ACOAs tended to perceive more of their problems as being out of their control, were more emotion focused, and tended to use more wishful thinking and avoidant strategies (i.e. eating, smoking, drinking) than controls. The combination of family environment, social support and coping variables were reported to be related to depression proneness and self esteem. It was suggested that social support and coping strategies were a means of survival in an alcoholic family.

Parental Factors

Ackerman (1987) studied the factors that could contribute to differing perceptions of ACOAs, and concluded that differing variables such as type and kind of alcoholic in the family, age at which the child was exposed, gender, resilience to stress, and other offsetting factors such as the presence of a significant individual (who may also be the non-alcoholic parent) who interacted positively with the child, may reduce the impact of the alcoholic parent.

In a continuation of the Beardslee et al. (1986) study, Drake and Vaillant (1988) concluded that poor adjustment in adolescent COAs was related to an unsupportive relationship with their mothers. However

they reported that by midlife many of the adjustment difficulties had been overcome, provided the individual had not become alcoholic themselves. Healthy adult development was reported to be related to factors such as escaping the alcoholic environment, leaving the non-alcoholic parent, developing task competence, experiencing healthy relationships and maturation of defense mechanisms. The results of this study appeared also to support the notion that a positive relationship with a non-alcoholic adult could mediate the effects of an alcoholic parent.

Summary

A review of related literature revealed a discrepancy in findings related to ACOA personality characteristics and functioning, with some studies indicating that ACOAs tended to have more emotional and psychological problems in adulthood than non-ACOAs, and others suggesting that ACOA's were not necessarily different from their peers. The role of intervening factors such as family environment or type of alcoholic parent were also claimed by some to affect ACOA functioning. However, ACOA research has been often based on personal observations, limited samples, or selections from objective tests, which has made generalization particularly unclear.

Based on the literature reviewed, the author of the current study sought to investigate some of the issues presented, using the following general research questions:

1. Are adult children of alcoholics (ACOAs) significantly different from a normative sample of North American adults?
2. What was the representation of ACOAs in the clinical range?
3. In which areas of personality were the scales elevated?

CHAPTER III

METHOD AND PROCEDURES

In this chapter the procedures and methods of data analysis used to conduct the present study will be discussed. The reliability and validity of the Basic Personality Inventory (BPI) and Short Michigan Alcoholism Screening Test (SMAST) will also be presented.

Procedure

Participants were given a copy of the questionnaire package (see Appendix 1), which was to be completed at home and returned using the self-addressed envelope provided. The questionnaire was prefaced with a paragraph which included a statement of purpose for the research study, as well as assurances of the anonymous nature of the study, voluntary participation, and the maintenance of confidentiality. The term "ACOA" was not used in the questionnaire, in order to include any interested individuals, not only those previously affiliated with specifically defined "ACOA" activities. The questionnaire referred to "individuals who grew up with a parent who drank heavily". Responses to questionnaires were entered into the computer by the researcher and tabulated.

Sample

Participants for this study were solicited from a variety of sources. Personal contact was initiated with numerous group leaders and counsellors who worked with ACOAs, and who were asked to distribute questionnaires to interested individuals. Because of the mail-back reply method, individuals could then choose not to complete the questionnaire without affecting their status in the group or class. One newspaper ad was also placed, and questionnaires mailed out to interested individuals. Of the 193 questionnaires distributed to potential subjects, 98 were returned, for a response rate of 50.8%. Six questionnaires were omitted due to respondent errors, such as omitting critical data, or not being ACOA. Sixteen arrived too late for the analysis, leaving a final sample of 76,(males N=19; females N=57), with a mean age of 33.5 years.

Instrumentation

A brief questionnaire, the Parental Alcohol Use Questionnaire, was composed in order to gather demographic data, as well as descriptions of ACOA status (see Appendix 1). In addition, the Short Michigan Alcoholism Screening Test (SMAST) was also administered to measure ACOA drinking habits. The Basic Personality

Inventory (BPI) was used to sample a variety of personality functioning.

Parental Alcohol Use Questionnaire

The Parental Alcohol Use Questionnaire (see Appendix 1) consisted of six demographic questions including: gender, age, level of education, marital status, birth order, and approximate family income. Participants were identified as being ACOA based on their positive responses to any one of four questions, all of which had been used individually in previous research (Berkowitz & Perkins, 1988). Participants were also asked if they had ever been a member of a support group related to being an ACOA.

Time for completion of this section was estimated to be five minutes. Data from this questionnaire was then coded and entered into a computer by the researcher, and later scored using the SPSS system.

