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Familial Factors And Attachment Styles Of Adult Children Of Alcoholics

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Familial Factors and Attachment Styles of Adult Children of Alcoholics

BY

Tiffany Marie Konz

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Familial Factors and Attachment Styles of Adult Children of Alcoholics

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Abstract

Substance abuse is a prevalent issue that has far-reaching implications for not only the abuser but also the family. Research on parental alcoholism and its effects on offspring have developed over the last several years. Following the lead of other researchers, the present study aimed to examine the relationship between parental alcoholism and attachment styles in adult children of alcoholics (ACOAs) and possible mediating or moderating effects of familial factors. A sample of 84 college students completed a series of measures on parental alcoholism, family satisfaction, family cohesion, parent-child attachment, and psychological and physical maltreatment. Participants were divided into two groups (ACOA, non-ACOA) based on their endorsement of parental alcoholism either through a yes/no demographic question or their total score on the Children of Alcoholics Screening Test. It was hypothesized that participants in the ACOA group would have more insecurity in relationships than participants in the non-ACOA group. As anticipated, results supported a relationship between ACOA status and insecure relationship patterns. ACOA participants had greater insecurity in relationships as evidenced on three of four dimensions of insecure attachment. In addition, ACOAs reported lower levels of family satisfaction and cohesion and well as more insecure parent-child attachments than did non-ACOAs. ACOAs also experienced more physical and verbal aggression than non-ACOAs. Suggestions for future research and clinical implications are also discussed.

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Familial Factors and Attachment Styles of Adult Children of Alcoholics

Substance abuse and dependence are extremely common issues within our society. Falk, Yi, and Hiller-Sturmhofel (2008) examined the prevalence of alcohol and drug use in the U.S. adult population using data from the 2001-2002 National Epidemiological Survey on Alcohol and Related Conditions (NESARC) conducted by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Results indicated that approximately 8.5 percent of adults in the U.S. suffer from an alcohol use disorder (i.e., alcohol abuse and/or alcohol dependence). When breaking the results down by age group, the percentage of young adults (aged 18-24) who suffer from an alcohol use disorder skyrockets to 18.4 percent. This number decreases slightly (10.5 percent) for adults in the 25-44 age range. Drug use disorders are also alarmingly prevalent in U.S. society with 2.2 percent of adults suffering from drug abuse or dependence. Similar to the results of alcohol use disorders, the percentage of adults aged 18-24 suffering from a drug use disorder increases to 7.0 percent (Falk et al., 2008). Additionally, more recent research conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2007 reports that 9.0 percent of the population aged 12 and older are either substance abusing or dependent (SAMHSA, 2008). Although the incidence (i.e., the number of newly diagnosed cases within a specific time frame) and prevalence (i.e., all diagnosed cases) rates vary according to the source, these estimates make it apparent that substance abuse and dependence are affecting a large number of individuals in the society. Therefore, these disorders should be researched thoroughly to fully explain the mechanisms that contribute to and are a result of these disorders.

As prevalence rates of alcohol and drug abuse have increased over the past few decades, research on the effects of substance abuse on families has also increased greatly (e.g., Johnson, 2001; Lease 2002; Rangarajan, 2008). One particular focus of this research has been on the effects parental substance abuse has on children in the family, with more recent exploration into how these effects extend into the child's adult life. Recent estimates state that 10% of children 5 years old or younger, 8% of children aged 6-11, and 9% of children aged 12-17 are living with at least one substance abusing or substance dependent parent (Office of Applied Studies, 2003). Taking these prevalence rates into account, it is safe to assume that from birth to 17 years old, children have a significant likelihood of being exposed to at least one parent abusing or being dependent on alcohol or other illicit drugs and have a very high likelihood of suffering from any associated consequences of living with a substance abusing and/or dependent parent.

Adult children of alcoholics (ACOAs) is the term commonly used in existing research to refer to adult offspring who grew up with an alcohol abusing or alcohol dependent parent (e.g., Kelley et al., 2005; Kerr & Hill, 1992; Nicholas & Rasmussen, 2006). For the purposes of this study, we will refer to adult children of substance abusing or dependent parents as ACOAs, regardless of the substance preferred by the parent(s). For convenience, we will also refer to a home in which at least one parent has a substance abuse or dependence problem as an alcoholic family or alcoholic household.

Although originally substance abuse was conceptualized as an individual problem, it is now commonly recognized as an issue that affects the entire family. For example, unstable and inconsistent family environments that are commonly associated with parental substance abuse have been linked with psychological and emotional

developmental problems among children (e.g., Gruber & Taylor, 2006; Keller, Cummings, & Davies, 2005; Sheridan & Green, 1993). In fact, some researchers (e.g., McCubbin, McCubbin, Thompson, & Han, 1999) have conceptualized parental alcoholism as a family risk factor, in and of itself. These authors suggest that parental alcohol abuse or dependence denotes a family risk because of its effects on the family dynamics and processes, rather than solely putting one individual member at risk for various negative consequences. The specific consequences found to be related to parental alcohol abuse will be reviewed later. Whereas the detrimental effects of parental substance abuse may be most obvious while the children are young enough to still be living in the home, these effects do not cease to affect children as they mature and move out of the household.

Although many people postulate that children exposed to parental alcoholism are at risk for numerous psychosocial problems as they enter adulthood, there is research that supports the notion that not every individual exposed to this environment eventually develops problems in adulthood (Lease, 2002). A majority of the research conducted on clinical samples of ACOAs has found differences on psychological and interpersonal dimensions between ACOAs and children who were not exposed to a substance abusing or dependent parent (e.g., Hinz, 1990). However, when research is conducted with a non-clinical sample, there are greater variations in the results (e.g., Kelley et al., 2005; Nicholas & Rasmussen, 2006). While some studies have attempted to differentiate non-alcoholic families from alcoholic families on different dimensions of family functioning (e.g., Johnson, 2001), there is a lack of research focusing on whether or not these specific

factors of functioning moderate the effects that parental alcoholism has on the children and overall family functioning.

Taking into consideration the aforementioned information, the primary purpose of this research study is to gain insight into the individual factors that may exacerbate or serve as a buffer to the potential long-term negative effects parental alcoholism can have on children as they mature into adulthood. Furthermore, this study will examine the relationships among various familial factors and adult attachment styles in ACOAs. The research in the areas being studied is reviewed below.

Adult Children of Alcoholics

A well-functioning family is characterized by cohesion, appropriate roles, effective communication, and regular expression of positive emotions among family members (Steinhauer, Santa-Barbara, & Skinner, 1984). These characteristics create an environment that encourages and allows for family members to successfully develop and offers them an atmosphere conducive to individuals' security and cohesiveness. (Steinhauer et al.). However, in families affected by parental substance abuse, the characteristics of a functioning family are often askew or missing. For example, when Kelley et al. (2007) researched the differences in family of origin experiences between female ACOAs and non-ACOAs, they found that ACOAs were more likely to report parentification evidenced by having more responsibility for various aspects of family functioning. This included tasks such as working to help with family finances, caring for younger siblings, and numerous household chores. Furthermore, ACOAs also reported being more burdened with the family's emotional problems than non-ACOAs. The term parentification refers to "children or adolescents who assume adult roles before they are

emotionally or developmentally ready" (Stein, Riedel, & Rothermam-Borus, 1999). Thus, these types of caretaking tasks and the associated stress they create for the child may result in adjustment problems for the child if they are not yet mature enough to handle a "parental role."

Other areas of dysfunction in ACOAs that have been explored include low self-esteem (Rangarajan, 2008), issues with control (Sheridan & Green, 1993), and substance abuse (Sheridan, 1995). Rangarajan (2008) studied the effects of parental alcoholism on adult offspring's self-esteem by examining ACOAs attending a university who responded to a online posting of the research. Results from this study supported the proposed hypothesis that parental alcoholism has harmful effects on the self-esteem of ACOAs. Interestingly, the results showed that paternal alcoholism was more detrimental to offspring self-esteem than maternal alcoholism. In addition, the results supported the mediating effect of parental attachment on offspring self-esteem and the author suggested that this finding may partially explain the difference in ACOA self-esteem. More specifically, it was found that the participant's retrospective reports of attachment to their parents mediated the effect of paternal but not maternal alcoholism on ACOA self-esteem. Rangarajan hypothesized that paternal alcoholism versus maternal alcoholism had a more detrimental effect on parental attachment because it is more normative for children to form secure attachments with their mother, out of survival instinct, even if she is typically unavailable or unresponsive and this is not the case for fathers. Thus, it is important to acknowledge the heterogeneous experience of living in an alcoholic family and the differing effects that may result for offspring (Rangarajan, 2008).

Other outcomes associated with ACOA status were studied by Sheridan and Green (1993). They examined differing family dynamics and individual characteristics that can result from growing up in an alcoholic home by examining a sample comprised of ACOAs currently receiving alcoholism-related treatment services, ACOAs not receiving treatment, and a control group (i.e., non-ACOAs). Their results revealed that ACOAs differed from non-ACOAs on variables such as individuation from parents (i.e., self-identity), issues with control, and self-esteem. Specifically, these three individual variables were the best variables to discriminate between non-ACOAs, ACOAs receiving professional help, and ACOAs not receiving professional help. Overall, ACOAs receiving help and ACOAs not receiving help both reported higher levels of family dysfunction and individual dysfunction compared to non- ACOAs. Family and individual dysfunction were operationalized as lower levels of family cohesion and competence, problems with self-esteem and self-identity, and more control issues. Furthermore, ACOAs receiving help displayed more extreme dysfunction in these areas than did ACOAs not receiving help.

In another study conducted by Sheridan (1995) in which substance abusing, incarcerated adults were examined, parental substance abuse was directly related to offspring substance abuse problems. Sheridan examined several psychosocial variables, with the exclusion of biological factors, that may impact substance abuse patterns. After reviewing the results, the authors postulate that there may be an indirect effect of parental substance abuse on offspring substance abuse through exposure to childhood abuse/neglect (Sheridan, 1995). That is, parental substance abuse was directly and positively related to exposure to childhood maltreatment indicating that children exposed

to parental substance abuse were at increased risk for childhood abuse/neglect. Additionally, childhood abuse was directly related to offspring substance abuse and, in fact, had a stronger relationship to offspring substance abuse than did parental alcoholism. Taking these results into account, the authors hypothesized that ACOAs may be at an increased risk for substance abuse issues because parental substance abuse increases the likelihood of childhood maltreatment which is strongly related to substance abuse problems.

However, growing up in an alcoholic home does not always result in children developing adjustment problems. Some researchers have attempted to separate out the commonly occurring dysfunction that typically, but not always, coincides with being raised by an alcoholic parent to determine if the problems associated with parental substance abuse are a direct result of the substance abuse itself or the coinciding dysfunction. For example, Nicholas and Rasmussen (2006) controlled for the effects of family violence (i.e., child emotional, physical, and sexual abuse, and inter-parental violence) and family support and found that growing up in an alcoholic home did not significantly predict depression in adult children of alcoholics. However, other researchers have found a significant relationship between ACOA status and depression when not controlling for these variables. After reviewing these results, it becomes apparent that when researching the adjustment of ACOAs, it is important to factor in the possible coinciding dysfunction that existed in the household and the contributions this may have on their adjustment.

An adjustment problem commonly associated with ACOA status is dysfunctional adult relationship patterns. One particular area that has gained interest in the past few

years has been the types of attachments ACOAs develop with their intimate partners. Much of the research conducted regarding adult attachment style is conceptualized using Ainsworth's (1978) attachment styles which described mother-child attachment patterns and was based on the attachment theories of John Bowlby.

Attachment Styles

Attachment Theory. Infant-caregiver attachment theory grew out of Bowlby's work with infants and young children (Bowlby, 1969). After observing how children react when separated from their primary caregiver, Bowlby noted that children go through a set of predictable, observable reactions. Protest, the first reaction, involves crying, actively searching for the caregiver, and refusing others' attempts to pacify them. The second reaction, despair, involves sadness and passivity of the child. The third and final reaction is detachment. This stage occurs when the caregiver returns to the child and the child reacts by actively refusing to acknowledge the caregiver and avoids the caregiver. Thus, it can be assumed that the frequency of separations from the caregiver determines how often a child cycles through this pattern of reactions identified by Bowlby and may determine how attainable the child perceives the caregiver to be (Bowlby, 1973).

Bowlby (1973) proposed that individuals develop a confidence level related to the availability of their attachment figure. This confidence, or lack of it, slowly develops throughout infancy, childhood, and adolescence and persists largely imperviously throughout the remainder of the life span. Thus, the formation of caregiver attachment during childhood impacts the formation of attachments throughout adult life.

