1998

Sons of alcoholic fathers : psychological and methodological considerations

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DOI: <https://doi.org/10.31979/etd.nbyz-5p7h>

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**SONS OF ALCOHOLIC FATHERS: PSYCHOLOGICAL
AND METHODOLOGICAL CONSIDERATIONS**

A Thesis

Presented to

The Faculty of the Department of Social Science

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science in Social Science

By

Dennis Haines

December, 1998

UMI Number: 1392814

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ABSTRACT

SONS OF ALCHOLIC FATHERS: PSYCHOLOGICAL AND METHODOLOGICAL CONSIDERATIONS

by Dennis Haines

With increased clinical attention to the psychological status of adult children of alcoholics (ACOAs), the emphasis has been on the severity of impairment, and the corresponding need for extended treatment. Current clinical literature suggests that ACOAs will almost always show internal impairments and that long-term psychotherapy is needed for recovery. Empirical evidence is challenging this. Some ACOAs may need long-term therapy for recovery, while others do not. This study attempts to understand why these inconsistencies exist by assessing subjects using two methodological approaches—one qualitative and one quantitative. By studying sons of alcoholic fathers, this thesis addresses whether one or both approaches are best used to adequately classify an individual as a child of an alcoholic or not.

ACKNOWLEDGEMENTS

I would like to sincerely thank those who have supported me in this research project. I especially want to thank my chair, Dr. Michael Alessandri, for all of his help throughout the writing of the thesis. I also want to thank Dr. Celia Orona and Dr. Maria Alaniz for serving on my committee and being my sounding boards throughout the seven long years. I very much appreciate their support and insight to the completion of this thesis.

I want to thank my friends and colleagues, Robert and Dorothy Jones for their eye for detail, computer wizardry, and statistical comments. I want to thank Anne Manyak for being so generous with her time while providing editorial expertise and helping with the printing of the final thesis draft.

I want to thank the many subjects from San Jose State University for participating in this thesis. I really appreciated the sacrifices during finals week of each of the three semesters this was tested. Your time lives on!

On the “home front,” this thesis and the Master’s program have been successfully completed with the ongoing love, patience, and support of my wife, Toni. I cannot begin to tell you how much I appreciate all your encouragement during some of the lean years. Your positive strokes kept me sane and focused enough to complete this thesis. As you said, “This is not just your thesis, but mine as well.” Honey we did it!

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CHAPTER ONE

Introduction

Alcoholism and its effects have taken on enormous proportions in our culture. Research on the effects of parental alcoholism has expanded rapidly in the past two decades. In a report based on a survey by the National Center for Health Statistics and the National Institute on Alcohol Abuse in 1991, seventy six million Americans, (approximately 43 % of the U.S. adult population), have been exposed to alcoholism in the family; almost one in five adult Americans (18%) lived with an alcoholic while growing up; roughly one in eight American adult drinkers is alcoholic or experiences problems due to the use of alcohol; and an estimated 26.8 million children of alcoholics (COAs) exist in the United States. Preliminary research suggests that over 11 million COAs are under the age of 18 (Eigen & Rowden, 1995). A consistent finding is that approximately 14% of the adult population in the United States suffers from alcoholism or a serious drinking problem (Berkowitz & Perkins, 1988; Claydon, 1987; Russell, Henderson, & Blume, 1985; Tweed & Ryff, 1991).

Drinking affects not only the individual, but the entire family. For each person with an alcohol problem, it is estimated that four family members are affected (Kinney & Leaton, 1983). For children growing up with one or more alcoholic parents, the early impact of alcoholism continues to affect their lives long after they become adults and leave their original alcoholic family. Many researchers agree that individuals who are raised as children in an unsafe, dysfunctional alcoholic household, develop common

symptoms and characteristics known and identified as adult children of alcoholics (ACOA) (Bradshaw, 1988; Kritsberg, 1986).

A closer look at the phenomenon of alcoholism is needed to better understand its impact on the individual and the family. Alcoholism is an addiction to the substance, ethyl alcohol. Overtime, the individual develops a pattern of alcohol abuse, and he or she can be labeled as a problem drinker or an alcoholic. The Diagnostic and Statistical Manual IV-R classifies psychoactive substance abuse as a pattern encompassing continued use despite persistent social, occupational, physical, or psychological problems and a minimal duration of disturbance for at least 1 month (DSM-IV-R, American Psychiatric Association, 1994).

Problems Associated with Alcoholism

Alcoholism and its accompanying problems can be exhibited in many different ways. Steele and Joseph (1990) reported that alcoholism could be a factor in antisocial behavior among its users. Antisocial behavior and the potential “acting-out” behaviors that can accompany drinking bouts may account for many of the social problems experienced in the United States. Steele and Joseph indicated that alcohol was implicated in nearly 70% of fatal automobile accidents; 65% of murders; 88% of knifings; 65% of spouse battering, and; 55% of violent child abuse.

The issue of potential long-term effects of parental alcoholism arises when looking at the impact alcoholism can have on family members and society as a whole. Within the familial alcoholism paradigm, it is easy to extrapolate from the above statistics that children reared in an alcoholic environment may be placed at “high-risk” for

violence, accidents, psychological disturbances, and an increased potential to become alcoholic (Cotton, 1979; Macdonald & Blume, 1986; Roosa, Sandler, Beals, & Short, 1988). Many studies have focused on the high-risk element of this influence and what potential outcomes could be for those growing up in an alcoholic home. Other researchers report mental illness and socialization problems and predict that COAs are at risk for depression, juvenile delinquency, academic and interpersonal problems, and hyperactivity (Burk & Sher, 1990; DeLuca, 1981; West & Printz, 1987). Studies show that certain forms of mental illness appear more frequently (specifically, depression and other psycho-pathological features) in relatives of alcoholics (Clair & Genest, 1987; Cotton, 1979; Sloboda, 1974).

Other research has shown that adult children of alcoholics (ACOAs) are more prone to psychological and physical distress, and emotional problems than are adult children of non-alcoholics (non-ACOAs). For example, several researchers have reported that ACOAs are at greater risk than non-ACOAs for anxiety and low self-esteem (Cole, 1988/1989; Knowles & Schroeder, 1990; Lease, 1990). Taliaferro and Aponte (1990) found that ACOAs manifested more cognitive distortions and a greater expectancy for failure than did non-ACOAs. Other studies have found that ACOAs have greater difficulty with trust and intimacy than do non-ACOAs (Black, Bucky, & Wilder-Padilla, 1986; Latham, 1988/1989; McCarthy Woods, 1988/89).

Children raised in an alcoholic home may find themselves victims of physical and/or psychological abuse and are often forced to self-parent. In some cases, these children assume a protective role toward the alcoholic parent. The consequence of this

familial dysfunction carries over into adulthood, often resulting in impaired family and social relationships (Sussman & Smith, 1992).

Controversy

Some research findings have been contradictory over the last decade regarding children of alcoholics and their functioning. Some researchers emphasize the resiliency of COAs (Werner, 1986), while others suggested that the label “COA” could make one become more depressed (Burk & Sher, 1990). Other studies report results indicating no significant differences between ACOAs and non-ACOA with regard to personality characteristics or psychological distress. For example, Berkowitz and Perkins (1988) found that ACOA college students were similar to their non-ACOA peers on almost all personality characteristics except levels of self-depreciation (ACOA reported greater self-depreciation than did non-ACOA). Similarly, Lundberg (1989) found no significant differences between ACOAs and non-ACOA in her investigation of: a) willingness to trust, and; b) fear of negative evaluation.

To better understand the variables involved in inconsistencies between ACOAs, a closer look at paternal aspects of parenting is needed. The father’s influence on his family can be positive or negative, subtle (i.e., role modeling) or blatant (i.e., sexual or physical abuse), and dependent upon various factors. Many variables can be associated with the way a father parents his children. Societal rules, cultural expectations, the stress of daily life, and how the father was parented can all play a part in how he, in turn, rears his children. Many studies show that fathers assume little responsibility for their

children's care or rearing (Lamb & Oppenheim, 1989). They are often seen as the child's playmate with little or no involvement in care-taking.

Lamb and Oppenheim (1989) suggest that four factors determine the quality of paternal childrearing involvement. The first factor is motivation or the extent to which fathers want to be involved. The second factor includes the father's skills and self-confidence; e.g., the father's ability to interpret his child's needs and act on them. The third factor consists of two kinds of support: the degree of maternal support, which may be lacking because the mother does not want to disrupt the status quo, and the father's need for societal support. The final factor has to do with institutional practices or the degree to which men are the primary breadwinners and, consequently, can be found to spend less time at home or less time involved in family work. If the father is motivated, has the childrearing skills and self-confidence needed, is a part of a supportive environment, and takes time from his work role to be actively involved with his children, there is an increased likelihood that the father will be more engaged in childrearing.

Alcoholic paternal childrearing can consist of some characteristics, which deviate from "normal" paternal childrearing practices. The alcoholic father may be less available to his children because of his involvement in drinking and the need for alcohol. His parenting may be inconsistent and fluctuate greatly depending on his state of intoxication or sobriety (Jarmas & Kazak, 1992). He may be intensely involved with marital problems to the point of separation or divorce making attention to the children a secondary concern. More numerous separations (45%) have been reported by adult

children of alcoholics (ACOAs) compared with non-ACOAs (22%) with no difference reported in parental divorce statistics between these two groups (Jarmas & Kazak, 1992).