Basic Personality Inventory (BPI)

The Basic Personality Inventory (BPI) (Jackson, 1989) is a 240 item true/false questionnaire, designed to measure aspects of personality and psychopathology both within the normal population, and the population experiencing psychological distress. It includes a

bipolar reading of twelve scales: Hypochondriasis, Depression, Denial, Interpersonal Problems, Alienation, Persecutory Ideas, Anxiety, Thinking Disorder, Impulse Expression, Social Introversion, Self Depreciation, and Deviation.

Although the BPI manual contains information related to the use of the BPI with various populations including alcoholics (see Skinner & Allen, 1982 in Jackson, 1989), no studies with ACOAs are reported.

A useful component of the BPI was the inclusion of separate adult norms. The norms were based on a sample of 1419 adults (709 males, 710 females) from both Canada and the United States. Adequate reliability and validity, with internal consistency reliabilities (KR20) in the range of .65 to .80 were also reported for a number of samples, and test re-test reliability was in the range of .62 to .87. Validity scores were reported to be .56 for regular scales and .60 for factor scales, when corrected for unstable criteria.

Although a newer measurement scale, the BPI appears to be well researched and constructed, and thus potentially able to provide reliable and valid data for the present study. Time for completion was estimated to be 40 minutes (Jackson, 1989).

When gathering the current data, it was found that

all BPI questionnaires were completed in full, with only a few omissions of individual questions. BPI scores were entered into the computer by the researcher and then analyzed using the SPSS program.

Short Michigan Alcoholism Screening Test (SMAST)

The SMAST was included in order to determine the drinking behavior of ACOA individuals.

The SMAST is a 13 item derivative of the 25 item Michigan Alcoholism Screening Test (MAST), which was devised to provide a consistent quantifiable instrument for the detection of alcoholism (Selzer,1971). It has been reported to have adequate reliability in differentiating personal drinking behavior (Selzer, 1971). The SMAST has also been reported to be as reliable as the MAST in screening for alcoholism (Conners & Tarbox in Kaiser and Sweetland 1985; Seltzer, Vinokur & VanRooijen, 1975), with a Pearson Product Moment correlation of .90 to .97 between the SMAST and the MAST. Reliability coefficients of the SMAST are reported to be .76 to .93, which compare favorably with the MAST. Seltzer et al. (1975) also suggested that scoring of the SMAST was proportional to that of the original 25 item MAST, with SMAST scores of 0-1 indicative of no drinking problems, scores of 2 suggestive of possible problems,

and scores of 3 or more suggestive of probable problems and possible alcoholism. As previously noted, the SMAST was developed to be used as a screening device, and thus a critical score was not to be interpreted as indicative of alcoholism without further assessment. Similarly, some responses to items may have related to past behavior, and thus increased scores may not necessarily be indicative of present behavior or current alcohol problems.

Scores were coded and entered on the computer by the researcher and scored using the SPSS program. Time of completion was estimated to be five minutes.

In summary, all questionnaires were coded, checked and entered into the computer by the researcher. There was no individual follow-up with the participants.

Research Questions

In order to explore personality characteristics of Adult Children of Alcoholics (ACOAs) the following questions were developed:

1. How did the mean scores of the ACOA sample compare to that of the BPI norm group?
2. What was the representation of ACOAs in the clinical range (T>70) when compared to a random sample of a general population?
3. Which BPI subscales were the most frequently

elevated?

4. What percentage of ACOAs had one or more scales in the clinical range?
5. Was there any relationship between personal drinking behavior and BPI subscales?
6. What was the relationship between the scales?

Data Analysis

Due to BPI gender specific norms, male and female mean scores were tabulated separately for each subscale. The means were then translated into T-scores for ease of comparison to each other and to the BPI published norm values. In order to track individual scores, group frequencies, and clinical ranges, a frequency of occurrence chart was constructed which enabled manual tabulation of subscale scores at specific ranges. A Chi square analysis was used to determine if there was any relationship between drinking behavior (as measured on the SMAST), and BPI subscales. Pearson Product moment correlations were calculated in order to discover the relationship between subscales, followed by Fisher's Z in order to ascertain if there was a significant difference between the scores of males and females on specific subscales.

For all statistics, the criterion for judging significance was $p < 0.05$.

CHAPTER IV

RESULTS AND DISCUSSION

In this chapter the sample is described and research findings presented.

Description of Sample

As previously indicated, the sample consisted of 76 participants, 19 males and 57 females, with a mean age of 34.6 years for males and 33.3 years for females, and a mean level of education of 13.7 years for both males and females (see Table 1).