Paralleling Bowlby's work on attachment, Ainsworth and colleagues (1978) proposed that three types of attachment exist which are derived largely from an individual's relationship with their primary caregiver. These authors suggest that a caregiver's responsiveness and sensitivity to an infant's needs, especially in the first year of life, is an important determinant of the attachment relationship that is formed. Based on the caregiver's responsiveness, the infant may form either a secure, anxious/ambivalent, or avoidant attachment type (Ainsworth et al., 1978). For example, when a caregiver responds to an infant's signals and communications sensitively and consistently, Ainsworth et al. posit that the infant trusts that the caregiver is still available even if they are not within sight. Thus, the infant is thought to be securely attached to the caregiver and is relatively unlikely to cry when the caregiver leaves the room. Furthermore, when securely attached infants were separated from their mothers in studies conducted by Ainsworth and colleagues (1978), they showed initial distress at the separation but found comfort shortly after their mother returned and then reengaged in exploratory behavior.

Conversely, if a caregiver responds in slow or inconsistent patterns to their infants' needs, there is a greater likelihood that the infant will cry frequently, exhibit less exploratory behaviors, and appear generally more anxious. In the aforementioned study conducted by Ainsworth et al. (1978), anxious-ambivalent infants were noticeably more distressed by their mother's departure, were not hastily comforted by reunion with their mothers and instead engaged in angry protest behaviors upon their mother's return. Finally, infants classified as avoidant did not appear distressed by separation from their mother, did not seek closeness to mother when she returned, and generally seemed

unaffected by her presence. The attachment types as described by Ainsworth et al. are characteristic of the observations Bowlby (1973) made regarding a child's reactions of separation from their caregiver. More specifically, infants labeled as anxious/ambivalent exhibit behaviors such as crying and actively searching for the caregiver which Bowlby labeled as protest. Also, infants who have an avoidant attachment type exhibit behaviors that Bowlby referred to as detachment.

Adult Attachment. Bowlby (1973) suggested that continuity of attachment type into adulthood is primarily due to interrelated mental models of the self and the social life that an individual maintains. Although this is still a topic of controversy, many researchers have used this idea to explore the relationship between childhood attachment and adult romantic love styles (e.g., Hazan & Shaver, 1987; Shaver, Hazan, & Bradshaw, 1988)

Hazan and Shaver (1987), examined the prevalence of each attachment style in adults (i.e., secure, anxious/ambivalent, avoidant) in two related studies. The first study was conducted via a 95-item questionnaire printed in a local newspaper which included a single-item measure designed to assess which of the three attachment styles (secure, avoidant, anxious/ambivalent) participants identified best with, a love-experience measure which assessed the way participants experience romantic love, and a third measure which examined the mental models of the self, social relationships, and relationships with parents that participants possess (i.e., attachment style and attachment history). The participants were instructed to answer the items while considering their most important love relationship, whether past or present. Analyses were conducted using the first 620 replies received of which 205 were male and 415 were women.

The second study was conduced shortly thereafter as a conceptual replication of the first study in an attempt to negate some of the limitations discovered after conducting the first study (e.g., self-selection bias, only examined limited aspects of subjects' mental models). Study two had 108 undergraduate students who completed the questionnaire as a class exercise. The questionnaire was comprised of the same items as in study 1 with the addition of several items designed to assess additional aspects of the participants' mental models. The authors also added measures of state and trait loneliness to the questionnaire used in the second study. Analyses were conducted for study 2 and then compared, when applicable, to the results obtained from the first study.

The results from both studies led Hazan and Shaver to conclude that the prevalence of each attachment style mirrored the prevalence of each attachment style in infancy. In a summary of American studies on infant attachment style, Campos et al. (1983) reported that 62% of infants are found to be secure, 23% are avoidant, and 15% are anxious/ambivalent. The studies conducted by Hazan and Shaver (1987) found similar percentages in their adult population. In other words, the percentage of adults classified in each of these attachment types was remarkably similar to the percentage of children who are classified as these attachment types. Therefore, there appears to be a connection between an individual's attachment in childhood and their attachment style later in adulthood.

Hazan and Shaver (1987) also noted that individuals who had the different attachment styles differed in their working models of self and relationships, meaning that they held different beliefs concerning the course of romantic love, the trustworthiness of others, and their worthiness of love. More specifically, secure individuals have working

models of the self that include beliefs indicating that they are easy to get to know and are likeable by most others. Secure individuals also are likely to endorse the belief that other people are typically well intentioned and good-hearted. On the other hand, anxious/ambivalent individuals are more likely to hold the belief that others are not as willing and able to commit to relationships as they are. They are also likely to have more self-doubt and experience feelings of being underappreciated and misunderstood by others. If viewing the mental models of self and others on a continuum with secure individuals on one end and anxious/ambivalent individuals on the other end, avoidant individuals are in the middle of the continuum. However, there is a tendency for the avoidant individuals to be closer to anxious/ambivalent individuals in their mental models than to secure individuals. Avoidant individuals also tend to remain aloof in intimate relationships perhaps as a result of a fear of intimacy (Hazan & Shaver, 1987).

An individual who is characterized by anxious/ambivalent attachment tends to lack confidence that others will respond reliably to them (Shaver & Hazan, 1994). Therefore, their primary goal of attachment is to feel secure and they seek to progress towards this goal by attempting (sometimes exhaustively) to keep others close by and engaged with them. On the other hand, someone characterized by avoidant attachment tries to reach security by avoiding intimacy, especially during periods of intense stress.

When looking at attributional style differences between securely and insecurely attached individuals, research (Kennedy, 1999) has shown that a person characterized by a secure attachment style attributes the causality of positive events internally and views them to be more stable and global than someone with an insecure attachment style. Additionally, when making attributions for negative events, secure individuals regard the

events as temporary and external (Kennedy, 1999). Although adult attachment style has been fairly well-researched over the past few decades, one particular area that has gained interested in recent years has been in comparing the attachment styles of adults who were raised in an alcoholic home to those who were not raised in alcoholic home.

Relation to ACOA Household. Parental substance abuse can have a significant negative impact on a child which can extend into their adulthood. For example, research shows that children from dysfunctional, substance abusing families frequently learn maladaptive role expectations that impair their relationships in adulthood (Craig, 1993). The author posits that this is due to the unrealistic expectations ACOAs hold of themselves and their problems with intimacy and trust. Other researchers posit that familial dysfunction itself, regardless of the presence of substance abuse, is significantly related to the type of intimate relationships ACOAs experience (Harrington & Metzler, 1997).

Results from numerous studies have supported the relationship between parental alcohol abuse and the prevalence of insecure attachment styles in children (e,g., Jaeger, Hahn, & Weinraub, 2000; Vungkhanching, Sher, Jackson, & Parra, 2004). Furthermore, some researchers believe that growing up in an alcoholic home contributes to an insecure attachment style in adulthood. In fact, some (Lease, 2002) have stated that this association is related to the negative transactions (e.g., angry and violent behavior) with significant others that ACOAs are likely to encounter during childhood. Others have suggested that the quality of caregiving may be hindered in an alcoholic family due to the parent's preoccupation with his/her own alcoholism or spouse's alcoholism. If this situation then affects the parents' ability to respond to their children, the children may be

likely to react in disruptive ways and be prone to develop an insecure attachment style (Erdman, 1998). While these studies may show that a relationship exists between children of alcoholics and specific attachment styles, there is a paucity of research examining the factors that may mediate or moderate this relationship.

Researchers have begun exploring possible factors that influence the effects of having an alcoholic parent on adult attachment styles. For example, Kelley et al. (2005) found that participants classified as ACOAs were more likely to report fearful and avoidant attachment styles than non-ACOA participants. However, their status as an ACOA did not predict these attachment types over and beyond their report of perceived parenting received in childhood. Thus, even though ACOA status was highly correlated with fearful and avoidant attachment types, perceived parenting was a more significant predictor of these two attachment types. These results imply that simply having an alcoholic parent may increase the likelihood of forming fearful and/or avoidant attachment types as an adult but the probability of developing these types of attachment styles increases even more with the presence of parenting that involves low levels of acceptance and high levels of psychological control (Kelly et al., 2005).

Conversely, Beesley and Stoltenberg (2002) examined a group of college student ACOAs and found that there were no significant differences between ACOAs and non-ACOAs on reporting secure versus insecure attachment styles. The researchers postulate that this finding may be a result of this specific subgroup of ACOAs (i.e., college students) having more resiliency than the majority of the ACOA population. In other words, this particular group of ACOAs may possess certain characteristics that help safeguard them from some of the negative effects of parental alcoholism. Another

explanation for this finding may be related to the amount of dysfunction within the family that both ACOA and non-ACOA groups experienced. Some of the non-ACOA participants may have experienced family dysfunction unrelated to parental alcoholism, however, this dysfunction created issues very similar to those experienced by ACOAs, thus the differences in attachment styles become less clearly established because of the similar family experiences encountered by both groups.

The existing conflicting results regarding the differences in adult attachment styles between ACOAs and non-ACOAs indicates that more research in this area is needed in order to better understand the effects of parental alcohol abuse or dependence on attachment styles. After reviewing the literature, it appears that there may be some factors that moderate the impact parental substance abuse has on offspring adult attachment styles. There may be factors which protect or buffer a child from the impact of parental alcoholism as well as factors that compound or magnify the dysfunctional adjustment of children raised in alcoholic homes. The current study will assess the impact of the following factors on the relationship between parental substance abuse and offspring adult attachment style: verbal aggression, levels of family cohesion and family satisfaction, and perceived parent-child attachment.

The Role of Abuse

Incidence of Child Abuse in Alcoholic Homes. Previous research has supported the theory that individuals who have at least one alcoholic parent while growing up are more likely than individuals without an alcoholic parent to experience an unhealthy family environment that includes more family dysfunction. One facet of dysfunction is an increased likelihood of children experiencing physical, verbal, and sexual abuse

(Johnson, 2001). In fact, other researchers have stated that child abuse is one of the most salient forms of family dysfunction that needs to be considered due to the high rates of child abuse found in alcoholic families (Nicholas & Rasmussen, 2006).

A report by The National Center on Addiction and Substance Abuse (2005) stated that substance abuse is a factor in approximately 70 percent of child maltreatment cases. Also noted, was that substance abusing parents were almost three times more likely to engage in abusive behavior towards their children than other parents. Hence, it is safe to assume that children growing up in an alcoholic household are at an increased likelihood to suffer from some form of abuse, whether it is physical, verbal, or sexual. Abuse in childhood may have far-reaching implications for adjustment as adults. The U.S Department of Health and Human Services, Children's Bureau (as cited in American Humane Newsroom, 2007) stated that children who grew up in an alcoholic home and suffered from some form of maltreatment, were likely to have problems in physical, intellectual, and social adjustment.

Physical and Sexual Abuse. The term physical abuse generally refers to aggressive acts that injure, significantly impact, or have potential to significantly impact a child (Heyman & Slep, 2006). In a study conducted by Walsh, MacMillan, and Jamieson (2003) retrospective reports of physical and sexual abuse as well as parental substance abuse were gathered and results indicated that both forms of abuse are twice as likely in homes where there is a substance abusing parent. Other researchers (e.g., Black, Bucky, & Wilder-Padilla, 1986; Kerr & Hill, 1992) have found similar results supporting the notion that the likelihood of physical abuse is greater in alcoholic families.

As previously mentioned, Walsh, MacMillan, and Jamieson (2003) reported that child sexual abuse is twice as likely in alcoholic homes than in non-alcoholic homes. These results coincide with the findings of an earlier study (Vogeltanz et al., 1999) which indicated that there is a significant relationship between childhood sexual abuse and parental drinking problems. More specifically, participants were more likely to report childhood sexual abuse if the family had experienced paternal alcoholism, with maternal abstinence, and parental separation or divorce. Also, childhood sexual abuse was more likely if the participant's mother was an alcoholic and the family was still intact. Although the authors pointed out that these research findings were strictly correlational in nature (i.e., the cause of these patterns is not determinable), Vogeltanz et al. did suggest a hypothesis for the latter pattern based on previous research with similar findings. Vogeltanz et al. posited that a marital relationship comprised of an abstinent father and alcoholic mother is a rarity and may be indicative of a conflictual marital relationship which is known to reduce the parental emotional support available to children. Thus, children (particularly emotionally needy children) may be more prone to seeking exploitative relationships with others to find the solace and emotional support they are lacking, hence the increased risk for childhood sexual abuse. These results make it is easy to infer that the likelihood of children raised in alcoholic homes being physically or sexually abused is generally higher than for children raised in non-alcoholic homes. However, an additional and less studied form of abuse, verbal abuse or verbal aggression, may also have a higher likelihood of being inflicted upon children raised in alcoholic homes.