Children of alcoholic fathers regard their fathers in a different light than do children of non-alcoholic fathers. Adolescents of alcoholic and recovered alcoholic fathers often view alcoholics as sick, depressed, and in need of help (Callan & Jackson, 1986). These same adolescents rated alcoholics as “dangerous” and commented on the fear associated with living with an alcoholic father. The lack of inhibitions surrounding the use of alcohol can make for an unsafe environment for all involved.

Statement of the Problem

Alcoholism is a progressive and potentially fatal disease, one that will ultimately “cause all its victims to behave in destructive and antisocial ways” (Johnson, 1973, p. 2). There are approximately 10 million Americans who suffer from alcoholism (Milam & Ketcham, 1983). A closer look at the phenomenon of alcoholism is needed to better understand its impact on the individual and the family. Spouses and children suffer from the disease of the alcoholic either through constant stress or from fears of various kinds, such as fear of outsiders, authority, abandonment, insanity, criticism, confrontations, and a child’s fear that things will go out of control (Marlin, 1989). Approximately 15 million school-age children in this country are growing up in alcoholic families (Deutch, 1984). Some estimates go as high as 17 - 18 million (Sussman & Smith, 1992; Eigen & Rowden, 1995). This figure climbs to 26.8 million ACOAs (Eigen & Rowden, 1995), and as high as 28 million ACOAs in the United States (Brown, 1992). Despite the consensus among clinicians that many children of alcoholics are severely impaired, relatively few empirical

studies have examined this issue (Barnes, Benson, & Wilswack, 1979; El-Guebaly & Offord, 1977; Jacob, Favorini, Meisel, & Anderson, 1978). Furthermore, most studies in this literature have been characterized by major methodological problems that, in effect, have rendered conclusions that are tentative or ambiguous. The focus of the present paper aims to address these concerns and includes a combined methodological approach: quantitative and qualitative assessment. That is, questionnaires (quantitative), followed by individual interviews (qualitative) were administered to subjects to assess both methodological approaches.

CHAPTER TWO

Review of the Literature

What exactly does the phrase ACOA mean and to whom does it refer? The movement to focus attention on persons who grew up with alcoholic parents is not entirely new. During England's early 18th century Gin Epidemic, artists such as William Hogarth recorded the havoc parental drunkenness created within families (Cermak, 1990). Later, in the United States, much of the Temperance Movement's emotional intensity came from those who spoke out on behalf of "the children of inebriates," and it was known that COAs were more likely to come in contact with the juvenile justice system.

In the 1960s, when a few people first described battered children, they were met with pervasive denial. Over the next decade, this denial was effectively dismantled, and today we have child protection services in nearly every community, safety nets to catch the most overtly abused children (Cermak, 1990). The term "children of alcoholics" was then used in the 1970s when research and clinical observation began to demonstrate that children growing up in alcoholic families were particularly vulnerable to psychological shortcomings and self-defeating tendencies. It is a term that describes an adult person who was raised in a family affected by parental chemical dependency and co-dependence (Black, 1984).

There are two main reasons for today's widespread interest in COAs: the growth of self-help programs for adult children of alcoholics (ACOA's), based on the original Alcoholics Anonymous (AA) framework, and the development of an autonomous

chemical dependency field. In the United States, major advances in treating alcoholics occurred in spite of (or because of) the benign neglect of the medical establishment. It was only when the treatment of alcoholism and other drug addictions budded off from traditional psychiatric practice that effective medical treatment became generally available.

During the 1970s, the concept of alcoholism as a “family disease” led to the establishment of family education programs in treatment centers throughout the country. In most cases, these were directed toward spouses. Rarely was appropriate education or treatment provided for young COAs. It was not until the 1950s and 1960s that COAs were established as a legitimate treatment population (Brown, 1988).

Those who study this field say that children growing up in households where one or both parents are alcoholic accommodate themselves by incorporating coping strategies and survival skills not required in a non-alcoholic family. Janet Woititz’s (1990) book,

Adult Children of Alcoholics describes 13 behaviors characteristic of ACOAs:

1. They guess at what normal behavior is. They look at things that appear to be normal and try to copy them. Yet, what they are copying may or may not be normal, so they’re behaving as if they are normal, without having a sound basis for making that decision.
2. They have difficulty following a project from inception through completion.
3. They may lie when it is just as easy to tell the truth.
4. They are unusually hard on themselves and often judge themselves without mercy.
5. They have difficulty having fun and letting loose, some seem to be perpetually on guard.
6. They take themselves very seriously.
7. They have difficulty with developing, maintaining, and sustaining intimate relationships.
8. They constantly seek approval, affirmation, validation, and acceptance.
9. They have a tendency to overreact to changes they cannot control.
10. They have trouble finding a happy medium regarding responsibility. They are either extremely responsible or extremely irresponsible.

11. They tend to believe that they are different from other people.
12. They tend to be extremely loyal, even when that loyalty may not be justified.
13. They tend to be impulsive, getting locked into a course of action without fully recognizing the consequences of that action (p. 119-120).

These 13 characteristics depict an individual suffering from low self-esteem and poor self-confidence. In addition, self-criticism and inflexibility are common (Sussman & Smith, 1992).

Some children split the alcoholic parent into two people, a good half and a bad half. Others simply downplay the importance of their emotions to alleviate the pain, becoming numb to the world. They convince themselves that they don't really want the things that they can't obtain or have and lie to their peers to cover up the things they lack. These children often take certain roles to try to survive their chaotic childhood (Stark, 1987).

Several studies, however, have noted that not all ACOAs fit the above description in the same way (Sussman & Smith, 1992). Research on "resilient" children is beginning to identify factors that protect children against harmful experiences (Garmesy, 1983; Werner, 1984, 1986; Wolin, Bennett, Noonan, & Teitelbaum, 1980). Resilient children demonstrate coping skills that provide resources that later are used to manage adult transitions (Crandell, 1989). Also, it has been reported that not all ACOAs "suffer identical emotional effects, in fact, some seem to survive quite well" (Ackerman, 1987, p. 47). Thus, some researchers state that it would be a mistake to conclude that all are impaired or in need of extended treatment (Crandell, 1989). In fact, there is some evidence that many ACOAs may grow up to be fairly well adjusted despite the

difficulties they have encountered in childhood (or, perhaps, because of the coping skills they have developed) (Jacob & Leonard, 1986).

Other ACOAs appear to be less fortunate, and the coping strategies developed to sustain survival during childhood may become dysfunctional once the child becomes an adult. Black (1981) asserts that the roles and skills adopted by children of alcoholics may appear functional at times, but in actuality serve only to cover up problems that may emerge in adulthood when previously adaptive roles are no longer sufficient.

The problem is that some research concludes that although being a child of an alcoholic may increase a child's chance for developing a wide-range of behavioral health problems, not all such children actually become casualties (Heller, Sher, & Benson, 1982). While many ACOAs may certainly be at risk for psychopathology, these researchers believe that it would be a mistake to conclude that all are impaired or in need of extended treatment (Crandell, 1989).

Children are affected not only by the alcoholic parent, but also by the nonalcoholic parent (if there is one). This results in neither parent being responsive and available on a consistent, predictable bases (Black, 1981). Black (1981) expressed the conviction that psychopathology is expected among all ACOAs by stating, "ALL CHILDREN RAISED IN ALCOHOLIC HOMES NEED TO BE ADDRESSED ALL CHILDREN ARE AFFECTED" (1981, p. 23 capitals in original). Those who expect extensive pathology among ACOAs urge extensive and usually long-term treatment, whether in self-help groups (Gravitz & Bowden, 1985; Larsen, 1985; Schaef, 1986; Subby, 1987); family therapy (Bepko, 1985; Dulfano, 1982); psychodynamic individual

therapy (Hibbard, 1987); or in group treatment (Bepko, 1985; Brown, 1988; Brown & Beletsis, 1986; Cermak & Brown, 1982). Because of this, ACOAs, according to Brown and Black, believe that long-term psychotherapy is needed for recovery.

The evidence noted above (Heller, et al., 1982; Crandell, 1989) challenges this assertion by indicating that many ACOAs are not psychologically impaired and that long-term therapy is not necessary (Ackerman, 1984). Brief treatment, however, may be appropriate for those with a focal conflict and the ego strength needed to resolve the issue (Strupp, 1981).

There are, then, two views regarding the functioning and needs of ACOAs: one view indicates that no or little therapy is needed for many ACOAs, while the other view states that all ACOAs need long term treatment. It is the aim of this study to clarify these divergent positions by analyzing methodological differences that may be contributing to conflicting results.

Hypothesis

Though clinical studies using questionnaires have concluded that not all ACOAs are affected by the alcoholic environment, this methodological approach alone may be insufficient and may not accurately provide the researcher reliable outcome data. A questionnaire may not unequivocally provide accurate and reliable responses from individual respondents. Therefore, a follow up study to support congruence or incongruence of their responses may be needed.