As detailed in Table 1, there were no significant differences between males and females in the areas of age, education, marital status, family position or levels of income. The positive responses to questions on the Parent Alcohol Use Questionnaire suggested that this ACOA sample appeared to be well aware of the drinking habits of their parents, and reported as adults to have been affected by their parent's drinking behavior.

Results of the Short Michigan Alcohol Screening Test (SMAST) suggested that 43% of this sample could possibly have had personal drinking problems. Not unexpectedly, it was noted that critical SMAST scores of 3.00 or greater (Seltzer et al. 1975) were more related to the males of the sample (67.4% of males) than the females (24.7%). The

mean SMAST score for the males was 5.00, which initially suggested that the males of the sample may have had significant problems with their own drinking behavior. However, an analysis of individual profiles demonstrated considerable variation in the male scores, which suggested a wide range of drinking behavior patterns.

Of the total sample, 64% reported either past or present association with a support group related to being an ACOA. Such a proportion suggests that this sample may not be typical of all ACOA's, and thus results should be interpreted with caution.

Responses to Research Questions

Question 1

In order to compare the mean scores of the ACOA sample to the BPI norm group, the scores were changed to T-scores, using the BPI gender specific norms.

Although there was considerable individual variation, both sexes had means which tended to be in the upper average range for the majority of BPI subscales, when compared to the more general population of North American adults (see Table 2).

From Table 2 it may be seen that both genders had the highest mean score on a common subscale, that of Persecutory Ideas, (T-score= 62 [male] and 60.6

[female]), fully one Standard Deviation (SD) above the expected value based on a general population. Although an elevated score on this subtest may not necessarily indicate a sense of paranoia, it may suggest that these individuals may tend to feel that they have been made victims, either by their parents or the educational or justice system (Jackson,1989).

Both genders also had means (M) which tended to be in the high average range on the subscales of Anxiety, Depression, and Self Depreciation. These scores suggest that individuals sampled may be experiencing high levels of psychological distress. They may also tend to have a poor self image, and may display a pessimistic attitude about themselves and their future. The increased scores on both Depression and Self Depreciation suggest that these individuals may have a tendency to a chronic rather than acute depressive state. They may demonstrate little confidence in their ability to cope with problems, and may possess a sense of helplessness in problem solving situations.

Although not statistically significant, it is interesting to note that males in this sample tended to score in the above average range on the subscale of Impulse Expression, suggesting a tendency toward impulsive behavior. Females tended to have scores in the

above average range on the scale of Social Introversion, suggesting that some individuals preferred solitary activities over social ones. This may be of some consequence in an individual's ability to cope with periods of unusual stress, as there is less of a natural support system to help them (Jackson,1989).

On the Deviation subscale, males and females demonstrated a 10 point discrepancy, which suggested that males in this sample may have tended to respond with more unusual answers than females.

Question 2

To determine whether ACOAs were overrepresented in the clinical range when compared to a random sample of a general population, a composite chart of individual scores was constructed. Each individual profile was then plotted, and the frequency of occurrence of scores noted. Critical levels, or those in the above average range, were defined as being one Standard Deviation (SD) above the mean (T-score>60<70).

Clinical levels, those significantly above average, were defined as 2 SD above the mean (T-score >70). Based on the expected distribution of scores of a general population, it was predicted that 14% of the sample would be expected to be in the critical range (T>60<70), and 2%

would be expected to fall in the clinical range (T>70).

As can be seen from Table 3, with the exception of the Denial subscale, a measure of defensiveness, the incidence of scores at the clinical range was greatly overrepresented on each subscale, both for the sexes individually, and for the sample as a whole. On the subscale of Persecutory Ideas, results suggested that clinical level scores significantly exceeded that normally expected, at 14 times the expected level. Similarly on the scales of Depression and Deviation, elevated scores occurred 11-12 times more than expected. Clinical level scores on the subscales of Social Introversion and Anxiety were also noted to occur 9-10 times more than expected.

