AN EXAMINATION OF THE RELATIONSHIP
BETWEEN COPING WITH STRESS AND ALCOHOLISM
IN ADULT CHILDREN OF ALCOHOLICS

by

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ABSTRACT

Given that alcoholism can be transmitted intergenerationally, some adult children of alcoholics (ACOAs) may be at risk of becoming alcoholic. The present research examined the process of appraisal and coping with stress, in relation to alcoholism in adult children of alcoholics. Subjects included 162 adult women recruited throughout a rural community. Subjects completed a survey containing measures to assess their appraisal and coping strategies, whether they were alcoholic, and whether they were adult children of alcoholic parent(s). The results suggested that the rate of alcoholism was higher among ACOAs than non-ACOAs indicating that ACOAs may be at risk for the intergenerational transmission of alcoholism. ACOAs were found to use appraisals of “I had to accept it or get used to it” less frequently than non-ACOAs in interpersonal stressful situations. This suggested that ACOAs appraise such stressful situations as controllable or changeable more frequently than non-ACOAs. In contrast, ACOAs and non-ACOAs were found to use the appraisal “I had to hold myself back from doing what I wanted to do”, problem-focused and emotion-focused coping similarly in interpersonal and non-interpersonal stressful situations. This suggested that ACOAs are no different from non-ACOAs in regards to appraisal and coping. The study concludes by discussing the implications for therapeutic support of ACOAs and suggestions for future research.
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INTRODUCTION

Adult children of alcoholics (ACOAs) have gone unnoticed for decades. They were once thought to be “forgotten children” (Cork, 1969) because most research focused on the drinking alcoholic and provided little or no attention to other family members, particularly to adult children. Today the literature is more complete with information on ACOAs and their defining characteristics. ACOAs are those adults who were raised in a family affected by parental alcoholism (Black, 1990). One of the most widely researched characteristics of ACOAs is their use and abuse of alcohol.

Although there are inconsistent findings as to whether ACOAs consume more alcohol than non-ACOAs (Jarmas & Kazak, 1992; Rodney, 1994; Wright & Heppner, 1991), there is general agreement throughout the literature that alcoholism is transmitted intergenerationally (e.g., Cotton, 1979; Koopmans & Boomsma, 1996; Light, Irvine, & Kjerulf, 1996; Sher, 1991), thereby placing ACOAs at risk to become alcoholic themselves. There is much debate, however, as to the form of such intergenerational transmission. Although mixed results are indicated, generally the literature suggests a genetic effect for the amount of alcohol consumed, particularly among males (Prescott, Hewitt, Heath, Truett, Neale, & Eaves, 1994a; Prescott, Hewitt, Truett, Heath, Neale, & Eaves, 1994b). However, the size of this effect is unclear. Females appear to be influenced more strongly by environmental factors (Light, et al., 1996; Prescott et al., 1994a, b). Regardless of how alcoholism is transmitted, the ACOA must learn coping strategies that are not related to the manifestation of alcoholism. Given that not all ACOAs are alcoholic, those appraisals and coping strategies that are not related to alcoholism need to be explored. It is equally important to study how ACOAs appraise and cope with stress in relation to alcoholism.
Lazarus and Folkman (1984) provide a widely accepted transactional, cognitive-phenomenological model of stress, appraisal and coping that can be utilized to understand how ACOAs cope with stress in relation to alcoholism. The coping process includes cognitive appraisals. These are evaluative processes that occur between the encounter of a situation and the individual’s reaction. Primary to analyzing the person-environment situation, individuals evaluate whether or not the situation is personally stressful. As well, one’s own coping resources and options are considered in the appraisal and coping process. Coping strategies such as emotion-focused or problem-focused coping may be utilized. This person-environment interaction allows for a newly formed situation. Reappraisal of the new situation determines whether further coping efforts are required.

*Emotion-focused coping* involves cognitions and behaviours aimed at alleviating or regulating the emotional impact of stress (distress). It includes such strategies as distancing, escape-avoidance, accepting responsibility or blame, exercising self-control over expression of feelings, seeking social support and positive reappraisal (Folkman, Lazarus, Dunkel-Scheter, DeLongis, & Gruen, 1986). Emotion-focused coping is often used following stressful situations which are appraised as *unchangeable*; that is, *having to be accepted*, or *having to hold oneself back from acting* (Folkman & Lazarus, 1985).

*Problem-focused coping* involves instrumental actions aimed at changing the stressful situation. This strategy of coping includes confrontive and interpersonal efforts, and planful problem solving (Folkman et al., 1986). Problem-focused coping often follows appraisals that the situation is *changeable*; that is, *something constructive can be done*, or *more information is required* (Folkman & Lazarus, 1980, 1985).
Previous research has suggested ACOAs have a greater tendency to appraise stressful situations as unchangeable or requiring acceptance, while non-ACOAs are more likely to appraise stressful situations as controllable (Clair & Genest, 1987). As well, ACOAs have been noted to use more emotion-focused coping such as wishful thinking and help seeking-avoidance than problem-focused coping, while non-ACOAs use both types of coping equally (Clair & Genest, 1987).

Further research on appraisal and coping in relation to alcoholism has suggested that stressful situations appraised as unchangeable and requiring acceptance are related to the expression of alcoholism (Easley & Epstein, 1991). As well, emotion-focused coping strategies such as using less positive reappraisal and less confrontive efforts may allow for continual tolerance and the perpetuation of alcoholism, while problem-solving coping strategies are not related to alcoholism (Easley & Epstein, 1991).