This study is designed to utilize a combined methodological approach: quantitative and qualitative assessment. Subjects filled-out questionnaires (quantitative)

that were followed by individual open-ended interviews (qualitative) asking several questions chosen from the questionnaire. If current research is reliable, there should be comparable responses across methodological formats. If interview responses are inconsistent with the questionnaires and responses, this will call into question the reliability of both, the questionnaires and the interview and will challenge their use as the only tool in measuring the impact of living in an alcoholic environment.

By proposing this study this researcher want to establish, specifically with sons of fathers who are alcoholics, that a questionnaire followed by an interview would be essential in providing an accurate interpretation that yields a more synthesized result. By establishing a possible imperfection in the present assessment and treatment for sons of fathers who are alcoholics, this researcher may be able to explore those individuals who will almost universally show some personality impairments and provide another assessment tool for long-term psychotherapy that may be indicated for their remediation.

CHAPTER THREE

Population and Sample

This study consisted of 54 subjects who were all students at least 21 years of age and attended San Jose State University at the time of assessment. A college population was chosen rather than a younger population to avoid the need for parental consent. Data were collected over a period of three semesters in order to obtain a reasonable sample size. Subjects were recruited from advertisements in the campus newspaper, by posting notices in the male dorms on campus, and receiving prior authorization from professors on campus to distribute a sign-up sheet in social science classes. The notice asked for volunteers to take part in a questionnaire and interview about alcoholism. The flyer included a confidentiality statement for this study (see appendix).

Instrumentation

In twelve single, 1-hour testing sessions, subjects were given a written informed consent statement and two questionnaires that assessed childhood history of alcoholism in their family. All subjects were requested to complete the Short Michigan Alcoholism Screening Test (SMAST) and the Children of Alcoholics Screening Test (CAST).

Method: Subjects completed the Shortened Michigan Alcoholism Screening Test (Sher & Descutner, 1986) which was used to divide the sample into sons of fathers of alcoholics (SOA), the target group, and sons of non-alcoholic fathers (SONA), the comparison group. Operationally, a father was defined as alcoholic if the subject's self-report score on the SMAST was 3 or higher (Selzer, Vinokur & van Rooijen, 1975). The highest possible SMAST score was 33. Of the sample ($n = 54$), 25 (46%) were placed in

the target group (alcoholic father). Twenty-nine (54%) were assigned to the comparison group (nonalcoholic father). Analyses were computed on the final total of 54 subjects.

Subjects also completed the Children Alcoholic Screening Test (CAST) which was used to determine if the subjects were from a family with alcoholism. This test was also used to divide the sample into children of alcoholics (COA), target group; and children of non-alcoholics (CONA), comparison group. Operationally, a subject was defined as a child of an alcoholic if he answered 6 or more questions as “yes” out of a possible thirty (Jones, 1982a, 1982b). The highest possible CAST score was 30. Of the sample ($n = 53$), 14 (26%) were placed in the target group (children of alcoholics). Thirty-nine (74%) were assigned to the comparison group (children of non-alcoholics). Analyses were computed on the final total of 53 subjects.

One of the subjects failed to complete the questionnaire in its entirety; therefore this subject's score was not computed in the final CAST analysis. The correlation coefficient between the SMAST and CAST was $r = .92$.

For the personal interviews, each respondent had taken both the SMAST and CAST test and were chosen for interviews based on their scores on the test. An assistant contacted the respondents by telephone with a standard greeting and stated the purpose of the research to solicit participation in the second part of this study.

The lab assistant scored the SMAST and the CAST questionnaires to determine those respondents who came from an alcoholic family and those who did not come from an alcoholic home. The lab assistant was instructed to separate, from the CAST questionnaire, ten respondents whose scores determined them to be a child of an

alcoholic family (COA), and ten respondents at random whose scores determined them to be a child from a non-alcoholic family (CONA). The lab assistant gave only the Face Sheets of the respondents' test package to the interviewer to do the interview. The interviewer did not know which ones were the COAs and which ones were the CONAs.

The format for the interview included several questions from the CAST. The most pertinent questions were #'s 1, 3, 5, 8, 10, and 12 (see table 6). These main questions were derived from the short form (CAST-6) which were found to be strongly correlated with the CAST-30 (Havey & Dodd, 1995). Each respondent answered nine questions. The nine questions were derived from the 30 CAST questionnaire. Where the CAST questionnaire questions asked for a true or false conclusion, the nine questions for the interview were each open-ended. Open-ended answers provided the basis for the gathering of data for grounded theory uses.

During the interview, each respondent was asked to read a consent form and then sign the consent form indicating that they understood that this interview would be taped and that confidentiality was of the utmost importance. Each respondent was informed that the tapes would be transcribed and analyzed by the interviewer only. This was an important step in gaining the confidence of the respondents from the beginning.

One of the first questions asked was whether the respondents had ever done a one-on-one interview prior to this study. Seventy percent of the respondents had never done a one-on-one interview for a study. Ten percent had done interviews for jobs. The remaining twenty percent did not give a reply.

To establish rapport, the interviewer first asked easy open-ended, short-answer questions about the respondent and his family. Because a Face Sheet was provided for each respondent, the questions basically were to create a relaxed atmosphere for the individual to be comfortable enough to open up to the more important questions.

Once the respondents answered questions about themselves, school, and then family, it led the interview into the first questions about their relationship with their father. All respondents were asked the same questions (see Table 6). As each question began to unfold and the respondents started opening up about their life and family, their stories became more than just a yes or no, or true or false answers.

During the course of the interviews, it became apparent after the first two questions which respondents came from a family with alcohol and which did not. From the standpoint of listening to the answers of the questions asked, each respondent had his own story and background. Layers and layers of their past unfolded.

Measures: Description of Instruments

The following instruments were used in the present study:

1. Shortened Michigan Alcoholism Screening Test (SMAST)
2. Children Alcohol Screening Test (CAST)
3. Grounded Theory

Shortened Michigan Alcoholism Screening Test

The Shortened Michigan Alcoholism Screening Test is a version of the 25-item Michigan Alcoholism Screening Test (Selzer et al., 1975). The SMAST's validity has been reported as valid (Hedlund & Vieweg, 1984). Because of time limitation, the shorter version of the MAST was chosen for the present study. Selzer et al. (1975)

acknowledged that when time and questionnaire space are limited, substituting the SMAST for the MAST is appropriate. Lastly, Connors and Tarbox (1985) reviewed the MAST and noted that it was applicable for use as a screening device among a college population. The present study used the SMAST with a college population, as have other researchers (Jarmes & Kazak, 1992; Sher & Descutner, 1986).

All MAST or SMAST items require a yes/no response and the measure can be completed in 5-10 minutes. For scoring purposes, Selzer (1971) assigned scores of 0, 2, or 5 points if answered in a significant direction. Three questions (3, 8 and 9) which were considered the most indicative of detecting alcoholism were give the greater weight of 5. Other questions (1, 2, 4, 5, 6, 7, and 10) were highly discriminative and given a weight of 2. The sum of all items determined one's alcoholism score with Selzer et al. (1975) operationally defining an individual as alcoholic when scoring 3 or above on the SMAST. The scoring system of the MAST is considered unsophisticated because it was developed on the basis of a visual analysis of response percentage distributions (Hedlund & Vieweg, 1984; Selzer, 1971) rather than on statistical item analysis, but it has been accepted and used consistently in the professional and scientific literature (Hedlund & Vieweg, 1984).

The cutoff score of 3 or more was used in the present study because it is the minimum MAST score attainable showing alcoholism among college-age subjects reporting on their fathers (Jarmes & Kazak, 1992) and was recommended by the original authors (Selzer et al., 1975). Selzer et al. suggested that a score of 0 or 1 on the SMAST

indicated non-alcoholics, a score of 2 indicated possible alcoholics, and a score of 3 or more points identified alcoholics.

Sher and Descutner (1986) recommended a cutoff of 5 in their research of inter-sibling agreement of paternal drinking. For their population, better levels of inter-sibling reliability were obtained with the cutoff of 5 or higher. Interclass correlation was used to estimate the inter-sib reliability and was found to be .85 ($p < .0001$). Yet the authors cautioned that as the cutting score moves toward the ceiling of the scale, the yield of positives rapidly decreases. Because Sher & Descutner used a different population and for the reasons cited above, participants in the present study were identified as ACA if they acquired a paternal SMAST score of 3 or higher, and were identified as non-ACA if their paternal SMAST score was 2 or less.

Several groups of researchers (Hedlund & Vieweg, 1984; Selzer et al., 1975; Zung & Charalampous, 1975) determined that the SMAST was as reliable and valid as the MAST. More detailed information on the test's psychometric aspects can be found in reviews by Jacobson (1976) and Hedlund & Vieweg (1984). For the purpose of the present study, the SMAST was used to operationally define the target population consisting of subjects with alcoholic fathers

The Children of Alcoholics Screening Test

The Children of Alcoholics Screening Test (CAST) was developed to aid in the identification of children of alcoholics (Jones, 1981a). This screening instrument can be used to psychometrically identify children who are living with, or have lived with, alcoholic parents. The CAST is a 30-item inventory that measures children's feelings,

attitudes, perceptions, and experiences related to their parents' drinking behavior. The test items are formulated from real-life experiences that were shared by clinically diagnosed children of alcoholics during group therapy and from published case studies (Jones 1981a, Jones 1982b).