Table 1

Reported Demographic Data of Sample Males and Females: Males (M) (N=19) Females (F) (N=57)

	M	SD	F	SD
Age (mean)	34.6	6.3	33.3	6.5
Education (in years)	13.7	4.3	13.7	2.6
SMAST	5.0	4.2	1.8	2.4

Marital Status	M%	F%
Single	26.3	21.1
Married	52.6	64.9
Divorced/Sep	21.1	14.1

Position in family	M%	F%
Only	15.8	1.8
Eldest	26.3	31.6
Middle	36.8	33.3
Youngest	21.1	33.3

Family Income	M%	F%
Under $20,000	15.8	10.5
$20-40,000	36.9	43.9
$40-60,000	42.1	22.8
Over $60,000	5.3	21.1
not reported	0.0	1.8

Parental Alcohol Use Questionaire

a Theme	M%	F%
1 Identified Alcoholic Parent		
Both	15.8	17.5
Father	68.4	75.4
Mother	15.8	5.3
2 Wished Parent Drink Less	94.7	84.7
3 Thought Parent Alcoholic	89.5	94.7
4 Parental Drinking Created Problem	94.7	98.2
5 Member of ACOA Group	73.7	56.1

a: the number of the question on the Parental Alcohol Use Questionaire

Table 2

Comparison of BPI Subscale Mean Scores and T-scores.

BPI Scale	Males (N=19) Mean	SD	T	Females (N=57) Mean	SD	T
Hypochondriasis	4.26	2.47	49	7.44	4.58	56
Depression	5.47	5.06	58.5	6.12	5.32	58
Denial	4.63	1.98	41	4.87	1.95	44
Interpersonal Problems	9.95	4.72	56	9.58	3.51	56.5
Alienation	5.53	3.12	55	3.51	2.94	52
Persecutory Ideas	6.79	3.23	62	6.68	3.85	60.6
Anxiety	8.16	4.09	58	10.32	4.42	59
Thinking Disorder	3.63	3.13	55.5	2.88	2.60	50.5
Impulse Expression	8.47	4.22	60	6.91	4.28	55
Social Introversion	7.26	4.72	57	7.46	4.95	60
Self Depreciation	3.26	4.72	58	3.70	3.57	58
Deviation	4.00	3.06	60	3.95	2.62	50

Question 3

In order to determine which scales demonstrated the most frequent elevations, the composite chart was again used to tabulate the total percentage of scores above average. These results indicated that from one third to one half of the total sample of ACOAs demonstrated scores in the critical to clinical range (T>60) on seven out of twelve subscales: Anxiety (51.3%), Persecutory Ideas (47.4%), Social Introversion (38.2%) and Depression (38.2%), Deviation (36.8%), Interpersonal Problems (35.5%), and Impulse Expression (35.5%).

At the clinical level (T>70), high scores most often occurred on the scales of Persecutory Ideas (28.9%), Depression (23.4%), Deviation (22.4%), Social Introversion (19.7%), and Anxiety (18.4%). When genders were considered separately, in addition to the above, 26.3% of males also tended to have scores at a clinical level on the subscale of Impulse Expression.

Table 3

Percentage of ACOA Elevated Scores in Comparison to Expected Percentage of General Population.

	Males(N=19)		Females(N=57)		Total(N=76)	
T-score	>60<70	>70	>60<70	>70	>60<70	>70
Expected	14%	2%	14%	2%	14%	2%
Hypochondriasis	10.5	5.3	22.8	15.8	19.7	13.2
Depression	15.8	21.0	14.0	24.6	14.5	23.4
Denial	0.0	0.0	0.0	0.0	0.0	0.0
Interpersonal Problems	21.0	15.8	22.8	12.3	22.4	13.2
Alienation	21.0	5.3	5.3	14.0	9.2	11.8
Persecutory Ideas	15.8	31.6	19.3	28.1	18.4	28.9
Anxiety	31.6	21.0	33.3	17.5	32.9	18.4
Thinking Disorder	15.8	15.8	8.8	8.8	10.5	10.5
Impulse Expression	15.8	26.3	21.0	12.3	19.7	15.7
Social Introversion	15.8	15.8	19.3	21.0	18.9	19.7
Self Depreciation	15.8	15.8	17.5	15.8	17.1	15.8
Deviation	21.0	15.8	12.3	24.6	14.7	22.4

Question 4

In order to determine what percentage of ACOAs had one or more subscale scores in the clinical range (T>70), the composite chart was also used to analyze individual profiles of BPI scores.

In all, 59% of the total sample (63% males, 57.8% females) had one or more subscales within the clinical range. This distribution of scores is in sharp contrast with the 2% expected from a general population. Whereas it would be expected that 1:50 of a general population sample would be in the clinical range, in this sample the ratio rose to approximately 3:5, or nearly a 60% chance that an ACOA of this sample might have one or more scales at the clinical range.

Of the total sample, there also appeared to be approximately twice as many individuals with scores in the clinical range (T>70) than with scores from T>60<70. Such a distribution suggested that individuals with elevated scores tended to have severe rather than mildly elevated scores. Such a pattern could suggest that ACOA individuals with elevated scores may tend to demonstrate behavior such as that represented at the more extreme ends of the specific subscales.