Verbal Aggression. Verbal aggression has been defined by Infante and Wigley (1986) as the act of speaking to another person with messages that are intent on attacking the self-concept of the other person and hurting them psychologically. Infante and Wigley also note that the typical outcome of these interactions is the person receiving the messages feeling inferior. There are various forms of verbally aggressive messages such as messages that attack another's character, messages that tease, ridicule or insult, as well as messages that attack another's competence. As stated earlier, children growing up in an alcoholic home are likely to encounter all forms of abuse, including verbal abuse; therefore, they are at a heightened risk of receiving aggressive messages.

Relation to alcoholic families. Parental alcoholism affects all members of the family, not just the parent. For instance, alcoholic families experience higher levels of overt unresolved conflict, fighting, blaming, and arguing (Johnson, 2001). Alcoholic families also exhibit lower levels of family togetherness and closeness as well as fewer expressions of positive feelings than those in non-alcoholic families (Johnson, 2001). These results lend support to the hypothesis that communication among family members in alcoholic families is typically strained and may be quite unhealthy.

Some researchers posit that the presence of parental alcoholism itself does not warrant poorer functioning for offspring in areas such as social adjustment. For example, Harter and Taylor (2000) examined the long-term effects of parental alcoholism and childhood sexual, physical, and emotional abuse as well as their co-occurrence in a sample of college students. Researchers separated participants into two groups based on their ACOA status as well as by creating mutually exclusive groups based on the participants' abuse histories. The results indicated that ACOA participants who had also

experienced emotional abuse reported the poorest functioning in school/work roles. Thus, Harter and Taylor further postulated, based on their results, that social and achievement strategies are most affected when parental alcoholism co-occurs with emotional abuse.

Long term impact of verbal aggression. The long-term impacts of suffering from parental verbal aggression in childhood are varied. Morimoto and Sharma (2004), using retrospective reports, found that the presence of parental verbal aggression had a strong negative impact on particular areas of individual development such as depression, aggressiveness, and interpersonal relationships. Weber and Patterson (1997) examined the effects of maternal verbal aggression on adult children's romantic relationships. The results led them to conclude that the presence of maternal verbal aggression in childhood, negatively affects the amount of perceived relationship solidarity and emotional support felt by adult children in their romantic relationships. Weber and Patterson then offered further insights by positing that an individual's verbal aggression increases when they are exposed to maternal verbal aggression, perhaps in an effort to defend themselves. Then as these children mature, they bring verbal aggression into their adult romantic relationships initiating a cycle of verbal aggression. Each partner further engages in verbal aggression as a means of defending the self and this leads to lower levels of relationship solidarity and emotional support.

Parental verbal aggression also negatively impacts other facets of a child's adjustment into adulthood. Nicholas and Rasmussen (2006) found that parental emotional abuse in the family of origin, particularly emotional abuse by the father, was a significant predictor of depressive symptoms in adult females. Nicholas and Rasmussen postulate that emotional abuse by fathers, rather than mothers, may be more predictive of

depression in daughters because of the characteristic societal view that fathers are protective of their daughters, therefore, when this societal standard is unmet, daughters may experience apprehension and feel devalued. This view may help shed light on why prior research has found a significant relationship between parental alcohol abuse and insecure attachment types (e.g., Kelly et al., 2005). Since child abuse (in its various forms, including verbal) is commonly found in alcoholic families (Nicholas & Rasmussen, 2006), many children raised in these homes may come to devalue themselves and either look to others for a sense of value and security (i.e., anxious/ambivalent attachment) or attempt to avoid becoming emotionally attached to others out of dread of being devalued again (i.e., avoidant attachment).

Familial Protective Factors

When taking into consideration that there have been contradicting results with respect to longer psychological outcomes in ACOAs, it can be assumed that some protective factors exist which buffer individuals from the possible detrimental effects parental alcoholism can have on family members, especially children. Researchers have begun to explore possible family characteristics that may negate some of the harmful consequences of parental alcoholism on offspring.

Certain family environmental factors have been identified as protective factors which safeguard adolescents and young adults who come from alcoholic families from acquiring alcohol and drug problems themselves. It has been proposed that strong family bonding and parental attachment are two such family environmental factors (Hawkins, Catalano, & Miller, 1992). Conversely, other researchers have suggested that the majority of difficulties observed in ACOAs are linked to the parenting that one receives in their

family of origin (Kelley et al., 2005). Therefore, factors such as these (i.e., parent-attachment and family bonding) may serve as mediating or moderating factors in the relationship between ACOA status and maladjustment. In other words, qualities such as family bonding and parental attachment appear to be negatively correlated with offspring dysfunction in a variety of contexts. That is, the stronger the level of family bonding or the healthier the parent-child relationship is, regardless of whether it is only with the non-abusing parent or with both parents, the less likely a child may be to suffer from the dysfunctions typically associated with growing up in an alcoholic home.

Family satisfaction and family cohesion are other variables that may serve to protect against the potential negative consequences of being raised in an alcoholic home. A brief review of the literature regarding these factors is presented below.

Family Cohesion. Strong emotional bonds among family members, a warm supportive environment, and helping one another with problem solving are typical characteristics that define families who are high in family cohesion (Roosa, Dumka, & Tein, 1996). The authors of FACES IV, a self-report measure designed to assess family cohesion and flexibility, define cohesion as "the emotional bonding that family members have toward one another" (Olson, Gorall, & Tiesel, 2007, p. 2). Researchers Olson and McCubbin (1983) have also defined family cohesion as the extent of perceived connectedness and closeness family members feel toward one another. Looking at these characteristics, it is sensible to conclude that family cohesion would relate to a child's adjustment.

Relation to alcoholic families. In a study conducted by Roosa, Dumka, & Tein (1996) family cohesion was found to be a mediator of the relationship between family

drinking problems and child adjustment, operationalized as the presence of conduct disorder and depression. In other words, family drinking problems significantly influenced child adjustment only through family cohesion. As family drinking problems increased and family cohesion levels lowered, child adjustment became more problematic.

In line with the results obtained from previous research, El-Sheikh and Buckhalt (2003) found that parental problem-drinking was associated with lower levels of family cohesion as well as more behavioral, social, and cognitive problems in 6-12 year old offspring of problem-drinkers as reported by their mothers and teachers. Also, family cohesion was found to be a protective factor against numerous problems such as externalizing, internalizing, and social problems that are typically associated with children who live with a parent who displays problem-drinking. Specifically, El-Sheikh and Buckhalt only found positive associations between parental problem-drinking and children's social and internalizing problems when children were in homes with low levels of family cohesion and adaptability. These results support the important role family cohesion has in child adjustment and it is logical to hypothesize that this would remain true as the child matures into adulthood.

Long term impact of family cohesion. Prior research has indicated that the perception of strong family cohesion by its members decreases the risk of certain unfavorable outcomes in individuals such as depression, low self-esteem, aggressive behaviors, and unsatisfying personal relationships (Morimoto & Sharma, 2004). Some researchers (e.g., Larson & Reedy, 2004) have examined the mediating effects of family cohesion on parental substance abuse and adult outcome variables such as the quality of

dating relationships. Results from their research led Larson and Reedy to postulate that parental alcoholism does not directly, negatively impact the quality of adult offspring's dating relationships. Rather, it is the dysfunction in family processes, associated with parental alcoholism, that impacts the quality of dating relationships in adult offspring. The researchers found that, as the level of family cohesion increased, the degree of dysfunction in dating relationship quality decreased. The authors postulate that if family cohesiveness is high, there is greater likelihood that the ACOAs will have a functional relationship on which to model their future dating relationships and increased perceived satisfaction in the relationships. Thus, results indicate that family cohesion serves as a buffer against the potentially negative effects parental substance abuse can have on adult offspring's interpersonal relationships.

Family cohesion has also been linked to certain adult romantic attachment styles. Kennedy (1999) found a significant positive correlation between family cohesion and secure attachment style. Thus, as family cohesion in the family of origin increased so did the likelihood that the adult offspring's attachment style was secure. These findings may help explain why some ACOAs report secure attachment styles in their adult romantic relationships but others do not. If the family was able to maintain high levels of cohesion, despite the presence of parental alcoholism, the protective effects of family cohesiveness may serve to decrease the detrimental effects of parental alcoholism on the attachment style of ACOAs.

Family Satisfaction

The concept of family satisfaction can be defined in many different ways. Researchers (Carver & Jones, 1992) define family satisfaction simply as "the degree to

which one is generally satisfied with one's family of origin and the constituent relationships imbedded therein" (p. 72). Barraca, Yarto, and Olea (2000) have devised a construct of family satisfaction that is slightly different from previous researchers. According to Barraca et al., (2000) family satisfaction is not a construct that a family possesses to a certain degree per se, but rather, it is the global judgment that each family member has which is comprised of all the interactions he/she has with the other family members. The interactions between family members can be verbal and/or physical and when these interactions are reinforcing to the individual, family satisfaction is perceived to be high, and when the interactions are punitive, it is perceived to be low.

A common underlying theme of the aforementioned definitions is that family satisfaction is best measured by perceived satisfaction or happiness rather than measuring the family on certain dimensions or structures. According to Carver and Jones (1992), the authors of the Family Satisfaction Scale, it is important to study family satisfaction to better understand how feelings and attitudes about ones family emerge and differ in normal and dysfunctional families. Children growing up in alcoholic homes tend to experience dysfunction of some manner in their families. It is reasonable to assume that there may be a difference in perceived family satisfaction between children of alcoholics and children not raised in an alcoholic home due to the dysfunction that is typically associated with alcoholic homes. This is a factor that has not previously been examined in ACOA research.

Perceived Parent-Child Attachment

Relation to alcoholic families. Prior research (e.g., Kerr & Hill, 1992) has supported the theory that ACOAs evaluate the relationships with their family members of

origin differently than non-ACOAs. Specifically, ACOAs report lower satisfaction in their relationships with parents than non-ACOAs. However, some ACOAs may still be able to form a secure attachment to at least one parent in the household whether it be to the alcoholic or the non-alcoholic parent and this attachment may buffer the negative effects parental alcoholism has on them. For example, Rangarajan (2008) found support for the direct, positive effect parental attachment has on adult offspring's self-esteem. A secure parental attachment between child and caregiver mediated the effects paternal alcoholism had on offspring self-esteem. Contrary to these findings, El-Sheikh and Buckhalt (2003) examined the interacting effects of children's attachment to both mothers and fathers with parental problem-drinking to predict their social and cognitive functioning. Results from this study led El-Sheikh and Buckhalt to conclude that while an insecure attachment to either parent was predictive of children's social and cognitive problems, regardless of problem-drinking, a secure attachment did not buffer them from the negative effects of parental problem-drinking. In other words, an insecure attachment more significantly predicted problems in child functioning rather than parental problem-drinking, and a secure attachment with a parent did not serve to buffer the child from the problematic effects of living in an alcoholic home.

Long term impact of perceived parent bond. When looking at differences in attachment history to predict adult romantic attachment styles, Hazan and Shaver (1987) found that relationship quality with parents and the parents' relationship with each other were the best predictors. These two factors predicted the participants' adult attachment style better than separation from parents during childhood and parental divorce. Additionally, certain characteristics of participants' relationships with their parents or

parental characteristics discriminate between participants with secure versus insecure attachment styles. For example, participants with a secure attachment style described their mothers as being respectful, confident, accepting, non-intrusive, and responsible. Avoidant participants were more likely to report that their mothers were cold and rejecting whereas anxious/ambivalent subjects described their fathers as being unfair (Hazan & Shaver, 1987). Therefore, it is logical to assume that perceived parent-child attachment may significantly impact adult attachment type, especially in the ACOA population.

Present Study

It is apparent from this review of the literature that the long-term impact of growing up in an alcoholic home has potentially negative outcomes for offspring. One particular outcome that has gained interest in the past decade is the impact of parental alcoholism on ACOA attachment styles. There appears to be conflicting research regarding the effect ACOA status has on adult attachment styles. Some researchers (e.g., Jaeger, Hahn, & Weinraub, 2000; Kelley et al., 2004) have found a correlation between parental alcoholism and insecure attachment styles while other researchers (e.g., Beesley & Stoltenberg, 2002; Kelley et al., 2005) have found that this relationship is not as direct. As mentioned previously, a few of the factors that other researchers have found that are contributory or protective factors for the various negative impacts of parental alcoholism include family cohesion and adaptability (El-Sheikh & Buckhalt, 2003), childhood abuse/neglect (Sheridan, 1995), and more specifically, emotional abuse (Harter & Taylor, 2000). Thus, while other researchers have begun to study these complicated relationships, this research hopes to shed additional light on the factors that mitigate the relationship

between parental alcoholism and negative offspring outcomes, particularly regarding adult attachment styles.

The primary purpose of this study is to examine additional factors that may alter the relationship between growing up in an alcoholic home and adult attachment styles in offspring. In particular, I wished to examine whether factors such as level of family cohesion, parent-child attachment, family satisfaction, and child abuse mediate the relationship between parental alcoholism and adult attachment. Figure 1 shows the proposed model of how these variables are related.