The CAST measures children's: a) emotional distress associated with a parent's alcohol use/misuse (e.g., question #2: Have you ever lost sleep because of a parent's drinking?); b) perception of drinking-related marital discord between their (e.g., question #14: Did you ever fear that your parents would get divorced due to alcohol misuse?); c) attempts to control a parent's drinking (e.g., question #3: Did you ever encourage one of your parents to quit drinking?); d) efforts to escape from alcoholism (e.g., question #7: Has a parent ever yelled at or hit you or other family members when drinking?); f) tendencies to perceive their parents as being alcoholic (e.g., question #22: Did you ever think your father was an alcoholic?); and g) desire for help (e.g., question #26: Did you ever wish you could talk to someone who could understand and help the alcohol related problems in your family?) (Jones, 1982b).

The CAST can be used to identify latency-age, adolescent, and adult children of alcoholics. Children nine years of age or older can usually complete the CAST with little or no assistance. All "yes" answers are tabulated to yield a total score. The total score can range from zero (no experience with parental alcohol misuse) to 30 (multiple experiences with parental alcohol abuse).

The CAST has been reported to be both valid and reliable. The CAST was anonymously administered to 82 clinically diagnosed children of alcoholics, 15 self-

reported children of alcoholics, and 118 randomly selected control group children (latency-age and adolescent). The 82 (Jones, 1982a, 1982b) clinically diagnosed children of alcoholics lived in a home where at least one parent was diagnosed as alcoholic by a psychiatrist, a psychologist, and a certified alcoholism counselor. The 15 self-reported children of alcoholics stated that at least one of their parents received personal alcoholism counseling, either because of their own or their spouse's alcoholism.

It was found that all 30 CAST items significantly discriminated children of alcoholics from control group children. In addition, children of alcoholics scored significantly higher on the CAST compared to control group children.

Since the two children of alcoholics groups did not significantly differ in their total CAST scores, these two criterion groups were combined, thus forming an overall child of alcoholics group. The 97 children of alcoholics were scored 2, and 118 control group children were scored 1. These group scores were correlated with the total CAST scores and yielded a validity coefficient of .78 ($p \leq .0001$).

Finally, it was found that a cutoff score of six or more reliably identified 100 percent to the clinically diagnosed children of alcoholics and 100 percent of the self-reported children of alcoholics. This cutoff standard also showed that 23% of the control group children were "at risk."

In another study, the CAST was administered to 81 adults ranging in age from 18 to 37 years (Jones, 1981b). Five subjects in this sample anonymously reported that one or both of their parents received treatment for alcoholism. These five subjects scored significantly higher on the CAST ($M = 12.8$, $SD = 9.7$) compared to the other 76 subjects

($\underline{M} = 4.4$, $\underline{SD} = 7.2$) $\underline{T}(79) = 2.5$, $p < .01$). Hence the CAST also appears to be valid with grown-up children of alcoholics.

In addition, a Spearman-Brown split-half (odd vs. even) reliability coefficient equal to .98 was obtained in both studies (Jones, 1981a; Jones, 1981b; Jones, 1982b).

Additionally, one of the criteria to qualify is to answer yes to whether their biological father was a “moderate to heavy drinker.” A moderate to heavy drinker was defined as one who drank from four to fourteen drinks per week (Goodwin, 1976). A drink was defined as one 12 ounce beer, one 4 ounce glass of wine, or 1 ounce of spirits (Goodwin, 1976).

Grounded Theory

Glaser and Strauss developed grounded theory in the early 1960s during a field observational study of hospital staff's handling of dying patients (Glaser & Strauss, 1967). Their approach to the qualitative analysis of data was termed grounded theory “because of its emphasis on the generation of theory and the data in which that theory is grounded” (Glaser, 1976, p.22).

Glaser and Strauss (1967) had been concerned with linking theory and research.

Strauss defined grounded theory as:

A detailed grounding by systematically and intensively “analyzing data, often sentence by sentence, or phrase by phrase of the field note, interview, or other document; by ‘constant comparison,’ data are extensively collected and coded,” thus producing a well constructed theory. The focus of analysis is not merely on collecting or ordering “a mass of data, but on organizing many ideas that have emerged from analysis of the data” (Strauss, 1987, p. 22-23).

Glaser and Strauss approach, called “grounded theory,” depends on participant observation (see Schatzman & Strauss, 1973) and a method of comparative analysis aimed at constructing theories inductively. Their “constant comparative method” of analysis involves four stages: 1) comparing the data applicable to each conceptual category; 2) integrating the categories and their properties; 3) delimiting the emergent theory, and; 4) writing up the theory (Glaser & Strauss, 1967).

“Grounded theory is based on a *concept-indicator* model, which directs the conceptual coding of a set of *empirical indicators*. The latter are actual data, such as behavioral actions and events, observed or described in the words of interviewees” (Strauss, 1987, p. 25).

There are four steps toward developing grounded theory. The first step requires the analyst to code each piece of data in terms of as many analytic/conceptual categories as applicable. These categories derive from the problems or questions of study as well as ideas emergent from participant observation. The coding process involves reviewing the data word by word, line by line, to produce impressions of the data with a goal of raising the data to a “higher conceptual level” (Orona 1990, p. 1249). During the coding phase, Berg (1995) outlined seven major elements with which to examine or code the data. Two of these elements, the “word” and the “theme” were used in this study. According to Berg:

The word is the smallest element or unit and generally results in a frequency distribution. The theme is a simple sentence, a string sentence, a sting of words with a respondent and a predicate (1995, p. 181).

Integrating the conceptual categories and the properties of those categories is the second step. As the analyst compares pieces of data with possible conceptual categories, attention tends to shift from a focus on the evidence and categories to consideration of the properties of the categories, as well as comparison of categories. Written memos are used to find patterns among the coded data. Orona stated that memos are used to document the beginnings of conceptualizing the data that emerge and thus provide a means of “tracking its levels from the raw data” (Orona 1990, p. 1250).

The next step is defining and specifying the emergent theory. As the analyst works through coding and comparing and identifies the properties of concepts as well as the linkages among them, a basic interpretative framework or theory emerges as a more or less integrated whole. From the memos, the researcher looks for “themes” to emerge. At this point the researcher often returns to the raw data, to the coded data and to the memos. This is the analysis phase. The themes that survived the scrutiny of all three levels rise to become the explanation or theory grounded in the data.

Writing up the theory completes the fourth and final step. By this point the analyst will have a body of coded data, and analytic descriptions of the concepts, properties, and relationships among them. Statement of the constructed theory involves collating, describing, and summarizing these materials as an answer to the study problem or problems (as modified throughout the research) (Jorgensen, 1989).

In this study, two methods were applied to the same subjects to test whether the two methods yield comparable results. This would include, without prior knowledge which one is “best” or more valid. High correlation among their results are often

interpreted as indicating that they assess the same underlying phenomena. This research design provides the basis for what has become known as multiple operationalism (Webb, Campbell, & Schwartz, 1966). It demands that research results be consistent across different methods, all of which purport to be sensitive to the same phenomena. It thereby aims at preventing findings that may be an artifact of a single method and possibly unrelated to other research results.

For this experiment, subjects were taped during their interview so the content could be analyzed. This provided a measure to record data in a durable medium.

Procedure

Informed consent letters were distributed. Signed copies were collected before instructions and testing materials were given out. Included in the consent letter was a notice informing subjects of the general nature of the study, whom to contact if counseling services were needed, and the author's name, address, and phone number of the University Social Science department.

For data collection purposes and the anonymity required during testing, all surveys were numbered so no identifying personal data would appear anywhere. Packets were distributed and the following instructions were given before starting: a) "No names or identifiers are to be written on these surveys. Numbers in the upper right hand corners are for data purposes only, so that packets can be put back together if clips or staples come apart;" b) "No writing is to be done on the booklets other than the answers to the questions." During the course of administering the quantitative testing, it was explained to subjects that the SMAST was a shortened 10-item version of the Michigan Alcoholism

Screening Test (MAST). It was also explained that the SMAST was devised by Dr. Selzer in 1971 to provide a consistent, quantifiable, structured interview instrument (Selzer, 1971). [Selzer validated the MAST by comparing the test responses of institutionalized and non-institutionalized alcoholics and non-alcoholics with corresponding records of the subjects' problems due to alcohol obtained from hospitals and social-service and enforcement agencies (Zung, & Charalampous, 1975)]. In 1975, Selzer shortened the MAST from 25 questions to 13 to 10 and verified the reliability of this shortened version and called it SMAST (Selzer et al, 1975). The final instruction was: "Please leave the packets face-down when leaving the room out of one door only."

After completion of the SMAST, the subjects completed a second test, the Children of Alcoholic Screening Test (CAST) (Jones, 1981a). This test was given to help the subjects recognize and identify what is or was going on in their home. It measures feelings, attitudes, perceptions, and experiences related to their parent's drinking behavior (Wilson & Blocher, 1990).

Prior to the completion of both the SMAST and the CAST, each subject completed a Face Sheet which included dates and times of availability in the event they were chosen to do the interview portion of this study.