Table 4

Percent of ACOAs with One or More BPI Subscales at Clinical Range (Cumulative)

	Males (N=19)		Females (N=57)		Total(N=76)	
T-score	>60<70	>70	>60<70	>70	>60<70	>70
1 scale	5.2	31.6	8.7	15.7	7.8	19.7
2 scales	10.4	36.8	17.4	19.2	15.6	23.6
3 scales	10.4	47.3	22.6	26.2	19.5	31.4
4 scales	15.8	63.0	27.8	57.8	24.8	59.0

Question 5

In order to ascertain the relationship between SMAST scores and BPI scores, the Chi square analysis was used. Individual scores on the Short Michigan Alcohol Screening Test (SMAST) were divided into "non-alcoholic" and "possibly alcoholic" groups, using the critical score of 3 (Seltzer et al, 1975) and contrasted with the 12 subscales of the BPI. Chi square analysis did not reveal any significance between SMAST scores and any of the BPI subscales. Such a finding suggested that the effects of personal drinking behavior on personality characteristics were not discernable using this measure.

Question 6

In order to determine the relationship between subscale scores on the BPI, Pearson Product Moment correlations were calculated for each gender. In order to test for significant differences, the relative correlations of male and female scores were then compared using Fischer's Z test for significance.

As can be seen from Table 5, the strongest relationships between BPI subscales for males appeared to be related to the subscales of Alienation, Persecutory Ideas, and Self Depreciation. The subscale of Alienation, was found to be significantly related to those of Thinking Disorder (r=.72), Impulse Expression (r=.72),

and Deviation (r=.69). The subscale of Persecutory Ideas was noted to be related to Depression (r=.71), Social Introversion (r=.71), and Self Depreciation (r=.63). There was also a significant relationship noted between Self Depreciation and Depression (r=.71), as well as Self Depreciation and Deviation (r=.71).

Similarly for females in this sample, the subscale of Persecutory Ideas was also related to a number of subscales, the strongest being Deviation (r=.72), and Depression (r=.69). Self Depreciation was also related to Depression (r=.70). There were also moderate correlations noted between Alienation and Impulse Expression (r=.69); and Hypochondriasis and Anxiety (r=.68).

The application of Fischer's Z test did not reveal any significant differences between male and female scores, with the exception of the subscales of Alienation and Thinking Disorder, in which the scores of the males were found to be significantly different from those of the females ($Z=2.10$ $p>.05$). Such scores suggested that the males of this sample tended to be more isolated and prone to unusual thoughts than the females of the sample.

Table 5
Pearson Correlation Coefficients Among BPI Subscales for Males (M) (N=19) and Females (F) (N=57) at $p \leq .05$

	1	2	3	4	5	6	7	8	9	10	11	12
1M	*	.42	--	--	.47	--	.56	.47	.55	--	--	.60
F	*	.46	--	--	.25	.45	.68	.56	.31	.31	.46	.59
2M		*	--	--	.45	.71	.69	.41	--	.60	.71	.56
F		*	--	.44	.40	.69	.53	.25	.35	.56	.70	.65
3M			*	-.45	--	--	--	--	.41	--	--	--
F			*	--	-.25	--	--	--	-.37	.28	--	--
4M				*	.48	.43	--	.50	.65	--	.52	.52
F				*	.33	.39	.25	--	.39	--	--	.26
5M					*	.48	--	.72	.72	--	.49	.69
F					*	.57	.35	.29	.69	--	.22	.47
6M						*	.54	.39	.46	.71	.63	.56
F						*	.61	.36	.56	.40	.48	.72
7M							*	.39	.48	.71	.63	.56
F							*	.36	.56	.40	.48	.72
8M								*	.60	--	--	.60
F								*	.31	--	--	.44
9M									*	--	.55	.61
F									*	--	.23	.48
10M										*	.67	.53
F										*	.47	.31
11M											*	.71
F											*	.51
12M												*
F												*

___= significant difference between male and female
1. Hypochondriasis 2. Depression 3. Denial 4. Interpersonal Problems 6. Persecutory Ideas
7. Anxiety 8. Thinking Disorder 9. Impulse Expression 10. Social Introversion
11. Self-Depreciation 12. Deviation

Summary and Discussion

The means of the BPI subscales tended to be in the high average range for both sexes, with two exceptions: Persecutory Ideas, in which the mean for both sexes was Above Average (T>60) and Denial in which the mean for both sexes was Low Average (T>40<45). Other scales with means in the High Average range were Anxiety, Depression, and Self Depreciation. There was no significant difference between scores of males and females except for the subscale of Deviation, in which males scores were higher by one Standard Deviation (males T=60).