The primary research questions and coinciding hypotheses are as follows:

Question 1: Do ACOAs differ from non-ACOAs with respect to adult attachment style? After reviewing the relevant literature, I hypothesize that there will be a relationship found between parental alcoholism and adult offspring attachment style. Insecure attachment styles (i.e., avoidant and anxious/ambivalent) will be more evident in ACOAs than in non-ACOAs and secure attachment styles will be more evident in non-ACOAs than in ACOAs.

Question 2: Will there be a difference in levels of family satisfaction, family cohesion, and parent-child attachment for ACOAs versus non-ACOAs? Previous research has indicated that familial factors such as these tend to be negatively affected when there is dysfunction within the family (e.g., El-Sheikh & Buckhalt, 2003; Kerr & Hill, 1992). If parental alcoholism is conceptualized as a particular form of family dysfunction, it is logical to assume that the same may be true for families who are suffering from alcoholism. Thus, it is hypothesized ACOAs will report lower levels of family

satisfaction and cohesion as well as a weaker parent bond than participants labeled as non-ACOAs.

Question 3: Do ACOAs experience more verbal and severe physical abuse from parental figures than children raised in a home where parental alcoholism is not present? Previous studies have found that the likelihood of all forms of child abuse (physical, verbal, and sexual) occurring increases in homes with at least one substance-abusing parent. Therefore, it is hypothesized that ACOAs will report higher levels of aggression in the family of origin than will non-ACOAs.

Question 4: Which factor or combination of factors best predicts adult attachment style in ACOA versus non-ACOA participants? We were unable to find previous research that examined these factors in combination, therefore, this research question is exploratory in nature and no hypotheses will be made.

Question 5: Do the proposed familial factors (i.e., family cohesion, family satisfaction, parent-child attachment, verbal aggression) moderate or mediate the relationship between severity of ACOA experience and attachment? It is hypothesized that those ACOAs with high levels of family cohesion and satisfaction, low levels of verbal aggression and physical abuse, as well as a positive attachment to their mother and father will be more likely to have a secure adult attachment style than will those ACOAs with low levels of family cohesion and satisfaction, high levels of verbal aggression and physical abuse, and a negative attachment to parents.

Method

Participants

Participants in this study were 84 college students from a regional, Midwest university. Females made up the majority of participants (n = 62; 74%) with only 22 participants (26%) of the overall sample being male. The age range of the participants was 18 to 57 years (M = 20.04; SD = 4.81) and over half (n = 47; 56%) were in their first year of college. Additionally, 69 (82%) participants were of Caucasian ethnicity, followed by African American (n = 13; 16%), Latin American (n = 1; 1%), or Asian (n = 1; 1%). Data were collected from 150 participants, however, due to completion errors, only the data from 84 participants were used. The final group of participants was divided into two groups (ACOA or non-ACOA) based on either their CAST score or their response to the demographic questions pertaining to parental alcohol problems. If participants' CAST scores were considered ambiguous but they had endorsed parental alcohol problems in the demographic questionnaire, they were added to the ACOA group.

The demographic data for the two groups differed for several variables (see Table 1). Of the 40 participants categorized as ACOAs, 28 (70%) were female and 12 (30%) were male. Similar to the overall sample, the age range was 18 to 57 years with a mean age of 20.68 (SD = 6.82). The ethnic breakdown of the ACOA group was comprised of 85% Caucasians (n = 34) followed by 13% (n = 5) African Americans. Most of the ACOA participants reported either an intact family structure (n = 13; 33%) or divorced parents who remained single thereafter (n = 15; 38%). Results of chi-square analyses indicate that the two groups (ACOA, non-ACOA) differed significantly with respect to

family structure. Specifically, non-ACOAs were significantly more likely to come from intact families than ACOAs, $\chi^2(1, N = 84) = 9.30, p < .01$.

When questioned about their own substance abuse, 13 (33%) reported that they had self-concerns regarding their use and 9 (223%) reported that others had expressed concern over their substance use. Further, four ACOA participants (10%) have received treatment for their substance use. In regards to receiving treatment for parental substance use problems, 12 (30%) participants reported that at least one parent had a history of receiving treatment for substance use or abuse. Furthermore, 13 (33%) of participants in the ACOA group reported that there was a history of family treatment for problems related to parental substance use or abuse.

The sample of non-ACOAs consisted of 10 (23%) male and 34 (77%) female participants. The age range of non-ACOA participants was 18 to 25 years (M =19.45; SD =1.37). With regard to race and ethnicity, 35 (80%) of the non-ACOAs were Caucasian, 8 (18%) were African American, and 1 (2%) was Latin American. Slightly over two-thirds of the participants in the non-ACOA sample (n = 30; 68%) reported an intact family structure, 11% followed by parental separation (n = 5; 11%). Both self-concern and other's concern over participant substance use was endorsed by 6 (14%) of the non-ACOA participants, although only 1 participant had received treatment for substance use issues.

Measures

Demographic Questionnaire. Participants were asked to complete a brief demographic questionnaire containing items related to their age, sex, education, ethnicity, relationship status, personal substance use and substance abuse treatment history.

Parental Alcoholism Question. All participants were asked to respond in a Yes/No format to the following questions: "Did your mother experience significant problems with alcohol/drug use or abuse?" "Did your father experience significant problems with alcohol/drug use and or abuse?" This will serve as the screening instrument to classify participants as ACOAs versus non-ACOAs, along with participant responses to the CAST.

Children of Alcoholics Screening Test (CAST). The participants completed this 30-item measure, in order to clarify the experience of living with an alcoholic parent(s) and to assess the severity of parental drinking (Pilat & Jones, 1984/85). The CAST measures children's attitudes, feelings, perceptions, and experiences related to their parents' drinking behavior through affirmation of statements that they believe describe their parents' alcohol use/abuse. A total score, ranging from 0 (no experience with parental alcoholism) to 30 (multiple experiences with parental alcoholism), is obtained by summing up the number of "yes" answers the participant endorses. A score of 6 or higher (i.e., six or more "yes" answers) indicates that the participant was exposed to parental alcoholism. A total score of 0 or 1 indicated that the participant was a non-ACOA and participants with a score of 2, 3, 4, or 5 are considered indeterminate.

The psychometric properties of the CAST suggest that it is a psychometrically sound instrument. As mentioned in Pilat and Jones (1984/85), the criterion-related validity is 0.78 and split-half reliability is sufficient as evidenced by a Spearman-Brown coefficient of 0.98. Furthermore, studies conducted by Pilat and Jones (1984/85) confirmed that all 30 items of the CAST differentiated self-reported and clinically

diagnosed children of alcoholics from children who were not exposed to parental alcoholism.

Attachment Style Questionnaire (ASQ). This was administered to study participants in order to determine their adult romantic attachment style (Feeney, Noller, & Hanrahan, 1994). This questionnaire is based on Hazan and Shaver's (1987) descriptions of secure, anxious/ambivalent, and avoidant attachment styles. The questionnaire consists of 40 items, answered on a 6-point Likert scale from "Totally disagree" to "Totally agree" and results in scores on 5 subscales: Confidence in Self and Others, Need for Approval, Preoccupation with Relationships, Discomfort with Closeness, and Relationships as Secondary. The Confidence subscale score represents secure attachment while the other four subscale scores represent particular aspects of insecure attachment styles. More specifically, the Discomfort with Closeness subscale is closely tied to avoidant attachment as it is defined by Hazan and Shaver (1987) and the Preoccupation with Relationships subscale correlates with the anxious/ambivalent attachment style. A sample item from the Confidence subscale that assesses for secure attachment styles is, "I feel confident that other people will be there for me when I need them." A sample item from the Relationships as Secondary subscale that assesses for insecure attachment styles is "doing your best is more important that getting on with others". A separate score for each of the five dimensions is calculated for each participant by simply summing the responses endorsed and reverse scoring particular items. These scores reflect the degree that each dimension is present in the participant's conceptualization of attachment. In other words, a greater score denotes that the person places greater emphasis on that particular aspect of attachment.

Feeney et al. (1994) found high levels of internal consistency among all 5 subscales. Cronbach's alpha coefficients ranged from .76 to .84 suggesting that there are high levels of internal consistency. Test-retest coefficients (computed over a 10-week period) were at an acceptable range from .67 to .78.

Parent-Child Conflict Tactics Scale (CTSPC). This instrument was used to measure the level of physical maltreatment within each participant's family as a means of managing interpersonal conflict (Straus et al., 1998). The CTSPC stems from the work done by Straus (1979) on the original Conflict Tactics Scale (CTS). The newer parent-child version is more applicable to child maltreatment and incorporates pertinent parental behaviors that were not included in the original CTS which were created for marital or dating relationships (Straus et al., 1998). Although the CTSPC is also a measure of non-violent discipline and psychological aggression, for the purposes of this study, it will only be used to help determine if participants experienced physical abuse and aggression, thus only the physical assault items will be included in the study questionnaire. The physical assault subscale of the CTSPC is comprised of 13 items that classify maltreatment into the following categories: no violence (absence of physical punishment in the family), minor and severe Corporal Punishment (e.g., child has been pushed or experienced some corporal punishment), severe assault (e.g., child has been hit or there has been an attempt to hit the child), and very severe violence (e.g., child has been beat up or threatened with a weapon). Participants were asked to complete the 8 items pertaining to the Severe Assault and Very Severe Assault subscales.

Participants respond to each item based on the worst year of living at home and rate the number of occurrences experienced during that year. Participants respond to each

item as it describes either their mother or their father. Response options range from 0 (never occurred) to 6 (occurred more than 20 times. Internal consistency reliability, as reported in Straus et al. (1998), for the physical assault scales of the CTSPC is .55 and an alpha coefficient of .60 has been found for the psychological aggression scale. Further, the internal reliability for the Severe Physical Assault subscale is only -.02. While these numbers may seem relatively low for determining that an instrument has good internal consistency, Straus and Hamby (1997) state that these numbers are somewhat expected because parents who engage in one form of maltreatment are not likely to engage in all forms of maltreatment. Additionally, Straus et al. (1998) noted that an explanation for the low reliability on the Severe Physical Assault subscale is due to the nature of the activities encompassed by the items; it is unlikely that severe assault is conducted on a regular basis by parents, it is typically a more rare event. Construct validity has been established in a variety of ways determining that the CTSPC is psychometrically sound. Straus et al. (1998) provide a full review of the psychometric properties of the CTSPC.

Psychological Maltreatment Scale (PMS). Participants completed this 7-item scale to assess the presence of parental verbal aggression (Briere and Runtz, 1988). Participants respond to each item by reporting the frequency with which each parent engaged in those verbal behaviors during an average year in childhood. Response options range from 0 (never) to 6 (more than 20 times a year). The item responses for mother and father are summed together to acquire a total verbal aggression score. Briere and Runtz report internal consistency alphas of .87 for both the psychological maltreatment by mother and by father scales.

Family Adaptability and Cohesion Evaluation Scales IV (FACES IV). This 42-item self-report questionnaire designed to assess the levels of family cohesion and flexibility present in the family of origin was completed by participants. This measurement tool is designed to expose both high and low levels of family cohesion and flexibility through the use of six subscales: Enmeshed, Balanced Cohesion, Disengaged, Chaotic, Balanced Flexibility, and Rigid (Olson, Gorall, & Tiesel, 2006). Respondents answer each item on a 5-point Likert-type scale according to how descriptive they perceive each item to be for their family of origin (1 = does not describe our family at all, 2 = slightly describes our family, 3 = somewhat describes our family, 4 = generally describes our family, 5 = describes our family very well). To determine the participants' subscale scores, the item scores for each item comprising the subscale are totaled. The higher the subscale score, the more of that construct the family possesses.

According to Olson, Gorall, and Tiesel (2007), the FACES IV instrument is relatively psychometrically sound. Internal consistency scores among the subscales range from .77 to .89 which is considered an acceptable range. Additionally, concurrent validity was established through correlations of the FACES IV scales to three other validation scales. Discriminant validity was also established for this measure and found to be sufficient (Olson et al., 2007).

For the purposes of this study, items from the three Cohesion subscales (Enmeshed, Balanced Cohesion, and Disengaged) will be used to determine the level family cohesion. A Cohesion Ratio score will then be computed to determine how balanced or unbalanced their families are on cohesion. The ratio score will be computed by averaging the participants' scores on the unbalanced scales (Disengaged and

Enmeshed) then dividing the Balanced Cohesion subscale score by this average. The higher the ratio score, the more balanced the system and the lower the ratio score, the more unbalanced the system is on cohesion.