The interview place and time was scheduled between 3 and 5 days after the completion of the SMAST and CAST. A lab assistant scored the SMAST and the CAST to determine those subjects who came from an alcoholic family and from those who did not come from an alcoholic home. The lab assistant was instructed to separate, from the CAST questionnaire, ten subjects whose scores determined they were a child of an

alcoholic family (COA) and ten subjects whose scores determined they were a child from a non-alcoholic family (CONA). From the subjects test package, the lab assistant was to give the Face sheets only to the interviewer to do the interview. The interviewer did not know which ones were the COAs and which ones were CONAs.

Notice informing subjects of the general nature of the study, whom to contact if counseling services were needed, and the author's name address and phone number of the University Social Science department, was handed to each student as he left the interview room (see Appendix F).

CHAPTER FOUR

Results: Analysis of Questionnaire Data

This study's hypothesis stated that though clinical studies using questionnaires have concluded that not all ACOAs are affected by the alcoholic environment, this methodological approach alone may be insufficient and may not accurately provide the researcher reliable outcome data. A questionnaire may not unequivocally provide accurate and reliable responses from individual respondents. Therefore, a follow up study to prove the congruence or incongruence of their responses may be needed. As Table 3 illustrates, there were significant intercorrelations between the SMAST scores and the CAST scores of the questionnaires indicating that these measures were highly related in the efforts to identify children of alcoholics.

Subjects completed the Shortened Michigan Alcoholism Screening Test (SMAST; Sher & Descutner, 1986) and were divided into sons of fathers of alcoholics (SOA), the target group and sons of non-alcoholics (SONA), the comparison group. A father was defined as alcoholic if the subject's self-report score on the SMAST was 3 or higher (Selzer et al., 1975). The highest possible SMAST score was 33. Of the sample ($n=54$), twenty-five (46%) were placed in the target group (alcoholic father). Twenty-nine (54%) were assigned to the comparison group (nonalcoholic father). Analyses were computed on the final total of 54 subjects.

Subjects also completed the Children Alcoholic Screening Test (CAST) which was used to determine if the subjects were from a family with alcoholism. This test was

also used to divide the sample into children of alcoholics (COA), the target group and children of non-alcoholics (CONA), the comparison group. Operationally, a subject was defined as a child of an alcoholic if he answered 6 or more questions as yes out of a possible thirty (Jones, 1982a, 1982b). The highest possible CAST score was 30. Of the sample ($n = 53$), 14 (26%) were placed in the target group (children of alcoholics). Thirty-nine (74%) were assigned to the comparison group (children of non-alcoholics). Analyses were computed on the final total of 53 subjects. One of the subjects failed to complete the questionnaire in its entirety, therefore this subject's score was not computed in the final analysis.

Results: Analysis of Personal Interview Data

During the interview portion of the study, twenty (20) subjects were selected to participate. Out of the twenty subjects, fifteen (15) completed the interview questions. The five subjects who could not complete the study were dismissed due to illness, extra curricular studies, or personal situations beyond their control. Due to time constraints and the scope of the study, it was therefore concluded that the study would rest on the fifteen subjects interviewed.

In order for themes to emerge from the interview, each question was marked on each transcribed interview. This was done to separate the questions one through nine, thus providing an avenue to easily analyze each question.

Next, open-coding was undertaken. This is unrestricted coding of the data to scrutinize the interview very closely, line by line. The aim was to produce concepts to reflect the data and to open up the inquiry. Because the transcribed interview was

formatted in a way which permitted about three inches of space on the right side of the paper, notes, words, phrases were written in each section which gave rise to core category or categories. This was done for each question for each interview.

From the fifteen interviews, a variety of responses with a wide range of answers were given. For example, to question number one: "Could you please tell me about your relationship with your father? Or significant other?" Responses ranged from: "distant, working excessively, scared, abusive, communicated difficulty, depressive, not the best, to loved each other, we were close and tight." The response to 'working excessively' also meant the father was away quite often. They were distant so a lack of communication made it difficult to talk to one another. Those who responded to being scared or abusive of their father also indicated this brought about a difficulty in communicating with them. "Loved one another, close and tight" responses came from those respondents whose father, though they worked hard, found time to be with them.

To question number two "How would you describe your relationship with your father and his drinking style?" Responses included: "drinks medically, no big deal, doesn't drink, drinks occasionally at parties and special events, and little drinking to professional drinker, uncomfortable, afraid, embarrassed, drug and alcohol addict, and denial." Respondents whose fathers did little or no drinking, were the same respondents who had close, tight relationships with their father. In fact, two went on to say they loved each other. Respondents who knew their father drank excessively and combined alcohol use with drugs, also embarrassed them, were afraid to be around them to the point of one respondent not even acknowledging his father in front of his friends.

More words and themes emerged to separate those sons who came from an alcoholic father and the sons who came from a non-alcoholic father. For example, responses like “other families are normal,” “hide,” “don’t talk,” “afraid,” “ashamed,” “stay away,” “went away,” came from respondents whose father drank alcohol. Responses like “parents stayed married,” “no problem,” “no issue,” “never saw him with a drink,” “father at games,” were from respondents who had little or no alcohol in their household.

The analysis from the coding of these interviews yielded two distinct clusters: the first cluster included dark, heavy emotions like scared, afraid, ashamed, distant, fear, denial, staying away (could be physically or emotionally) and learning to take care of one’s self. The second cluster included a softer, gentler type of feeling like love, caring for one another, close, no big deal, no problem, no issue, learned to drive a car, and being taught to help others.

Based on the data, the use and non-use of alcohol in the home was the most distinctive variable. Two major themes emerged from the groups: one theme focused on fears, the second focused on relationships. The following discussion describes these two themes.

Theme # 1 – Fear

Fear emerged in a multitude of ways. Fear was disguised in words like distress, scared, apprehension, pain, worry, sorrow, dread, anxiety, uneasiness, concern, and trouble from the respondents while discussing their home life. Fear was a daily part of

their lives. It shaped the way they started their day and ended their night. As spoken by Roy, a 34-year-old housing developer and college student describing his youth:

If he was not drinking he was upset because he was not drinking. And just the abuse we had to go through with him. I remember most of the time being a kid being scared because dad was coming home. And he was going to hit my mom or he was going to hit anyone of us children and that's not a nice feeling you know when you have to live in something like that every day.

James, a 24-year-old physical therapy student, also described his relationship with his father as a fearful one:

He wasn't really affectionate with us kids, so we had a very distant relationship. He wasn't really like a dad to me, I mean he was my dad, but it was based on, like fear alone, and my mom was the one who went to all my sports and helped me (emphasis added).

James went on to say:

He told me he was going to kill me a couple of times. So it wasn't a great relationship, but once that happened it kind of severed the ties.

Although fear shaped the child during the early years, several respondents found inner strength as they reached adulthood, in fact James, for example, went on to say after he severed ties with his father:

At about 16 I started to feel and became my own person. I kind of said to him one day, I was like 'You know you can say anything you want to me to cut me down, but its not going to hurt, its not going to bother me anymore because I've had enough', I'd taken enough at that point.

Strength in children from non-alcoholic fathers surfaced from another direction. Several had similar responses as Don:

I never saw any negative things. I never saw where he was out of control or where I was scared, or anything, so there was never any reaction to it.

Because alcohol was not present in their own family, it was easier to distinguish it among their friends and their friend's family. "Steven" summed it up well when he said,

A big difference in from my friend, I particularly remember, was whenever his father was drunk, I could see the fear in my friend's face, like he was afraid to do anything. Most of the time he tried to avoid to being at home. He would always come to our house just to stay away from his dad.

A bond developed between the mother and siblings, in fact this became the second theme: relationships.

Theme #2 – Relationships

Although fear was pervasive, some found coping skills to deal with that fear in the bonds which were formed between the respondents and their mothers and siblings.

Several, for example, incorporated the approaches that "Roy" did:

I think one of the skills that I know that I have is that I can be a good listener. Because of that same reason, I guess being so close to my mom and being at home most of the time, I became the 'counselor' with the family, you could say that. Not professionally, but people would come up to me and ask me well what do you think I should do here by my brothers. Umm, in a way it was something I never asked for and I never wanted and without even thinking, it just happened. Even now days you know, they call me to, or I remember, again not having a father while you were there, you need to replace it with something and I guess I was there and it was easy for me to take over some of those roles.

Whether there was the use of alcohol in the family or if the father worked excessively and was not present due to long hours away from home, the mother took on the role of the absent parent. The mother became the individual that kept the family together economically, emotionally and physically. Comments ranged from taking care of the children emotionally, as in the case of Dennis:

My mother was a typical Southern Mediterranean mother who was totally over bearing, but she showered me with love and care and made sure I never worried about anything and took real good care of us, especially after the divorce.

Roy who saw his mother as someone who encouraged them through the actions their mother showed:

All I can tell you is that she has been probably the inspiration to us all.

Due to an absent parent, Donald saw his mother take on both the mother and the father as a dual parent:

We could talk to her really easily about anything. So, whenever we have anything that we need, we turn to her. We never ask our father pretty much about anything. She's always there for us and she's kind of our mother and father at the same time.

From his mother's perspective, John learned the values of a male figure through the eyes of his mother:

I learned a lot of things from my Mom about caring for people and being honest. All the qualities that I learned to become a man or become a better person I learned from my mom.