When the frequency of occurrence of clinical level scores (T>70) was compared to that expected of a general population, each subscale except Denial was found to be greatly overrepresented, with that of Persecutory Ideas occurring with the most frequency, more than 14 times the expected level. Other frequencies of note were the subscales of Depression and Deviation, which were 11-12 times more inflated than expected, and Social Introversion and Anxiety which were 9-10 times greater than expected.

The absence of any increased scores on the scale of Denial was an interesting phenomenon, which suggested that this particular sample of ACOAs were quite open and

realistic in their approach to problems, and not afraid to discuss unpleasant topics. However, these low scores may have been related in part to the sample selection, rather than representative of ACOAs in general, as many of the subjects were knowledgeable of ACOA status, and as such may have been more self aware than the general population.

Care must be taken in the interpretation of BPI scores, as critical scores may not necessarily be indications of pathology. For example, as Jackson (1989) cautions, a clinical score on the subscale of Persecutory Ideas " may not be necessarily indicative of pathological levels of paranoia" (p.21), but rather a sense of victimization, factors that may have some basis in reality, especially if other issues such as physical, sexual or emotional abuse were present.

Similarly, high scores on the Depression subscale may indicate a pessimistic attitude, rather than a clinical diagnosis. Although this scale does not differentiate between situational or acute depression without further data (Jackson,1989), the increased scores on the scale of Self Depreciation could be interpreted to suggest the possibility of a chronic rather than acute depressive state (Jackson, 1989).

In addition, although high scores on the Deviation

subscale could represent either non-purposeful answers, or a number of serious symptoms (Jackson,1989,p 22), reference to chart of individual scores indicated that such scores tended to be grouped rather than singular occurrences, a finding which tended to support the notion of symptomatic behavior rather than a random selection of responses.

This study found that scores in the clinical range most often occurred on the scales of Persecutory Ideas, Depression, Deviation, Social Introversion and Anxiety, listed in descending order. Interestingly, when the above average scores (T>60) were included, elevations on the subscale of Anxiety occurred in more than one half of the total sample, making it the highest occurring subscale overall. Similarly, increased scores on the Social Introversion subscale also became more prominent, as did Interpersonal Problems and Impulse Expression. Such a change in scores suggests that pre-clinical levels of certain factors may be a part of ACOA functioning in certain individuals.

When reviewing the number of individuals with one or more subscale scores at the clinical level, 59% of the total sample, or three out of five ACOA individuals sampled, had one or more subscales within the clinical range, a significant finding when compared to the

expected 2% of a general population.

For the total sample, it appeared that approximately twice as many individuals had scores at the clinical level (T>70) than at the lower critical level (T>60<70). This finding suggested that individuals with elevated scores may tend to have severely elevated scores rather than mildly elevated scores.

No relationship was found between personal drinking behavior and BPI scores, suggesting that personality characteristics may not have been discernable using this measure.

In comparing associations between subscales, those of Alienation, Persecutory Ideas, Self Depreciation, Deviation and Depression had the highest inter-correlations. Male scores on the subscales of Alienation and Thinking Disorder, were found to be significantly different from those of the females ($Z=2.10$ $p>.05$). Such scores suggested that the males of this sample tended to be more isolated and prone to unusual thoughts than the females of the sample.

Further implications remain to be discussed in Chapter V.

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This descriptive study was conducted in order to objectively describe ACOA personality characteristics. Seventy-six volunteers were solicited to complete an anonymous mail-back questionnaire, including the 240 item Basic Personality Inventory (BPI), the Short Michigan Alcohol Screening Test (SMAST), and the Parental Alcohol Use Questionnaire. The data was tabulated and entered into the computer by the researcher. Individual profiles were tabulated by hand on a chart in order to compare the frequency of occurrence of subscales in specific ranges. A Chi Square analysis was used to determine the relationship between drinking behavior and BPI subscales, and Pearson Product Moments were calculated in order to ascertain the relationship between the BPI subscales. Based on the results of this study, the following conclusions were formed:

1. In comparison to BPI norms, the means of the current sample tended to be significantly above average on the scale of Persecutory Ideas, and in the high average range for many others, such as Anxiety, Depression, and Self Depreciation.

2. Clinical level scores (T>70) were overrepresented in comparison to a random sample population, with that of Persecutory Ideas at more than 14 times expected level of occurrence; Depression and Deviation, 11-12 times expected level; and Social Introversion and Anxiety 9-10 times expected level.