Family Satisfaction Scale (FSS). This measure was completed by the participants to assess perceived level of satisfaction with their family of origin. Although the original FSS consists of 14 items, we utilized the newer 10-item version. Each of the items is answered on a 5-point Likert scale ranging from 1 (very dissatisfied) to 5 (extremely satisfied). Total scores can range from 10-50 and are calculated by summing the scores for each item (Thomas & Ozechowski, 2000). A total score within the 40-50 point range indicates that the participant is very satisfied with his/her family. A total score within the 36-39 point range indicates that the participant is moderately satisfied while a score within the 30-35 point range indicates they have low satisfaction. Additionally, scores within 10-29 indicate the participant is very dissatisfied. For the purposes of this study, the FSS score will be treated as a continuous variable. Thomas and Ozechowski (2000) report that the FSS has a Cronbach's alpha coefficient of .92 and a 5-week test-retest reliability of .75, thus it can be considered psychometrically sound.

Parental Attachment Questionnaire (PAQ). The 55-item PAQ, designed by Kenny (1987) was used to assess participants' attachment to their parents. It is comprised of three subscales: affective quality of relationships, parents as facilitators of independence, and parental source of support. The participant responds to each item on a five-point Likert scale, ranging from 1 = *not at all* to 5 = *very much*. The total score for each participant is calculated by summing the participant's responses and reverse scoring particular items. A higher total score indicates that a participant has a positive view of the

parent-child relationship, perceives high levels of parental support, and feels that independence is supported by his/her parents.

Kenny (1987) established reliability for the original, single-rating, questionnaire through internal consistency and test-retest methods. Cronbach's alpha of .95 for female participants and .93 for male participants was obtained. Additionally, test-retest reliability was .92 within a 2-week interval. The updated version of the PAQ, later developed by Kenny and colleagues (1993), includes separate ratings for each parent instead of one rating for both parents. Internal consistency was computed by combining the mother and father scores for each scale resulting in Cronbach's alphas of .95 for affective quality of relationships, .88 for parents as facilitators of independence, and .83 for parental source of support. Construct validity of the PAQ was established through convergent validity methods. Kenny and Donaldson (1991) compared the PAQ to related, well-known, scales and found that they were assessing similar constructs.

Procedure

Participants were recruited through the University's research participation management system. Undergraduate students who participated in this study received credit towards the completion of their Introductory Psychology course. Participants for this study were asked to complete a questionnaire packet online which included the assessment instruments described above. Before beginning, participants were required to read through an informed consent document stating that they have the right to withdraw from the study at any point without being penalized and that their results are anonymous and confidential. After reading the informed consent, participants clicked on an "I Consent" button before being able to proceed on to the questionnaire ensuring that they had read

and agreed with the contents of the consent form. Participants were provided with a printable feedback form after completing the measures.

Results

Data Transformation

For the Children of Alcoholics Screening Test (CAST) a total score was computed by summing all participant responses. Items on the Attachment Style Questionnaire (ASQ) were reverse coded as necessary to calculate subscale scores in the domains of Relationships as Secondary (RS), Need for Approval (NA), Discomfort with Closeness (DC), Preoccupation with Relationships (PR), and Confidence (C). Further, all items from the Confidence subscale were reverse scored and summed. This score was then subtracted from the total of the four subscales representing a more insecure attachment style (RS, NA, DC, PR). This calculation allowed for an overall ASQ sum score with higher scores denoting a more insecure attachment style and lower scores representative of a more secure attachment style.

For the Parent-Child Conflict Tactics Scale (CTSPC), the items were totaled to compute a sum score for the scale. The same was done for the Psychological Maltreatment Scale (PMS). Items on the Family Adaptability and Cohesion Evaluation Scales IV (FACES IV) were entered into an Excel spreadsheet provided by the authors that calculated a raw Cohesion Dimension score by summing participant responses on the Disengaged and Enmeshed subscales and dividing this total by four then summing it with the participant's total on the Balanced Cohesion subscale. The raw scores were then automatically converted to percentile scores in the spreadsheet with the use of a percentile conversion chart (Olson, Gorall, & Tiesel, 2006). The resultant Cohesion

Dimension score was manually entered into the SPSS data file. The Family Communication Scale is a component of FACES IV and the authors of the scale requested it be added to the questionnaire survey. The data were collected but then not used in analysis for this study.

The Family Satisfaction Scale (FSS) was computed by summing participant responses on all items. For the Parental Attachment Questionnaire (PAQ) items were reverse coded as needed and subscale scores on the dimensions of Affective Quality of Relationships, Parents as Facilitators of Independence, and Parents as Source of Support were calculated separately for mother and father by summing the appropriate items. Additionally, an overall ASQ score was computed separately for mother and father by summing all subscale scores.

Parental Alcoholism and Offspring Adult Attachment Style

The first hypothesis posits that ACOAs will evidence more insecure attachment styles than non-ACOAs. A *t*-test for independent means was conducted on attachment style with the independent variable being ACOA status (ACOA, Non-ACOA) and the dependent variable being ASQ scores. ACOAs ($M = 137$, $SD = 20$) evidenced less secure attachment than did non-ACOAs ($M = 118$, $SD = 24$), $t(79) = 3.60$, $p = .001$. The range of possible scores for the ASQ is 40 – 240 and the means for both groups were below the midpoint (i.e., less than 140) on the continuum from secure to insecure which implies that although ACOAs were more insecurely attached than non-ACOAs, they were not at the extreme end of insecurity. Additional *t*-tests using the five ASQ subscales as dependent variables found that in all dimensions ACOAs were less securely attached than non-ACOAs with the exception of the need for approval subscale (see Table 2).

In order to assess if the level of parental substance abuse made a difference on attachment style, bivariate correlations were conducted between participant CAST scores and the ASQ scale scores (total sum score and 5 subscale scores). Results indicated that higher CAST scores (i.e., higher levels of family dysfunction related to parental substance use) were positively correlated to a greater tendency to put relationships second to other life factors (e.g., vocational success) ($r = 0.28$; $p = .01$), discomfort with closeness ($r = 0.26$, $p = 0.02$), and preoccupation with relationships ($r = 0.28$, $p = 0.01$), and negatively related to confidence in relationships ($r = -0.28$, $p = 0.01$). The CAST scores had a marginally significant correlation with need for approval scores ($r = 0.21$, $p = 0.05$), indicating that there was a trend for parental substance use and its accompanying family dysfunction to increase participants' need to seek approval from others.

Familial Protective Factors

Family satisfaction, family cohesion and parental bond were conceptualized as protective factors that may serve to buffer individuals from the harmful effects of parental alcoholism. Although these factors may be protective in nature, it was hypothesized that ACOAs will have lower levels of family satisfaction and cohesion as well as a weaker parent bond than participants labeled as non-ACOAs. This hypothesis was supported.

Four *t*-tests for independent means were with the independent variable being ACOA status (ACOA, non-ACOA) and the dependent variables being PAQ with mother score, PAQ with father score, family satisfaction scale score, and family cohesion score. ACOAs ($M = 181$, $SD = 40$) evidenced less secure attachment to mothers than did non-ACOAs ($M = 226$, $SD = 30$), $t(79) = -5.65$, $p < .001$. Additionally, ACOAs ($M = 177$, SD

=42) also were less securely attached to fathers than non-ACOAs (M = 212, SD = 36), $t(74) = -3.85$, $p < .001$. ACOAs (M = 31, SD =10) evidenced less family satisfaction than non-ACOAs (M = 41, SD =9), $t(80) = -4.63$, $p < .001$. The mean scores indicate that overall, ACOAs have low family satisfaction whereas non-ACOAs have high family satisfaction. Further, ACOAs (M = 41, SD = 33) had significantly less family cohesion than non-ACOAs (M = 68, SD =27), $t(47) = -3.43$, $p = .001$ (see Table 3), however, the means for each group fall in the midrange between somewhat connected and very connected (i.e., they are both still considered to be connected).

To assess whether the familial factors were correlated with one another and to determine if the level of dysfunction associated with parental alcoholism made a difference on these factors, bivariate correlations were conducted between the participants' CAST scores and the PAQ with mother, PAQ with father, FACES, and FSS scores. Results indicated that the familial factors were correlated in the expected direction. More specifically, all familial factors (i.e., PAQ with mother, PAQ with father, FACES, and FSS scores) were positively correlated with each other and all were negatively correlated with CAST scores (see Table 4). This means that as CAST scores increased (i.e., higher dysfunction), the positive familial factors decreased.

Role of Abuse

To determine if verbal or severe physical abuse is more prevalent in alcoholic homes, four t-tests for independent means were conducted with the ACOA status (ACOA, Non-ACOA) being the independent variable and overall parental verbal abuse, verbal abuse from mother only, verbal abuse from father only, and physical abuse, being the dependent variables. Results indicate that ACOAs (M =66, SD =39) evidenced more

verbal abuse from either parent than non-ACOAs (M = 43, SD = 38), $t(82) = 2.75$, p = .007. Additionally, ACOAs (M =35, SD = 25) received significantly more verbal abuse from their mothers than non-ACOAs (M = 23, SD =22), $t(82) = 2.36$, p = .021. A marginally significant finding was that there was a trend in the data of ACOAs (M =31, SD =27) reporting more verbal abuse from their fathers than did non-ACOAs (M =20, SD 24), $t(82) = 1.99$, p = .05. Furthermore, ACOAs (M = 17, SD =14) experienced significantly more physical abuse from parents than did non-ACOAs (M =9, SD = 2), $t(41) = 3.89$, $p < .001$.

In order to assess if the level of parental substance abuse made a difference in the occurrence of emotional or physical abuse, bivariate correlations were conducted between participant CAST scores and the scores on PMS mother only, PMS father only, PMS total, and the CTS. Results indicated that higher CAST scores (i.e., higher levels of family dysfunction related to parental substance use) were related to greater levels of emotional abuse from mothers ($r = 0.22$; p = .05), from fathers ($r = 0.27$, p = .02), and from either parent ($r = 0.30$, $p < 0.01$). Furthermore, higher CAST scores were also related to greater physical abuse from parents ($r = 0.52$, $p < 0.01$) indicating that as the family dysfunction associated with parental alcoholism increases, the likelihood of child physical abuse increases.

A final aim study was to assess which factor or combo of factors best predicted adult attachment style and whether family factors mediated the relationships between ACOA status and attachment. Due to limited sample size, these research questions were not able to be addressed in this study.

Discussion

The aim of this study was to gain a better understanding of familial factors that may alter the experiences of children growing up in an alcoholic home. More specifically, the goal was to examine whether or not factors such as family cohesion, parent-child attachment, family satisfaction and child abuse affect the relationship between ACOA status and adult attachment style. While researchers have examined the effect of some of these variables on this population, no one has looked at all of these variables combined to find out if the familial factors mediate the relationship between ACOA status and adult attachment styles. This research aimed to do that.

The first objective of this study was to clarify previous findings that ACOAs differ from non-ACOAs in terms of adult attachment style, and specifically to determine whether or not ACOAs report more insecure attachment styles than non-ACOAs. Previous research has led to conflictual results regarding this hypothesis. Some researchers (e.g., Beesley & Stoltenberg, 2002) found no significant difference between ACOAs and non-ACOAs on secure versus insecure attachment styles. Other researchers, however, have found that significant differences between the two groups exist (e.g., Jaeger, Hahn, & Weinraub, 2000; Kelley et al. 2004). The results from this study support the hypothesis that ACOAs report more insecure attachment styles than non-ACOAs.

Not only did ACOAs display an overall more insecure attachment style than did non-ACOAs, they had significantly higher scores on three of the four attachment dimensions that are considered representative of insecure attachment (relationships as secondary, discomfort with closeness, preoccupation with relationships) indicating that they possessed more of these insecure relationship attributes than did non-ACOAS. There

was also a trend in the data implying that ACOAs also have a higher need for approval than non-ACOAs, However, this relationships needs further examination before definitive conclusions can be drawn.

This research was able to expand on the work done by previous researchers particularly as a result of the differences found between groups in specific dimensions of insecure attachment. For example, Vungkhanching et al. (2004) was able to determine that ACOAs reported more insecure attachment patterns than did non-ACOAs but they were unable to determine if any differences existed between the groups in terms of specific insecure relationship patterns. The same was true for Jaeger, Hahn, and Weinraub (2000) when they assessed attachment styles in adult daughters of alcoholic fathers. One conclusion that can be drawn from these results is that the measure of adult attachment utilized in this research (the Attachment Style Questionnaire) may tap into the specific dimensions of attachment that differentiate ACOAs and non-ACOAs better than the measures of attachment previously used which may be assessing the dimensions of attachment too generally or broadly to pick up on the specific nuances that separate the participants in terms of attachment style.