Responses like these were common whether alcohol was present or not. Mothers take over the responsibilities of the partner who is not present, making allowances, forgiving unforgiving behavior, and continuing to try to be loving and caring in the face of abuse. Parents close their eyes to suspicious behavior to meet their own needs. The question of an enabling mother arises as the responsible parent protective of her children.

In fact “James” saw his mother protect the family from physical and emotional harm when he said:

We were always protected by our mother because she took a lot more physical and emotional abuse than we did.

Mike’s mother was saying everything was all right and that there was no problem in the home, but hiding the fact something abusive was happening in his parents’ marriage:

When they were living together it was kind of a hush hush thing. I really didn’t know what was going on or didn’t understand it, so I never consoled her even though she was usually unhappy.

CHAPTER FIVE

Discussion

The general findings of the present study did support the hypothesis that using questionnaires concluded that not all ACOAs were affected by the alcoholic environment. This methodological approach alone appeared to be insufficient and did not accurately provide reliable outcome data. A follow-up interview was undertaken after the questionnaire to determine the congruence, or incongruence, of their responses.

During the interview, four of the subjects' answers to question number two indicated that their father either did not drink or saw their father drink two or less times during their childhood. They were correctly classified as sons of non-alcoholic fathers from the SMAST and children of non-alcoholics from the CAST. Four of the subjects' answers to question number two indicated their father had repeated drinking habits. They were correctly classified as sons of alcoholic fathers from the SMAST and children of alcoholics from the CAST. Four of the subjects' answers to question number two indicated they had not seen their father drink, however, scored high on the SMAST indicating they were sons of alcoholic fathers, yet scored low on the CAST indicating they were children of non-alcoholics. Two of the subjects' answers to question number two indicated they had seen their father drink two or less times in their childhood. They were correctly classified as sons of non-alcoholic fathers from the SMAST, however scored high on the CAST indicating they were children of alcoholics. One of the subjects' answers to question number two indicated his father had repeated use of alcohol

use, yet scored low on the SMAST indicating a son of a non-alcoholic father, but scored high on the CAST indicating a child of an alcoholic family.

As Table 3 illustrates, there were significant inter-correlations between the SMAST scores and the CAST scores. Of the 53 total subjects, 14 had scores on the SMAST that classified them as sons of alcoholics (SOA), but classified them as children of non-alcoholics (CONA) on the CAST. Also, 7 subjects on the SMAST that classified them as sons of non-alcoholics (SONA) but classified them as children of alcoholics (COA) in the CAST. A total of 21 or 39.6% of the subjects who took both questionnaires indicated different classifications.

The choice to use the SMAST and the CAST simultaneously as a questionnaire instrument was due in part to the fact that each represented a true validity of determining whether a subject was the son of an alcoholic, as in the case of the SMAST, or children of an alcoholic family, as in the case of the CAST.

There could be several reasons to conclude that subjects responded differently to the two questionnaires and then to the interview. Schnuckit (1987) reported that his failure to demonstrate significant differences between well-functioning sons of alcoholic and well-functioning sons of non-alcoholics might have resulted from over-sampling the opposite or least psychopathological, end of the continuum. Therefore, the inconsistent findings in this research of children of alcoholics and children of non-alcoholics may be the result of sample selection differences, as well as sample size.

The SMAST tested for sons whose father was an alcoholic. It did not test sons who came from an alcoholic family. Therefore, the test did not include whether a

mother, sibling, or significant other had a problem with drinking alcohol. The CAST on the other hand tested for children of an alcoholic family. It could be concluded that one of the reasons for the difference in scores between those sons, who did not test high in the SMAST, but did score high in the CAST, was that the CAST included everyone in the family where the SMAST asked only for the father.

Ackerman and Gondolf (1991) indicated in their paper that there is no substantial validation of the ACOA self-identification. They say that some non-ACOA's with high scores, particularly in the student sample, could be ACOA's "in denial" or minimizing parental alcohol problems, or they could be children from dysfunctional families without alcohol problems. From the interview, several subjects seem to minimize the number of drinks their parents drank or how often they drank. Several made light of the fact that "he would come home and have one or two glasses of wine each night, but he never got drunk."

Also noticeable was the definition of alcohol. In more than one occasion during the interview, alcohol was understood to mean hard liquor like vodka, tequila, scotch, and whiskey. Beer and wine were regarded as low level, non-addicting types of alcohol. One such comment that was repeated several times was "He only had a couple of beers" or "He only drank one or two glasses of wine." One of the subjects whose score on the SMAST indicated a son of a non-alcoholic father, but whose score on the CAST indicated he was a child of an alcoholic, responded that his father was an "intelligent drinker." Over the course of the interview it could be determined that his father had a drinking problem due to the fact that he was a manic-depressive. It should be noted that

while answering questions specifically targeted toward a specific gender in the family structure, there could be a sense of protection, to protect the family name, to protect the family from embarrassment, or to protect one's self from acknowledging that a problem existed. Hibbard (1987) indicated in his studies that most ACOAs hold a deep and abiding sense of shame, embedded in the self and in object representations, at various developmental levels. Woititz (1983) in her book reported that identification of children from alcoholic families have been difficult for several reasons, including embarrassment, ignorance of alcoholism as a disease, denial, and protection of children from unpleasant realities.

As reviewed in Kashubeck & Christensen (1992), research on the effects of parental alcoholism on persons had rapidly expanded in the past decade. Some of this research had shown that adult children of alcoholics (ACOAs) are more prone to psychological and physical distress and emotional problems than are adult children of non-alcoholics (non-ACOAs). On the other hand, several investigations have reported results indicating non-significant differences between ACOAs and non-ACOAs with regard to personality characteristics or psychological distress.

Kashubeck and Christensen go on to say that some of the conflicting findings may be attributable to sample-selection issues. For example, many of the existing studies reporting significant differences between ACOAs and non-ACOAs (e.g., Black et al., 1986; Lease, 1990; Sheridan, 1988) have used ACOA subjects who: a) were undergoing some form of treatment; b) were in an ACA group; c) were in Al-Anon, or; d) had a parent who was in treatment for alcoholism (Nardi, 1981; West & Prinz, 1987).

On the other hand, many of the studies reporting no differences between ACOAs and non-ACOAs were conducted with college students, who may also represent a skewed sample (e.g., Berkowitz & Perkins, 1988; Churchill, Brodia, & Nicholson, 1990; Duprez, 1987; Lundberg 1989).

This study utilized the college student population, of which most of the subjects were taking a psychology class needing a certain number of points in research testing for their grade. Perhaps other types of subjects might have shown a more consistent testing result, especially between the SMAST and CAST correlation. It is also conceivable that other factors (i.e., alcoholic mother, both parents as alcoholic, adaptive behaviors within the family, minimization of the problem) which are not addressed in the present paper could account for the non-significant results of this paper (Black, 1981).

Blume stated “there is another factor that is likely to distort the results of any research but is generally overlooked or minimized: the techniques that children of alcoholics’ survivors use to survive their family dysfunction. These include denial, repression, blocking out a period of childhood or a person or place, and blocking out the more painful aspects of the abuses” (1990, p. 27). She proceeded to suggest that self-blame might result in a survivor’s not acknowledging their victimization.

Another question to be asked is how easily and accurately can one self-report on the impact of a trauma, especially if the trauma occurred many years before. Future research should more carefully define children or sons of alcoholics and children or sons of non-alcoholics and separate out variables, which could impact the dysfunction (i.e., alcoholism, family violence, mental illness, etc.).

As a final assessment of the present study, it is important to note that several methodological concerns limit its scope. First, the results are based on 54 subjects, all male, all over the age of 21 testing whether they were sons of alcoholics or sons of non-alcoholics. This small sample size may limit the finding of the SMAST and CAST results.

Generalization from the present study can be limited because of small sample size, use of a four-year college population, and the fact that the subjects were acquired from a limited geographical area. While the present study used four-year college students, two of the prominent researchers referenced in this study (Jarmes & Kazak, 1992) used Temple University students. The advantage of using university students could include working with a population, which is less sophisticated educationally and in research (i.e., naïve subjects who have minimal knowledge of experimental analyses). Future research could utilize a combination of subjects (i.e., diverse age groups with varying educational levels) to obtain a broader cross-section of subjects for study.

One possible disadvantage to the present study was that all results were founded upon self-report and retrospective measures. There is an inherent problem in asking adults to remember and report on childhood experiences because of time lapsed, colored perceptions as time passes, and difficulty in attempting to establish causality among the reported variables (Benson & Heller, 1987). However, since there are few other ways in which to collect this type of data, subjective self-reports appear to be an accepted method. Others have utilized this method with an alcoholic population and report quite accurate results (Sobell & Sobell, 1978).

What appeared to be a very important observation in the present study were the ages of the subject population. The differences between the oldest age to be reported on in the questionnaires (age 21) and the average present age of the subjects (25 years old) was only four years. Many men may either still be living at home or have recently left to further their adult lives. It is possible that many of the men have not addressed family environmental issues that were pertinent to their childhood because of the necessity to remain embroiled within their family's dynamics (Black, 1981; Blume, 1990). As a result, it is possible that significant differences could have been found in the present study on some or all of the measures, had an older, less naïve population been utilized. In addition, inconsistencies may be attributed to personal dynamics between the interviewer and respondents, and that the two methods tap into different elements of a subject's experience.