3. Clinical level scores most often occurred on the scales of Persecutory Ideas (28.9% of sample), Depression (23.4%), Deviation (22.4%), Social Introversion (19.7%), and Anxiety (18.4%).

4. Of the total sample, approximately three out of every five ACOA individuals (59%) had one or more subscales within the clinical range, significantly more than the 2% expected with a general population.

5. No discernable relationship was found between ACOA personal drinking behavior and BPI scores.

6. Pearson's analysis revealed significant relationships between the following subscale scores.
    a) Persecutory Ideas was noted to be related to Depression, Social Introversion, Self Depreciation and Deviation.

b) Self Depreciation was related to Depression and Deviation.

c) The subscale of Alienation was found to be related to Thinking Disorder, Impulse Expression, and Deviation.

d) There was a significant difference between male and female scores on the subscales of Alienation and Deviation.

Discussion

Through the use of an objective measure, the Basic Personality Inventory, it was found that the scores of those sampled were significantly different from those of the BPI norm population, suggesting that many ACOAs may have certain personality characteristics different from the more general population. The heterogeneous nature of ACOAs was also demonstrated by the wide range of individual scores in this sample, thus supporting suggestions of previous researchers such as Barnard and Spoentgen (1986). However it is also to be remembered that because of the voluntary nature of this sample, the participants of this study may not be representative of ACOAs in general, and as such current results must be interpreted with caution.

One of the major findings of the current study was

that nearly 60% of ACOAs studied were found to have had at least one scale in the clinical range. These results appeared to contradict those of previous researchers such as Barnard and Spoentgen (1986) who suggested that ACOAs were more like than dislike their non-ACOA counterparts. However, it is to be noted that their study compared individuals on pre-selected subscales rather than a wide spectrum measure, such as the BPI, and so their findings may have been limited to a more restricted area of personality functioning.

Although Beardslee, Son, and Vaillant (1986) suggested that the main effects of being an ACOA appeared to be largely related only to those who developed alcoholism themselves, results of this study were unable to support or reject such an hypothesis. Although some of the individuals in this sample were admitted alcoholics, the lack of relationship between scores on the SMAST and those on the BPI suggested that the effects of personal drinking behavior on personality characteristics were not discernable using these measures.

In a review of recent research it was found that several personality characteristics were hypothesized to be factors in ACOA functioning, such as self esteem (Plicia-Pikus et al,1988), depression, lack of trust, and anxiety (Black et al., 1986; Edwards & Zander,1985). The

results of t .rrent study tended to lend some objective support to these hypotheses, with the finding of significantly increased levels of personality characteristics such as low self confidence, depression, and anxiety in comparison to a general population. In addition, current results also suggested the presence of characteristics such as feelings of victimization, pessimistic attitudes about self and future, and a preference for solitary activities.

As previously noted, the interpretation of the BPI subscales must be carefully made. However, the finding of increased scores on the scale of Depression may tend to support the findings of Clair and Genest (1987) in their suggestion that ACOAs may be prone to depression, as well as those of Parker and Harford (1987,1988) in which daughters of alcoholics were found to be at increased risk for depressive symptomatology. In this study, it was demonstrated that males as well as females may have increased scores on the Depression subscale, suggesting the possibility that depressive tendencies or pessimistic outlook was not necessarily related only to females.

Further, in contrast to researchers such as Berkowitz and Perkins (1988) or Ackerman (1987) who hypothesized that the effects of being ACOA might be gender specific, the findings of the present study

suggest that ACOA males and females are not significantly different in their personality characteristics. Scores on all scales, including Self-Depreciation and Depression, were found to be high for both genders, and not exclusive to either males or females.

An interesting finding was the increased incidence of Social Introversion, with a occurrence 10 times greater than expected. As there did not appear to be any studies in this area, it would be interesting to find out if there was any difference between personality characteristics of ACOAs who were socially extroverted versus those socially introverted.

Despite limiting factors of this study, current results also appeared to be contradictory to those of previous researchers who supported ACOA resiliency (see Werner, 1986; Beardslee, Son & Vaillant, 1986). An interesting point was Garmetzy's (1974) notion that a belief in "good outcomes" may be a factor in positive resiliency. As current scores suggested that many ACOAs of this sample tended to have pessimistic views of life, and may feel that they were victims, Garmetzy's hypothesis may merit further investigation.