There are several possible explanations for the differences among insecure attachment dimensions found in ACOAs and non-ACOAs. One hypothesis for ACOAs' increased scores in preoccupation with relationships is that this dimension is related to decreased self-confidence, which may be more likely to develop in childhood for ACOAs due to the unavailability or inconsistent availability of an attachment figure (i.e., parents). Bowlby's work on attachment (1973) posits that individuals develop their self-confidence in childhood based on the availability of an attachment figure and this self-confidence

usually continues on into adulthood. Since previous researchers (e.g., Gruber & Taylor, 2006) have noted that parental alcoholism leads to inconsistent and unstable family environments, it is logical to conclude that in some alcoholic homes there is very little availability of the caregivers or inconsistent availability which leads to low levels of self-confidence in offspring, particularly with respect to relationships. Furthermore, Hazan and Shaver (1994) have reported that a common relationship pattern for individuals with little confidence is to seek security through attempting to keep others close by, which may explain ACOAs' increased scores on the preoccupation with relationships subscale.

Bowlby's (1969; 1973) work with children on development of self-confidence and attachment may also offer an explanation for the trend in data finding that ACOAs only have slighlty more need for approval in relationships than non-ACOAs. As stated previously, Gruber & Taylor (2006) found that inconsistent family environments are highly associated with parental alcoholism. Further, if children seek approval from their primary attachment figure throughout childhood and their approval needs are not met or are addressed in inconsistent ways, this may reduce their willingness in adulthood to seek approval from others. So, although it appears that ACOAs and non-ACOAs are similar in terms of not portraying relationship insecurity through the need for approval from others, the underlying reason for this may differ markedly between the two groups.

As mentioned previously, not all researchers have found data that support the notion that ACOAs are more insecurely attached than non-ACOAs. For example, Beesley and Stoltenberg (2002) examined a population very similar to the one used in this study (i.e., college students from a Midwestern university) and were not able to support this hypothesis. One factor to consider when comparing these conflicting results is that

Beesley and Stoltenberg ensured that the groups (ACOA, non-ACOA) did not differ significantly on demographic variables such as gender, age, ethnicity, family income, and also parental education level. The two groups in the present study did vary somewhat on demographic variables, particularly in terms of family structure. Slightly over two-thirds (68%) of the non-ACOA participants reported an intact family structure while only 32.5% of ACOA participants were from intact families. Thus, the greater insecurity found in our sample of ACOAs may be in part due to dysfunction associated with separation of parents rather than dysfunction associated with parental alcoholism. Furthermore, Beesley and Stoltenberg had a higher proportion of males in the ACOA group (45%) than were included in our sample of ACOAs (30%). It is likely that gender differences may exist. For example, male ACOAs might be more hesitant to disclose negative information (i.e., portray themselves in a more positive manner than is realistic) or believe it is easier for them to not internalize the dysfunction associated with parental substance use.

The second aim of this study was to determine if ACOAs differ notably from non-ACOAs with respect to levels of family satisfaction, family cohesion, and parent-child attachment. It was hypothesized that ACOAs would report lower levels of these familial attributes than non-ACOAs and this hypothesis was supported. ACOAs reported less secure attachments to both parents as well as less family satisfaction and cohesion. These results offer some insights into the ACOA experience. Although it is important to note that the relationship among positive familial factors and ACOA status is correlational, and causation cannot be inferred, some tentative conclusions can still be drawn from these correlations within the context of this study.

Family satisfaction, family cohesion and secure parent-child attachment were negatively correlated with participant CAST scores for the sample as a whole. These findings provide evidence that, in general, greater family dysfunction as a result of parental substance use is associated with family satisfaction, family cohesion, and secure parent-child attachment which provides some support for the potential protective function of these familial factors. Because family satisfaction is under-researched in the ACOA field, there is no previous research to support or dispute the protective function of this factor.

Our findings are consistent with previous research by El-Sheikh and Buckhalt (2003) who also found a correlation between parent-child attachment and parental alcoholism dysfunction. Moreover, El-Sheikh and Buckhalt noted that although these factors were correlated, a secure parent-child attachment did not necessarily serve as a protective factor against parental alcoholism (measured by child social and cognitive functioning). This may be due to the relatively small sample size in the ACOA groups or it could mean that there is an additional factor that needs to be teased out from the analysis to more clearly understand the relationship between parent-child attachment and parental alcoholism.

Our findings are also consistent with previous research by Larson and Reedy (2004) who found that as family cohesion increased, dysfunction in dating relationships of ACOAs decreased. Our results found a similar correlation in that as family cohesion increased, attachment styles became more secure (r = -.29). Thus, it appears that family cohesion serves a protective role in the outcomes of ACOAs in terms of attachment styles.

The next research objective was to determine if there was a difference in the levels of verbal and severe physical abuse experienced by ACOAs versus non-ACOAS. The results supported the hypothesis that ACOAs experience more verbal and severe physical abuse than non-ACOAs. These results are in line with previous studies that have examined child abuse in alcoholic families and found a relationship between experiencing abuse and parental alcoholism (e.g., Walsh, MacMillan, & Jamieson, 2003). These findings reaffirm the notion that child abuse, particularly verbal abuse and severe physical abuse are typically present in alcoholic homes.

It should be noted that originally the Parent-Child Conflict Tactics Scale to be used as a screening instrument to remove participants with severe physical abuse histories from the ACOA population. This was part of the study design because we did not wish for dysfunction associated with severe physical child abuse to confound the dysfunction related to parental alcoholism. However, doing this would have caused a significant portion of the already limited ACOA group to be removed because there was an alarmingly high rate of child abuse present in the sample of ACOAs (60% endorsed some form of severe physical abuse). It is important to highlight this because child abuse may be acting as a confound or may be exacerbating the insecure attachment styles found in our sample of ACOAs. Additionally, the present study only used the severe assault and very severe assault subscales of the CTSPC. Child abuse, in less severe forms, may prove to be a more collective ACOA experience than our results suggest because the Minor Physical Assault and Psychological Aggression subscales of the CTSPC were not included in the survey questions. Using these subscales may have resulted in additional ACOAs endorsing a child abuse history.

The experience of a severely violent parent, even in the absence of alcoholism, likely contributes to negative psychological outcomes in children (e.g., Schumm, Stines, Hobfoll, & Jackson, 2005; Turner & Finkelhor, 1996). This is supported by our data as further analysis revealed that participants' child abuse histories were negatively correlated with family satisfaction and parent-child attachment to both parents. In other words, as child abuse increased, family satisfaction decreased and parent-child attachments with both parents were more insecure. These findings emphasize the importance of considering abuse history when studying the effects of parental alcoholism on offspring. The interaction between abuse and parental alcoholism and long term outcome in children is still in need of further study.

The final two aims of this research were to determine which combination of familial factors best predicts adult attachment styles in ACOA versus non-ACOA participants and to determine if these factors mediate or moderate the relationship between severity of ACOA experience and adult attachment. Due to limited sample size, these research questions were not able to be statistically addressed in this study. However, the overall pattern of results is promising with respect to identifying potential mediating variables such as family satisfaction and exacerbating variables such as physical abuse.

The fact that only a small number of ACOAs consented to participate is interesting to note. Great efforts were made by the researcher to obtain a larger number of participants in order to accomplish all research objectives of this study. First, all potential research participants from the University's research management system were required to complete a series of screening questions, one of which questioned them on

parental substance use. Invitations to partake in this study were sent to these participants but only a limited number actually agreed to participate.

Secondly, the difficulty in obtaining ACOA participants was not restricted to the college students After collecting data from 150 college students, it was clear that more ACOA participants were needed so the researcher attempted to obtain data from additional ACOAs by utilizing ACOA online communities. The majority of the researchers' emails to these websites were not returned or permission was denied to provide information about the study to the ACOA members. An invitation to participate in this research study was posted on the one website which provided permission, but no additional ACOA participants were obtained due to the extreme hesitation to disclose by ACOA chat room members. Furthermore, certain comments sent to the researcher online by members indicated negative reactions to participating in such a study.

Finally, a large number of ACOA participants omitted items when completing the surveys. This may be from discomfort associated with the topics of certain items or they simply had a haphazard approach to answering. The former explanation seems to be more accurate because there appears to be a loosely related pattern of the specific items that ACOA participants tended to omit. A majority of the items that were not completed were regarding parental alcoholism (e.g. CAST items) and parental treatment for alcohol issues. It would be interesting to explore in future research the mechanisms behind this hesitation to disclose and the omission of several items.

Clinical Implications

Results from this study have several clinical implications. First, because ACOA status was correlated with insecure attachment styles it would be useful for clinicians to

inquire about typical relationship patterns as well as cognitions and emotions that ACOA clients hold concerning their romantic relationships. Because it has been noted that basic relationship patterns are learned in childhood, it may be wise for the clinician to aid the client in uncovering what familial patterns resulted in current insecure relationships patterns. Also, because the likelihood of child abuse is notably increased for ACOAs versus non-ACOAs, it would be important to inquire about abuse history if parental alcoholism has been established as abuse can result in dysfunction separate from and above that of parental alcoholism.

Another clinical implication from this research is that ACOAs may hesitate in forming close relationships. Due to the increased likelihood of ACOAs having insecure relationship patterns, they may have a difficult time forming close relationships with others. This pattern is likely to be true when attempting to form a therapist-client relationship as well. Therefore, the clinician may need to spend additional time establishing rapport with ACOA clients before a close therapeutic relationship can be established and trust is established well enough to uncover the extent of family history in areas such as abuse, substance use, and parent-child attachments.

As it is likely that familial variables such as family satisfaction can serve as a protective factor against parental alcoholism, clinicians may benefit from working with the entire family when working with either adult or child ACOAS. Working with the family as whole may also unearth dysfunctional patterns within the family system that can be altered through therapeutic techniques and decrease the negative impact of parental alcoholism on offspring.

Limitations

While the data did show support for the hypotheses regarding more insecure attachment styles in ACOAs then non-ACOAs and the relative absence of positive familial factors in ACOAs, the results should be evaluated within the context of the limitations associated with this study. The small sample size made statistical analyses less powerful and prohibited us from testing our model. Further, the limited diversity in terms of age, ethnicity, and gender make the results from this study inapplicable to the general population, however this information remains useful for college-aged ACOAs.

Another caution is that it may not suffice to apply the findings from this study to children raised in homes in which a parental substance abuse problem existed for substances other than alcohol. It is very likely that growing up in a home where a parent is abusing prescription medications, for example, may look very different from growing up with parental alcoholism in terms of the disruptions in family functioning that occur because of the abuse. Additionally, growing up with a substance dependent parent who has a comorbid mental health diagnosis would result in a very different ACOA experience.

Furthermore, this study relied solely on self-report data without having family members corroborate the report of parental alcoholism. Furthermore, a broader measure of child abuse may have allowed for greater sensitivity in determining the history of abuse experienced by participants.

Suggestions for Future Research

This research has brought attention to several areas that could be examined further to better understand the ACOA experience. Replications of this study with a larger

population would provide the means to test our proposed model and further substantiate the protective function of the familial factors we examined. However, due to the strong correlations between many of the study variables, future research with this model should be attentive to the possibility of multicollinearity. Replicating the study with a larger population and greater diversity in terms of age would allow this data to be more applicable to the general population and age or developmental stage could be entered as an additional study variable to examine.

One major area for future research is in the protective function of familial factors such as family satisfaction, cohesion, and parent-child attachment for ACOAs. Family satisfaction lacks substantial research that examines the protective effects it has for shielding children from the detrimental affects of parental alcoholism. Further analysis of this variable will serve as a basis for comparison for the results obtained in this study and will also benefit the ACOA community. Although family satisfaction and cohesion are more researched within the ACOA field, there is still a paucity of research that examines the interrelatedness of these variables and what specific function they can serve in protecting ACOAs from dysfunction associated with parental alcoholism, thus further analysis of these variables is warranted.

Because of the high rate of parental divorce and separation in our ACOA sample, it is unclear if the results are related to parental alcoholism or the parental separation. The same is true for physical and verbal child abuse. Controlling for parental separation and divorce and child abuse would help remove these as possible confounding variables. Additionally, controlling for specific demographic variables (e.g., gender, parental education level and income) may help to distinguish if some of the dysfunction assumed

to be related to parental alcoholism is instead, related to factors such as lower socioeconomic status.

Further examination of our finding regarding no differences in need for approval between ACOAs and non-ACOAs is needed. Although a decreased score on the Need for Approval subscale typically represents more security in relationships, it may actually be a facet of insecurity or distrust of others for ACOAs. Future researchers could conduct a more qualitative study and interview ACOAs to understand this relationship better.

Conclusion

Results from this study suggest that ACOAs are more insecure in their relationships than non-ACOAs. However, our sample had a large proportion of participants from non-intact families and many of the ACOAS had experienced severe physical abuse in childhood. Because abuse itself is commonly referred to as a form of family dysfunction (e.g., Nicholas & Rasmussen, 2006), it is important for future researchers to bear in mind that dysfunction associated with the child abuse, may explain negative outcomes over and above the dysfunction associated solely with parental alcoholism. Although this research may help shed light on factors that are generally protective against parental substance abuse issues, ACOAs remain a very heterogeneous group and over-generalizations should not be made in regards to their experiences and outcomes.