Future research could refine the theoretical foundation and the methodological aspects to be assessed when researching the adult children of alcoholics population.

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Table 1**The Brief MAST: A Shortened Version of the Michigan Alcoholism Screening Test Results.**

Subjects	Questions #1-10										Score	SOA/SONA
	1	2	3	4	5	6	7	8	9	10		
DH001	N	N	N	Y	N	Y	N	N	N	N	8	SOA
002	Y	Y	N	N	N	N	N	N	N	N	0	SONA
003	N	N	N	N	N	N	N	N	N	N	4	SOA
004	N	N	N	N	N	N	N	N	N	N	4	SOA
005	N	N	N	N	N	N	N	N	N	N	4	SOA
006	Y	Y	N	N	N	N	N	N	N	N	0	SONA
007	N	N	N	N	N	N	N	N	N	N	4	SOA
008	N	N	Y	Y	Y	Y	Y	N	N	N	17	SOA
009	Y	Y	N	N	N	N	N	N	N	N	0	SONA
010	--	--	--	--	--	--	--	--	--	--	N/A	N/A
011	Y	Y	N	N	N	N	N	N	N	N	0	SONA
012	--	--	--	--	--	--	--	--	--	--	N/A	N/A
013	Y	Y	N	N	N	N	N	N	N	N	0	SONA
014	Y	Y	N	N	N	N	N	N	N	N	0	SONA
015	Y	Y	N	N	N	N	N	N	N	N	0	SONA
016	Y	Y	N	N	N	N	N	N	N	N	0	SONA
017	Y	Y	N	N	N	N	N	N	N	N	0	SONA
018	N	N	N	N	N	N	N	N	N	N	4	SOA
019	N	N	N	N	N	N	N	N	N	N	4	SOA
020	N	N	N	N	N	N	N	N	N	N	4	SOA
021	Y	Y	N	N	N	N	N	N	N	N	0	SONA
022	Y	Y	N	N	N	N	N	N	N	N	0	SONA
023	Y	Y	N	N	N	N	N	N	N	N	0	SONA
024	N	N	N	N	N	N	N	N	N	N	4	SOA
025	Y	Y	N	N	N	N	N	N	N	N	0	SONA
026	N	N	N	N	N	N	N	Y	N	N	9	SOA
027	N	N	Y	Y	Y	Y	Y	Y	Y	N	27	SOA
028	Y	Y	N	N	N	N	N	N	N	N	0	SONA
029	Y	Y	N	N	N	N	N	N	N	N	0	SONA
030	N	N	N	N	Y	N	N	N	N	N	6	SOA
031	Y	Y	N	N	N	N	N	N	N	N	0	SONA
032	Y	Y	N	N	N	N	N	N	N	N	0	SONA
033	N	N	N	Y	Y	N	N	N	N	N	8	SOA
034	N	N	N	N	N	N	N	Y	N	N	9	SOA

Table 1 - Continued

The Brief MAST: A Shortened Version of the Michigan Alcoholism Screening Test Results.

Subjects	Questions #1-10										Score	SOA/SONA
	1	2	3	4	5	6	7	8	9	10		
035	N	N	N	N	N	N	N	N	N	N	4	SOA
036	N	N	N	N	N	N	N	N	N	N	4	SOA
037	Y	Y	N	N	N	N	N	N	N	N	0	SONA
038	Y	Y	Y	N	N	N	N	Y	N	Y	12	SOA
039	Y	Y	N	N	N	N	N	N	N	Y	2	SONA
040	Y	Y	N	N	N	N	N	N	N	N	0	SONA
041	Y	Y	N	N	N	Y	Y	N	N	N	4	SOA
042	N	N	N	N	N	N	N	N	N	N	4	SOA
043	Y	Y	N	N	N	N	N	N	N	N	0	SONA
044	Y	Y	N	N	N	N	N	N	N	N	0	SONA
045	Y	Y	N	N	N	N	N	N	N	N	0	SONA
046	Y	Y	N	N	N	N	N	N	N	N	0	SONA
047	N	N	N	Y	N	N	N	N	N	N	6	SOA
048	Y	Y	N	N	N	N	N	N	N	N	0	SONA
049	N	N	N	N	N	Y	N	Y	Y	N	16	SOA
050	N	N	Y	Y	Y	Y	Y	Y	Y	N	27	SOA
051	Y	Y	N	N	N	N	N	N	N	N	0	SONA
052	--	--	--	--	--	--	--	--	--	--	N/A	N/A
053	N	N	N	N	N	N	N	N	N	N	4	SOA
054	Y	Y	N	N	N	N	N	N	N	N	0	SONA
055	--	--	--	--	--	--	--	--	--	--	N/A	N/A
056	Y	Y	N	N	N	N	Y	N	N	N	2	SONA
057	--	--	--	--	--	--	--	--	--	--	N/A	N/A
058	--	--	--	--	--	--	--	--	--	--	N/A	N/A
059	--	--	--	--	--	--	--	--	--	--	N/A	N/A
060	--	--	--	--	--	--	--	--	--	--	N/A	N/A
061	--	--	--	--	--	--	--	--	--	--	N/A	N/A
062	--	--	--	--	--	--	--	--	--	--	N/A	N/A
063	--	--	--	--	--	--	--	--	--	--	N/A	N/A
064	--	--	--	--	--	--	--	--	--	--	N/A	N/A
065	N	N	N	N	N	N	N	N	N	N	4	SOA

Note. n = 54 ; SONA = 29; SOA = 25

Table 2

Subject(s)	Questions #1-30																													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
D1001	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
002	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
003	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
004	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
005	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
006	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
007	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
008	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
009	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
010	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
011	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
012	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
013	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
014	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
015	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
016	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
017	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
018	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
019	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
020	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
021	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
022	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
023	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
024	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
025	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
026	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
027	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
028	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
029	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
030	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
031	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
032	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
033	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
034	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
035	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
036	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
037	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
038	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
039	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

The CAST: Children of Alcoholics Screening Test

Results.

Results.

Table 2 – Continued

[illegible]

Note. $\underline{n} = 52$; $\underline{\text{CONA}} = 38$; $\underline{\text{COA}} = 14$

		CAST Questions #1-30																													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Totals																															
Yes		13	11	11	13	10	3	9	15	7	9	6	16	6	9	4	10	2	5	14	26	2	10	15	6	2	10	3	10	9	8
No		39	41	41	39	42	49	43	37	45	43	46	36	46	43	48	42	50	47	38	16	50	42	37	46	50	42	49	42	43	44

Table 2 – Continued

CAST: Children of Alcoholics Screening Test Results:

Subject(s)	Yes	No	CONA/ COA
DH001	---	---	N/A
002	0	30	CONA
003	0	30	CONA
004	0	30	CONA
005	0	30	CONA
006	0	30	CONA
007	16	14	COA
008	27	3	COA
009	0	30	CONA
010	---	---	N/A
011	0	30	CONA
012	---	---	N/A
013	4	26	CONA
014	0	30	CONA
015	3	27	CONA
016	0	30	CONA
017	2	28	CONA
018	0	30	CONA
019	11	19	COA
020	0	30	CONA
021	2	28	CONA
022	0	30	CONA
023	6	24	COA
024	0	30	CONA
025	0	30	CONA
026	0	30	CONA
027	20	10	COA
028	0	30	CONA
029	15	15	COA
030	4	26	CONA
031	11	19	COA
032	1	29	CONA
033	16	14	COA

Subject(s)	Yes	No	CONA/ COA
034	18	12	COA
035	0	30	CONA
036	9	21	COA
037	0	30	CONA
038	3	27	CONA
039	6	24	COA
040	0	30	CONA
041	23	7	COA
042	0	30	CONA
043	6	24	COA
044	3	27	CONA
045	3	27	CONA
046	2	28	CONA
047	2	28	CONA
048	17	13	COA
049	15	15	COA
050	16	14	COA
051	0	30	CONA
052	---	---	N/A
053	3	27	CONA
054	4	26	CONA
055	---	---	N/A
056	11	19	COA
057	---	---	N/A
058	---	---	N/A
059	---	---	N/A
060	---	---	N/A
061	---	---	N/A
062	---	---	N/A
063	---	---	N/A
064	---	---	N/A
065	1	29	CONA

Table 3

Correlations of Short Michigan Alcoholism Screening Test (SMAST), Children of Alcoholics Screening Test (CAST), and the Interview.

Subject(s)	SMAST SCORES		CAST SCORES		INTERVIEW QUESTIONS
	SONA <4	SOA >5	CONA <5 Yes	COA >6 Yes	Yes = SOA
DH002	0		0		NO
DH008		17		27	YES
DH009	0		0		NO
DH011	0		0		NO
DH023	0			6	NO
DH026		9	0		NO
DH027		27		20	YES
DH029	0			15	YES
DH030		6	4		YES
DH031	0			11	YES
DH032	0		1		NO
DH038		12	3		YES
DH047		6	2		NO
DH049		16		15	YES
DH050		27		16	YES

Note: n = 15

SONA = son of non-alcoholic

SOA = son of alcoholic

CONA = children of non-alcoholic

COA = children of alcoholic

Table 4**The Brief MAST**

The brief versions of the MAST incorporates a simple method of scoring.