Suggestions for Further Research

The results of this study have raised further questions as to personality variables affecting ACOAs. To date, research studies remain inconsistent in their findings related to ACOA personality functioning. Further investigations using objective measures to clarify current popular assumptions is needed, as well as validation of specific findings. The results of this study have initiated further questions such as the following:

a) Is there a cluster of personality characteristics associated with ACOAs?

b) Are ACOA personality characteristics similar to those reportedly associated with individuals who have experienced physical or sexual abuse?

c) Are socially introverted ACOAs more at risk for clinical level scores than ACOA extroverts?

d) Are ACOAs with optimistic viewpoints more resilient than ACOAs with pessimistic views of life?

Conclusions

The author of this study has attempted to clarify some personality characteristics of ACOAs by means of an objective measure, the Basic Personality Inventory. Despite limiting factors, such as a relatively small sample size, and a sample consisting of self-selected ACOA volunteers, there appeared to be a number of personality characteristics that occurred at significant levels more often than others. These included: feelings of victimization, depression or pessimistic outlook, unusual thought processes, social introversion and anxiety. Such results suggest that some ACOAs at least may have more difficulty in certain personality areas than non-ACOAs. It is hoped that the results of this study will encourage further ACOA research. It is also hoped that eventually there will be enough consistent research to enable the majority of ACOAs, as yet unidentified, to be able to relate to their life experiences in a positive way, and to obtain therapeutic intervention if necessary.

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Appendix 1

PARENTAL ALCOHOL USE QUESTIONNAIRE

Thank you for participating in this research study. The purpose of this research is to investigate some of the factors that may affect individuals who grew up with a parent who drank heavily.

Please note that <u>your name is NOT required</u>, and the contents of your questionnaires will remain confidential. The information compiled will be analyzed on a group basis, and is to be used for research only. Your participation is strictly voluntary and will remain COMPLETELY ANONYMOUS.

DIRECTIONS: Please complete the questionnaire on the pages given. Disregard the numbers on the right side of the page. They are for computer scoring only. Completing the questionnaire should take approximately 30-40 minutes.

RETURN ALL QUESTIONNAIRES (complete or incomplete) using the self addressed envelope provided. No postage is required.

Should you wish further information, please contact Dr.Peter Calder, University of Alberta (492-3696). THANK YOU FOR YOUR PARTICIPATION!

* * * * * * * * * * * * *

Please provide the following information:

1. Circle your sex: 1. Male / 2. Female 5

2. Age _____ years 6-7

3. Marital status: 1. Single/ 2. Married/3. Divorced/ 4.Separated 8

4. How many years of formal schooling do you have? _____ years 9-10

5. What was your position in your family?
   1. Only child/ 2. Eldest / 3. Middle/ 4. Youngest 11

6. What is your approximate family income?
   1. under $20,000 2. $20-40,000 3.$40-60,000 4. over $60,000 12

The following questions require your opinions. Please circle your response as it applies to you. If you need more room to explain your answer, please continue on the back of this booklet.

1. Have you ever thought that one or both of your parents had a drinking problem?

   1. Both parents /2.Father only /3.Mother only /4.Neither parent 13

CONTINUE ON BACK OF PAGE

Appendix 1 cont'd

2. Have you ever wished that either or both of your parents would drink less? .....YES / NO 14

   Can you explain ?_____

3. Have you ever considered either of your biological parents to be an alcoholic?.....YES / NO 15

   Can you explain?_____

4. Has the drinking of either parent created a problem for you? .....YES / NO 16

   In what way?_____

5. Are you now or have you ever been a member of a support group related to being an adult child of an alcoholic?..... YES / NO 17

The following questions are about your own drinking patterns. Please check YES or NO as it applies to you. There are no right or wrong answers, and remember your answers are anonymous.

	YES / NO	
1. Do you feel that you are a normal drinker? (By normal we mean do you drink less than or as much as most other people).....	___ ___	18
2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?.....	___ ___	19
3. Do you ever feel guilty about your drinking?.....	___ ___	20
4. Do friends or relatives think you are a normal drinker?.....	___ ___	21
5. Are you able to stop drinking when you want to?.....	___ ___	22
6. Have you ever attended a meeting of Alcoholics Anonymous?.....	___ ___	23
7. Has drinking ever created problems between you and your wife, husband, a parent or other near relative?.....	___ ___	24
8. Have you ever gotten into trouble at work because of drinking?.....	___ ___	25
9. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?.....	___ ___	26
10. Have you ever gone to anyone for help about your drinking?.....	___ ___	27
11. Have you ever been in a hospital because of drinking?.....	___ ___	28
12. Have you ever been arrested for drunken driving, driving while intoxicated or driving under the influence of alcoholic beverages?.....	___ ___	29
13. Have you ever been arrested, even for a few hours because of other drunken behavior?.....	___ ___	30