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Table 1

Demographic Variables for ACOA and Non-ACOA Participants

Variables	Overall Sample (n = 84)	ACOA Participants (n = 40)	Non-ACOA Participants (n = 44)
Gender			
Male	22 (26%)	12 (30%)	10 (23%)
Female	62 (74%)	28 (70%)	34 (77%)
Ethnic Background			
Caucasian	69 (82%)	34 (85%)	35 (80%)
African American	13 (16%)	5 (13%)	8 (18%)
Latin American	1 (1%)	0 (0%)	1 (2%)
Asian	1 (1%)	1 (3%)	0 (0%)
College Level			
Freshman	47 (56%)	23 (58%)	24 (55%)
Sophomore	27 (32%)	13 (33%)	14 (32%)
Junior	8 (10%)	4 (10%)	4 (9%)
Senior/Graduate Student	2 (2%)	0 (0%)	2 (5%)
Family Structure			
Intact	43 (51%)	13 (33%)	30 (68%)
Parents Never Married	2 (2%)	1 (3%)	1 (2%)
Parents Separated	8 (10%)	3 (8%)	5 (11%)
Parents Divorced/Not Remarried	19 (23%)	15 (38%)	4 (9%)
Parents Remarried	12 (14%)	8 (20%)	4 (9%)

Variables	Overall Sample (n = 84)	ACOA Participants (n = 40)	Non-ACOA Participants (n = 44)
Own Substance Use Concern			
Concerned	19 (23%)	13 (33%)	6 (14%)
Not Concerned	65 (77%)	27 (68%)	38 (86%)
Participant History of Treatment			
Received Treatment	5 (6%)	4 (10%)	1 (2%)
No Treatment History	79 (94%)	36 (90%)	43 (98%)
Parents' History of Treatment[a]			
Received Treatment	12 (14%)	12 (30%)	0 (0%)
No Treatment History	64 (76%)	20 (50%)	44 (100%)
Family History of Treatment[a]			
Received Treatment	14 (17%)	13 (33%)	1 (2%)
No Treatment History	67 (80%)	24 (60%)	43 (98%)

Note. [a] Not all participants responded to this item

Table 2

ASQ[a] by ACOA Status

	ACOA		Non-ACOA			
ASQ Scale	*M*	*SD*	*M*	*SD*	df	*t*
Relationship as Secondary[b]	20.89 (n = 38)	4.74	18.25 (n = 44)	4.52	80	2.59**
Need for Approval[b]	23.10 (n = 40)	6.01	21.07 (n = 44)	5.84	82	1.57
Discomfort with Closeness[c]	37.56 (n = 39)	6.94	33.60 (n = 43)	9.08	80	2.20*
Preoccupation with Relationships[d]	29.48 (n = 40)	5.02	25.75 (n = 44)	6.50	82	2.92***
Confidence[d]	31.64 (n = 39)	6.75	36.30 (n = 44)	5.81	81	3.38***
ASQ Total[a]	136.34 (n = 38)	19.97	118.42 (n = 43)	24.26	79	3.60***

Note. Higher scores indicate more insecure attachment styles.

[a] ASQ = Attachment Style Questionnaire. Range of possible scores is 40 – 240. [b]Range of possible scores is 7 – 42. [c]Range of possible scores is 10 – 60. [d]Range of possible scores is 8 – 48.

*$p < .05$. **$p \leq .01$. ***$p \leq .001$

Table 3

Group Differences in Family Protective Factors

Family Protective Factors	ACOA		Non-ACOA			
	M	*SD*	*M*	*SD*	df	*t*
Family Satisfaction[a]	31.41 (n = 39)	9.51	40.72 (n = 43)	8.69	80	-4.63**
Family Cohesion[b]	41.27 (n = 26)	33.16	68.30 (n = 38)	27.31	46.78	-3.43**
Parental Attachment						
With Mother[c]	180.86 (n = 37)	40.46	225.72 (n = 44)	30.97	79	-5.65**
With Father[c]	177.09 (n = 35)	42.10	211.70 (n = 41)	36.41	74	-3.85**

Note. On all scales, higher scores indicate more of that attribute.

[a]Range of possible scores is 10 – 50. [b]Range of possible scores is 10 – 100, however in some cases it can be a negative number or a score over 100. [c]Possible range of scores is 55 – 275.

**$p < .01$

Table 4

Intercorrelations for CAST[a], FACES IV[b], FSS[c], and PAQ[d]

Measure	1	2	3	4	5
1. PAQ with mother	--				
2. PAQ with father	.38*** (n = 74)	--			
3. FACES	.48*** (n = 61)	.38*** (n = 57)	--		
4. FSS	.58*** (n = 79)	.54*** (n = 75)	.68*** (n = 62)	--	
5. CAST	-.44*** (n = 81)	-.33*** (n = 76)	-.37*** (n = 64)	-.50*** (n = 82)	--

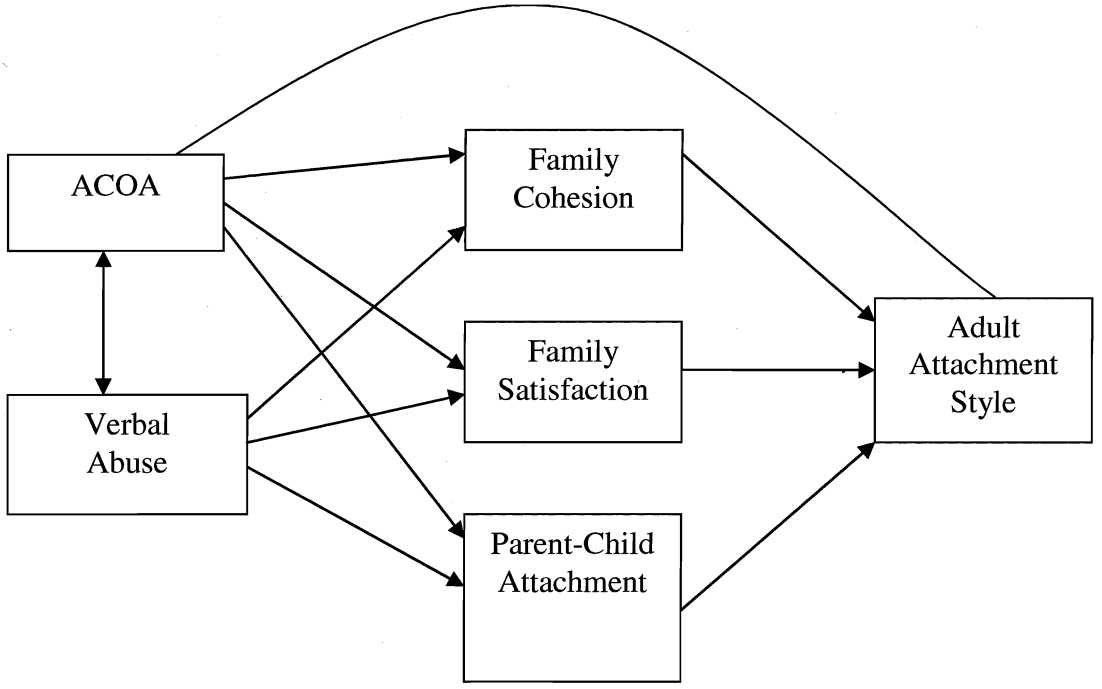
Note. On all measures the higher the score, the greater the attribution.

[a]CAST = Children of Alcoholic Screening Test. [b]Faces = Family Adaptability and Cohesion Evaluation Scales IV. [c]FSS = Family Satisfaction Scale. [d]PAQ = Parental Attachment Questionnaire.

***$p < .001$.

Figure Caption

Figure 1. Proposed model of relationship between ACOA status, attachment and family factors.


ACOA
Verbal Abuse
Family Cohesion
Family Satisfaction
Parent-Child Attachment
Adult Attachment Style

APPENDIX A

Demographic Questionnaire

Please fill out the following information.

1. Age: _____

2. Gender: Male _____ Female _____

3. Ethnicity:
   Caucasian _____ African American _____ Native American _____
   Latin American _____ Other _____

4. College Level:
   Freshman _____ Sophomore _____ Junior _____ Senior _____
   Graduate Student _____

5. Family Structure in childhood:
   _____ Intact (Parents Married)
   Never Married _____
   Parents Separated _____
   Parents Divorced/Not Remarried _____
   Parents Remarried _____

6. Have you ever been concerned about your own substance use (i.e., alcohol or drug use)?
   Yes _____ No _____

7. Has anyone else ever expressed concern about your substance use?
   Yes _____ No _____

8. Have you ever received treatment for your substance use?
   Yes _____ No _____

9. Did your mother experience significant problems with alcohol use or abuse?
   Yes_____ No_____

10. Did your mother experience significant problems with other substances (use or abuse)?

    Yes _____ No _____

11. If yes, what substance(s) were used or abused? _____

12. Did your father experience significant problems with alcohol use or abuse?
    Yes_____ No_____

13. Did your father experience significant problems with other substances (use or abuse)?
    Yes _____ No _____

14. If you answered 'yes' to question # 13, what substance(s) were used or abused?
    _____

15. Did either of your parents receive treatment for substance use or abuse?
    Yes _____ No _____

16. Did anyone in your family ever receive treatment related to your parent's substance use or abuse?
    Yes _____ No _____

APPENDIX B

Children of Alcoholics Screening Test (CAST)

Please check the answer below that best describes your feelings, behavior, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "Yes" or "No."

Yes	No	Questions
_____	_____	1. Have you ever thought that one of your parents had a drinking problem?
_____	_____	2. Have you ever lost sleep because of a parent's drinking?
_____	_____	3. Did you ever encourage one of your parents to quit drinking?
_____	_____	4. Did you ever feel alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking?
_____	_____	5. Did you ever argue or fight with a parent when he or she was drinking?
_____	_____	6. Did you ever threaten to run away from home because of a parent's drinking?
_____	_____	7. Has a parent ever yelled at or hit you or other family members when drinking?
_____	_____	8. Have you ever heard your parents fight when one of them was drunk?
_____	_____	9. Did you ever protect another family member from a parent who was drinking?
_____	_____	10. Did you ever feel like hiding or emptying a parent's bottle of liquor?
_____	_____	11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
_____	_____	12. Did you ever wish that a parent would stop drinking?
_____	_____	13. Did you ever feel responsible for and guilty about a parent's drinking?
_____	_____	14. Did you ever fear that your parents would get divorced due to alcohol misuse?
_____	_____	15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?
_____	_____	16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
_____	_____	17. Did you ever feel that you made a parent drink alcohol?
_____	_____	18. Have you ever felt that a problem drinking parent did not really love you?
_____	_____	19. Did you ever resent a parent's drinking?
_____	_____	20. Have you ever worried about a parent's health because of his or her alcohol use?

_____ _____
_____ _____ 21. Have you ever been blamed for a parent's drinking?
_____ _____ 22. Did you ever think your father was an alcoholic?
_____ _____ 23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
_____ _____ 24. Did a parent ever make promises to you that he or she did not keep because of drinking?
_____ _____ 25. Did you ever think your mother was an alcoholic?
_____ _____ 26. Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?
_____ _____ 27. Did you ever fight with your brothers and sisters about a parent's drinking?
_____ _____ 28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
_____ _____ 29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
_____ _____ 30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

APPENDIX C

Attachment Style Questionnaire (ASQ)

Show how much you agree with each of the following items by rating them on this scale:
1 = totally disagree
2 = strongly disagree
3 = slightly disagree
4 = slightly agree
5 = strongly agree
6 = totally agree.

1 2 3 4 5 6	1.	Overall, I am a worthwhile person.
1 2 3 4 5 6	2.	I am easier to get to know than most people.
1 2 3 4 5 6	3.	I feel confident that other people will be there for me when I need them.
1 2 3 4 5 6	4.	I prefer to depend on myself rather than other people.
1 2 3 4 5 6	5.	I prefer to keep to myself.
1 2 3 4 5 6	6.	To ask for help is to admit that you're a failure.
1 2 3 4 5 6	7.	People's worth should be judged by what they achieve.
1 2 3 4 5 6	8.	Achieving things is more important than building relationships.
1 2 3 4 5 6	9.	Doing your best is more important than getting on with others.
1 2 3 4 5 6	10.	If you've got a job to do, you should do it no matter who gets hurt.
1 2 3 4 5 6	11.	It's important to me that others like me.
1 2 3 4 5 6	12.	It's important to me to avoid doing things that others won't like.
1 2 3 4 5 6	13.	I find it hard to make a decision unless I know what other people think.
1 2 3 4 5 6	14.	My relationships with others are generally superficial.
1 2 3 4 5 6	15.	Sometimes I think I am no good at all.
1 2 3 4 5 6	16.	I find it hard to trust other people.
1 2 3 4 5 6	17.	I find it difficult to depend on others.