The numerical values are adjacent to the yes and no answers.

QUESTIONS		Circle Correct Answers	
1.	Do you feel your father's a normal drinker?	Yes(0)	No(2)
2.	Do friends or relatives think he is a normal drinker?	Yes(0)	No(2)
3.	Has your father ever attended a meeting of Alcoholics Anonymous (AA)?	Yes(5)	No(0)
4.	Has your father ever lost friends or relatives because of his drinking?	Yes(2)	No(0)
5.	Has your father ever gotten in trouble at work because of his drinking?	Yes(2)	No(0)
6.	Has your father ever neglected his obligations, his family or his work for two or more days in a row because of his drinking?	Yes(2)	No(0)
7.	Has your father ever had delirium tremens (Dts), severe shaking, heard voices or seen things that weren't there after heavy drinking?	Yes(2)	No(0)
8.	Has your father ever gone to anyone for help about his drinking?	Yes(5)	No(0)
9.	Has your father ever been in a hospital because of drinking?	Yes(5)	No(0)
10.	Has your father ever been arrested for drunk driving or driving after drinking?	Yes(2)	No(0)

Table 5**Analysis of Findings****SMAST Findings:**

Total subjects tested: 53

Subjects who tested Sons of Alcoholics: (SOA) 25

Subjects who tested Sons of Non-Alcoholics: (SONA) 28

CAST Findings:

Total subjects tested: 53

Subjects who tested Childres of Alcoholics: (COA) 18

Subjects who tested Children of Non-Alcohol (CONA) 35

Table 6

Questions for interview in correlations to the Children's Alcohol Screening Test (CAST)

CAST Questions	Interview Questions
1	Could you please tell me about your relationship with your Father? (Or significant individual)
8	How would you describe your relationship with your father and his drinking style?
12	Could you describe your relationship with your mother? Your siblings?
10	Could you describe to me the similarities and differences in your household versus you're friend's household while your where growing up?
3	As a child, how would you react to your father's drinking?
5	How would your siblings deal with the use of alcohol by your father or mother?
	Could you describe ways in which you dealt with the use of alcohol by your father in your household while you were growing up?
	What where some of the ways you protected yourself or your family members from the use of alcohol?
	Could you describe any skills you learned as child that you use today?

Code #:
Date:
Researcher:

APPENDIX A

FACE SHEET

Name:

Address: _____ Phone:

AGE: _____ Sex:

San Jose State Student (Yes) ____ (No) __

Do you think of yourself as belonging to any ethnic or national group?
(Yes) ____ (No) ____ (If Yes, which)

(Caucasian, African American, Mexican American, Asian, Other)

Is your father your biological father or other?

Does your father drink? (Yes) ____ (No) __

Is your father a moderate to heavy drinker? (4 to 14 drinks per week, where one drink = one 12 oz beer, 4 oz wine, or 1 oz of spirits) (Yes) ____ (No) __

Code #:
 Date:
 Researcher:

APPENDIX B

QUESTIONNAIRE ABOUT DRINKING PROBLEMS: The SMAST

Directions: If a statement says something true about your father, put a check () in the nearby space under YES. If a statement says something not true about your father, put a check in the nearby space under NO. Please answer all the questions.

	<u>YES</u>	<u>NO</u>
1. Do you feel your father is a normal drinker?	_____	_____
2. Do friends or relatives think he is a normal drinker?	_____	_____
3. Has your father ever attended a meeting of Alcoholics Anonymous (AA)?	_____	_____
4. Has your father ever lost friends or relatives? because of his drinking?	_____	_____
5. Has your father ever gotten in trouble at work because of his drinking?	_____	_____
6. Has your father ever neglected his obligations, his family or his work for two or more days in a row because of his drinking?	_____	_____
7. Has your father ever had delirium tremens (DTs), severe shaking, heard voices or seen things that weren't there after heavy drinking?	_____	_____
8. Has your father ever gone to anyone for help about his drinking?	_____	_____
9. Has your father ever been in a hospital because of drinking?	_____	_____
10. Has your father ever been arrested, for drunk driving or driving after drinking?	_____	_____

Code #:
 Date:
 Researcher:

APPENDIX C

CAST - CHILDREN OF ALCOHOLICS: Screening Test

Check the answers below that best describe 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."

		<u>YES</u>	<u>NO</u>
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 your parent would stop drinking?	___	___
13.	Did you ever feel responsible or 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 you mother was an alcoholic?	___	___
26.	Did you ever wish 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 you 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?

Total Number of "Yes" Answers

**APPENDIX D
CONSENT FORM**

Agreement to Participate in Research: (Questionnaire)

Responsible Investigator(s):

Title of Protocol: Effects of family alcohol use on sons: Psychological adjustment and methodological considerations.

1. I have been asked to participate in a research study investigating the effects of family alcohol use on sons.
2. I will be asked to complete the SMAST (Short Michigan Alcohol Screening Test) and CAST (Children Alcohol Screening Test) questionnaires.
3. I understand that no risk is anticipated in this research study.
4. I understand the results from this research study may benefit future screening test questionnaires.
5. I grant rights of use and publication of the research results to the responsible investigator. I understand that all, part, or none of the materials may be used for publication.
6. I agree to no compensation for participation in this research study.
7. I understand that all questions about the research study may be addressed to Dennis Haines (408-279-7650). Complaints about the research may be presented to the Department Chair (Soo-Young Chin, Ph.D., 408-924-5713). Questions or complaints about research, subjects' rights, or research-related injury may be presented to Serena Stanford, Ph.D., Associate Academic Vice President for Graduate Studies and Research, at (408) 924-2480.

Subject's Initials
Investigator's Initials

Consent Form
(page two)

8. I understand if I choose not to participate in this study, I will not lose or jeopardize any service of any kind entitled to me.
 9. I voluntarily consent to this research study. I understand I may refuse to participate in the study or in any part of the study. If I decide to participate in the study, I am free to withdraw at any time without prejudice to San Jose State University or any other participating institutions.
 10. I have received a signed and dated copy of this consent form.
- * **The signature of a subject on this document indicates agreement to participate in the study.**
 - * **The signature of a researcher on this document indicates agreement to include the above named subject in the research and attestation that the subject has been fully informed of his rights.**

Subject's Signature

Date

Investigator's Signature

Date

APPENDIX E CONSENT FORM

Agreement to Participate in Research Permission to use Interview and Tape Recorder

Responsible Investigator(s):

Title of Protocol: Effects of family alcohol use on sons: Psychological adjustment and methodological considerations.

1. I have been asked to participate in a research study investigating the effects of family alcohol use on sons.
2. I will be asked to participate in a interview. A tape recorder will be used in this interview. The date of this interview is _____, 19___. The location is _____, San Jose, California.
3. I understand that no risk is anticipated during this interview.
4. I understand the results from this interview may benefit future screening test questionnaires.
5. I grant rights of use and publication of the interview results to the responsible investigator. I understand that all, part, or none of the materials may be used for publication.
6. I agree to no compensation for participation in this interview.
7. I understand that all questions about the research study may be addressed to Dennis Haines (408-279-7650). Complaints about the research may be presented to the Department Chair (Soo-Young Chin, Ph.D., 408-924-5713). Questions or complaints about research, subjects' rights, or research-related injury may be presented to Serena Stanford, Ph.D., Associate Academic Vice President for Graduate Studies and Research, at (408) 924-2480.

Subject's Initials
Investigator's Initials _____

Consent Form
(page two)

8. I understand if I choose not to participate in this study, I will not lose or jeopardize any service of any kind entitled to me.
 9. I voluntarily consent to this interview. I understand I may refuse to participate in the interview or in any part of the interview. If I decide to participate in the interview, I am free to withdraw at any time without prejudice to San Jose State University or any other participating institutions.
 10. I have received a signed and dated copy of this consent form.
- * **The signature of a subject on this document indicates agreement to participate in the interview.**
 - * **The signature of a researcher on this document indicates agreement to include the above named subject in the research and attestation that the subject has been fully informed of his rights.**

Subject's Signature

Date

Investigator's Signature

Date

APPENDIX F**REFERENCES**

ACA Group Information (Adult Children of Alcoholics)	(408) 459-6682
ACA Group Information – San Francisco	(415) 442-7998
Alcoholics Anonymous	(408) 297-3555
Al-Anon – Santa Clara County	(408) 379-1051
California Self-Help Center	(800) 222-5465
Regional Self-Help Center	(415) 921-4044
Community Alcohol Center	(408) 899-4131
Rational Recovery	(408) 739-7230

APPENDIX G

A campus of The California State University

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San Jose, California 95192-0025 • 408/924-2480

Psychology
Dr. Michael Alessandri
To: Dennis Haines
1110 Leigh Avenue, #2
San Jose, CA 95126

From: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies and Research

Date: September 1, 1993

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"Effects of Family Alcohol Use on Sons:
Psychological Adjustment and Methodological
Considerations"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted. If you have questions, please contact me at 408-924-2480.

IMAGE EVALUATION TEST TARGET (QA-3)

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