1 2 3 4 5 6	18.	I find that others are reluctant to get as close as I would like.
1 2 3 4 5 6	19.	I find it relatively easy to get close to other people.
1 2 3 4 5 6	20.	I find it easy to trust others.
1 2 3 4 5 6	21.	I feel comfortable depending on other people.
1 2 3 4 5 6	22.	I worry that others won't care about me as much as I care about them.
1 2 3 4 5 6	23.	I worry about people getting too close.
1 2 3 4 5 6	24.	I worry that I won't measure up to other people.
1 2 3 4 5 6	25.	I have mixed feelings about being close to others.
1 2 3 4 5 6	26.	While I want to get close to others, I feel uneasy about it.
1 2 3 4 5 6	27.	I wonder why people would want to be involved with me.
1 2 3 4 5 6	28.	It's very important to me to have a close relationship.
1 2 3 4 5 6	29.	I worry a lot about my relationships.
1 2 3 4 5 6	30.	I wonder how I would cope without someone to love me.
1 2 3 4 5 6	31.	I feel confident about relating to others.
1 2 3 4 5 6	32.	I often feel left out or alone.
1 2 3 4 5 6	33.	I often worry that I do not really fit in with other people.
1 2 3 4 5 6	34.	Other people have their own problems, so I don't bother them with mine.
1 2 3 4 5 6	35.	When I talk over my problems with others, I generally feel ashamed or foolish.
1 2 3 4 5 6	36.	I am too busy with other activities to put much time into relationships.
1 2 3 4 5 6	37.	If something is bothering me, others are generally aware and concerned.
1 2 3 4 5 6	38.	I am confident that other people will like and respect me.
1 2 3 4 5 6	39.	I get frustrated when others are not available when I need them.
1 2 3 4 5 6	40.	Other people often disappoint me.

APPENDIX D

Parent-Child Conflict Tactics Scale (CTSPC)

Here is a list of things your parents might have done when you had a conflict or disagreement with them. We would like you to try and remember what went on <u>your worst year during the time you were living at home.</u> Please indicate how often your parents did it.

		Never	Once	Twice	3-5	6-10	11-20	>20
1. Hit me with a fist or kicked me hard.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
2. Grabbed me around the neck and choked me.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
3. Beat me up, that is he/she hit me over and over as hard as he/she could.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
4. Burned or scalded me on purpose.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
5. Hit me on some other part of the body besides the bottom with something like a belt, hairbrush, a stick or some other hard object.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
6. Threatened me with a knife or gun.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
7. Threw or knocked me down.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
8. Slapped me on the face or head or ears.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6

APPENDIX E

Psychological Maltreatment Scale (PMS)

Verbal arguments and punishment can range from quiet disagreements to yelling, insulting, and more severe behaviors. When you were living at home, how often did the following happen to you in the average year? Answer for your mother and your father.

		Never	Once	Twice	3-5	6-10	11-20	>20
1. Yell at you.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
2. Insult you.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
3. Criticize you.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
4. Try to make you feel guilty.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
5. Ridicule or humiliate you.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
6. Embarrass you in front of others.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6
7. Make you feel like you were a bad person.	Mother	0	1	2	3	4	5	6
	Father	0	1	2	3	4	5	6

	Never	Once	Twice	3-5	6-10	11-20	>20

APPENDIX F

Family Adaptability and Cohesion Evaluation Scales (FACES-IV)

For the following questions, please choose the best option that applies to YOUR family.

1	2	3	4	5
DOES NOT describe our Family at all	SLIGHTLY describes our family	SOMEWHAT describes our family	GENERALLY describes our family	VERY WELL describes our family

_____ 1. Family members are involved in each others lives.

_____ 2. Our family tries new ways of dealing with problems.

_____ 3. We get along better with people outside our family than inside.

_____ 4. We spend too much time together.

_____ 5. There are strict consequences for breaking the rules in our family.

_____ 6. We never seem to get organized in our family.

_____ 7. Family members feel very close to each other.

_____ 8. Parents equally share leadership in our family.

_____ 9. Family members seem to avoid contact with each other when at home.

_____ 10. Family members feel pressured to spend most free time together.

_____ 11. There are clear consequences when a family member does something wrong.

_____ 12. It is hard to know who the leader is in our family.

_____ 13. Family members are supportive of each other during difficult times.

_____ 14. Discipline is fair in our family.

_____15. Family members know very little about the friends of other family members.

_____ 16. Family members are too dependent on each other.

_____ 17. Our family has a rule for almost every possible situation.

_____ 18. Things do not get done in our family.

_____ 19. Family members consult other family members on important decisions.

_____ 20. My family is able to adjust to change when necessary.

_____ 21. Family members are on their own when there is a problem to be solved.

_____ 22. Family members have little need for friends outside the family.

_____23. Our family is highly organized.

_____ 24. It is unclear who is responsible for things (chores, activities) in our family.

_____ 25. Family members like to spend some of their free time with each other.

_____ 26. We shift household responsibilities from person to person.

_____ 27. Our family seldom does things together.

_____ 28. We feel too connected to each other.

_____ 29. Our family becomes frustrated when there is a change in our plans or routines.

_____ 30. There is no leadership in our family.

_____ 31. Although family members have individual interests, they still participate in family activities.

_____ 32. We have clear rules and roles in our family.

_____ 33. Family members seldom depend on each other.

_____ 34. We resent family members doing things outside the family.

_____ 35. It is important to follow the rules in our family.

_____ 36. Our family has a hard time keeping track of who does various household tasks.

_____ 37. Our family has a good balance of separateness and closeness.

_____ 38. When problems arise, we compromise.

_____ 39. Family members mainly operate independently.

_____ 40. Family members feel guilty if they want to spend time away from the family.

_____ 41. Once a decision is made, it is very difficult to modify that decision.

_____ 42. Our family feels hectic and disorganized.

APPENDIX G

Family Satisfaction Scale (FSS)

For the following questions, please choose the best option that applies to YOUR family.

1	2	3	4	5
DOES NOT describe our Family at all	SLIGHTLY describes our family	SOMEWHAT describes our family	GENERALLY describes our family	VERY WELL describes our family

How satisfied are you with:

_____ 1. The degree of closeness between family members.

_____ 2. Your family's ability to cope with stress.

_____ 3. Your family's ability to be flexible.

_____ 4. Your family's ability to share positive experiences.

_____ 5. The quality of communication between family members.

_____ 6. Your family's ability to resolve conflicts.

_____ 7. The amount of time you spend together as a family.

_____ 8. The way problems are discussed.

_____ 9. The fairness of criticism in your family.

_____ 10. Family members concern for each other.

APPENDIX H

Parental Attachment Questionnaire

1 Not at all (0-10%)	2 Somewhat (11-35%)	3 A Moderate Amount (36-65%)	4 Quite a Bit (66-90%)	5 Very Much (91-100%)

In general, my mother/father….

M	F	
____	____	1. is someone I can count on to listen to me.
____	____	2. supports my goals and interests.
____	____	3. sees the world differently than I do.
____	____	4. understands my problems and concerns.
____	____	5. respects my privacy.
____	____	6. limits my independence.
____	____	7. gives me advice when I ask for it.
____	____	8. takes me seriously.
____	____	9. likes me to make my own decisions.
____	____	10. criticizes me.
____	____	11. tells me what to think or how to feel
____	____	12. gives me attention when I want it.
____	____	13. is someone I can talk to about anything.

M	F	
____	____	14. has no idea what I am feeling or thinking.
____	____	15. lets me try new things out and learn on my own.
____	____	16. is too busy to help me.
____	____	17. has trust and confidence in me.
____	____	18. tries to control my life.
____	____	19. protects me from danger and difficulty.
____	____	20. ignores what I have to say.
____	____	21. is sensitive to my feelings and needs.
____	____	22. is disappointed in me.
____	____	23. gives me advice whether or not I want it.
____	____	24. respect my decisions, even if they don't agree.
____	____	25. does things for me which I would rather do for myself.
____	____	26. is someone whose expectations I feel I have to meet.
____	____	27. treats me like a younger child.

1 Not at all (0-10%)	2 Somewhat (11-35%)	3 A Moderate Amount (36-65%)	4 Quite a Bit (66-90%)	5 Very Much (91-100%)

During time spent together, my mother/father was someone…

M	F	
____	___	28. I looked forward to seeing.
____	___	29. With whom I argued.
____	___	30. With whom I felt comfortable.
____	___	31. Who made me angry.
____	___	32. I wanted to be with all the time.
____	___	33. Towards whom I felt cool and distant.
____	___	34. Who got on my nerves.
____	___	35. Who made me feel guilty and anxious.
____	___	36. I liked telling about what I have done recently.
____	___	37. For whom I felt feelings of love.
____	___	38. I tried to ignore.
____	___	39. To whom I told my most personal thoughts and feelings.
____	___	40. I liked being with.
____	___	41. I didn't want to tell what has been going on in my life.

Following time spent together, I leave my mother/father…

M	F	
____	___	42. With warm and positive feelings
____	___	43. Feeling let down and disappointed.

When I have a serious problem or an important decision to make…

M	F	
____	___	44. I look to my family for help.
____	___	45. I go to a therapist, school counselor, or clergy (priest, rabbi, or minister).
____	___	46. I think about what my mom or dad might say.
____	___	47. I work it out on my own, without help from anyone.
____	___	48. I talk it over with a friend.
____	___	49. I know that my family will know what I should do.
____	___	50. I ask my family for help if my friends can't help.

When I go to my mother/father for help…

M	F	
____	___	51. I feel more sure of my ability to handle the problems on my own.

___ ___
___ ___ 52. I continue to feel unsure of myself.
___ ___ 53. I feel that I would have gotten more understanding from a friend.
___ ___ 54. I feel sure that things will work out as long as I follow my parent's advice.
___ ___ 55. I am disappointed with their response.

1 Not at all (0-10%)	2 Somewhat (11-35%)	3 A Moderate Amount (36-65%)	4 Quite a Bit (66-90%)	5 Very Much (91-100%)

APPENDIX I

Informed Consent

You are invited to participate in a research study conducted by Tiffany Konz, a Master's degree candidate in the Clinical Psychology M.A. program at EIU, under the supervision of Dr. Anu Sharma of the EIU Psychology Department. The purpose of this study is to examine the relationship between childhood family experiences and adult functioning. These findings can potentially help researchers and clinicians better understand the long term impact of different types of childhood family experiences.

If you agree to participate in this study, you will be asked to complete an online questionnaire which is expected to take approximately 30 minutes to complete. You must be at least 18 years old to participate. Participation is fully voluntary, and you may withdraw from the study at any time without penalty. The answers you provide will remain anonymous and used only for research purposes. There are no risks associated with this study. Students enrolled in Introductory Psychology will receive course credit for their participation.

Should you have any questions regarding your participation in this study, or any questions about the study in general, you are invited to contact the lead researcher via email at tmtaylor@eiu.edu.

If you have any questions or concerns about the treatment of human participants in this study, you may call or write: Institutional Review Board , Eastern Illinois University, 600 Lincoln Ave., Charleston, IL 61920. Telephone: (217) 581-8576. E-mail: eiuirb@www.eiu.edu.

You will be given the opportunity to discuss any questions about your rights as a research subject with a member of the IRB. The IRB is an independent committee composed of members of the University community, as well as lay members of the community not connected with EIU. The IRB has reviewed and approved this study.

By clicking the "I consent" icon below, you are indicating that you are at least 18 years old, and have read, understand, and accept the terms outlined above.

APPENDIX J

Feedback Statement

As prevalence rates of alcohol and drug abuse have increased over the past few decades, research on the effects of substance abuse on families has also increased greatly (e.g., Johnson, 2001; Rangarajan, 2008). One particular focus of this research has been on the effects parental substance abuse has on children in the family, with more recent exploration into how these effects extend into the child's adult life. The primary purpose of this research study is to gain insight into the individual factors that may exacerbate or serve as a buffer from the potential long-term negative effects parental alcoholism can have on children as they mature into adulthood. Furthermore, this study will examine the relationships among various familial factors and adult attachment styles in adult children of alcoholics.

I want to sincerely thank you for participating in this study. If you have any questions about this research, please do not hesitate to contact me, Tiffany Konz, at tmtaylor@eiu.edu, or Dr. Anu Sharma at 217-581-6089, at asharma@eiu.edu.

For information regarding counseling services, please consult the following resources:

Eastern Illinois University Counseling Center
Charleston, IL
(217) 581-3413
http://www.eiu.edu/~counsctr/cslwelc.html

References

Johnson, P. (2001). Dimensions of functioning in alcoholic and nonalcoholic families. *Journal of Mental Health Counseling, 23*(2), 127-136.

Rangarajan, S. (2008). Mediators and moderators of parental alcoholism effects on offspring self-esteem. *Alcohol & Alcoholism, 43*(4), 481-491.