The purpose of the present study was to examine the relationship between appraisal and coping with stress in relation to alcoholism in female ACOAs. Lazarus and Folkman's (1984) approach to appraisal and coping will be used as a theoretical framework for examining the hypotheses. Therefore, this study will utilize a number of subscales from the Ways of Coping Questionnaire (WCQ; Folkman & Lazarus, 1988) and four appraisal items (Folkman & Lazarus, 1980) to measure the ways ACOAs appraise and cope with stress. Alcoholism will be measured using the Short Michigan Alcoholism Screening Test (SMAST; Selzer, Vinokur, & van Rooijen, 1975). This measure provides for a wholistic approach to defining alcoholism as it incorporates items relevant to cultural, behavioural, and physiological dimensions of the medical perspective as well as moral-legal aspects of alcoholism. Whether the respondent is ACOA or not will be
measured with the Children of Alcoholics Screening Test - 6 (CAST-6; Hodgins, Maticka-Tyndale, El-Guebaly, & West, 1993). This measure is designed to identify children and adults who are living, or have lived with one or more alcoholic parent(s). Finally, a demographic questionnaire will be administered to elicit relevant information about the participants and their parents.

In this study the rate of alcoholism was assessed between ACOAs and non-ACOAs. These two groups were compared to determine whether there were significant differences in terms of how they appraised and coped with stress in relation to alcoholism. In order to better understand the results, the context of the stressful situations reported by the respondents was taken into consideration. ACOAs and non-ACOAs were compared on the use of the appraisals “I had to accept it or get used to it” and “I had to hold myself back from doing what I wanted to do” in interpersonal stressful situations. As well, they were compared on the use of emotion-focused coping in interpersonal stressful situations and coping strategies in non-interpersonal stressful situations.
LITERATURE REVIEW

In Canada in 1995 there were approximately three quarters of a million adult alcoholics (aged 18 and older) (The Canadian Centre on Substance Abuse and The Addiction Research Foundation of Ontario, 1995). Research suggests that approximately 2.4% of Canadians aged 20 and over are alcoholic. If these rates hold consistent, based on the estimated July, 1997 population of adult Canadians (20 and older), this would mean there are approximately 654,483 adult alcoholics.

The Canadian Centre on Substance Abuse and The Addiction Research Foundation of Ontario (1995) have noted that “43.9% of respondents [strangers] reported that they experienced some problem due to other people’s drinking” (p. 18). Difficulties surrounding an individual’s drinking, however, often affect those people who are closest to the drinker -- people such as employers, relatives, friends and family (Woititz, 1983). Included in the category of family are the children and adult children of the alcoholic. In North America today, 6.6 to 11 million children of alcoholics (COAs) and 22 to 28 million adult children of alcoholics (ACOAs), are affected by their parent’s alcoholism (National Clearinghouse for Alcohol and Drug Information (NCADI) The National Association for Children of Alcoholics, http://www.health.org/nacoa/kidkit.htm, October 1997; Office for Substance Abuse Prevention, 1991). Although COAs and ACOAs appear widespread throughout North America, it has taken over four decades for valid attention to be drawn to these “forgotten children” (Cork, 1969).

The earliest documented research on children of alcoholics dates back to the mid-1940s (Holden, 1945; Roe & Burks, 1945). During that time however, the focus of research, treatment, and intervention in the field of alcoholism was mainly on the drinking alcoholic, and the drinking
male alcoholic in particular. It was with the efforts of Jackson (1954) and others (Fox, 1962, Futtermen, 1953, Jacob, Favorine, Meisel & Anderson, 1978, MacDonald, 1956 as cited in Brown, 1988), that attention was turned to alcoholism as a "family disease". This is the idea that all family members in the "alcoholic family" are affected by alcoholism and in turn, affect the perpetuation of the alcoholism.

That is, by merely living in the home where alcohol is present, "every member in such a family is affected by it - emotionally, spiritually and in most cases economically, socially and often physically" (Fox, 1962, p. 72 as cited in Brown, 1988, p. 12). As well, each member was posited to enable the perpetuation of alcoholism via a mechanism described by Jackson (1954) as "family homeostasis". Homeostasis in the alcoholic family involves alcohol as the central organizing principle. Each member was thought to organize and stabilize around the reality of parental drinking, thus leading to the "normalcy" of alcoholism for the family (Brown, 1988). By adapting individual beliefs and behaviours, and familial roles, rules and boundaries around the alcohol and the alcoholic, the family was thought to become caught-up in a "double-bind". The "double-bind" is that balance in the family is maintained while simultaneously surrendering to the dominance of the "family disease".

From this perspective, research shifted to focus on women, particularly toward the wife of the alcoholic as a key player in the perpetuation of alcoholism in her mate (Brown, 1988). Much of this research looks at the "co-alcoholism" of the non-alcoholic spouse (Black, 1981), and the co-dependence of the alcoholic husband and (non-)alcoholic wife (Beattie, 1987; Black, 1981). These relationships are described as being characterized by the non-alcoholic (typically the woman's) "reactive, submissive response to the dominance of the drinking alcoholic [typically
described as male]” (Brown, 1992, p. 52). Hence, the non-alcoholic partner is blamed for the perpetuation and sometimes for the origins of the alcoholic’s drinking.

The later refinement of the term co-dependence has further exemplified the negative and unhealthy aspects of dependence (i.e., dependence of each partner and family member on the other for a definition of self) (Brown, 1992; Subby, 1987). These labels have drawn attention to the partner of the alcoholic, however they further stigmatize the non-alcoholic spouse and family members leading to negative consequences for the labelled “co-dependent” individual. Such terms are rarely liberating, rather they often do not allow for much hope nor freedom for the individual to actualize change.

The concept of the “alcoholic family” also drew attention to the children of these families. These children were once described as the “forgotten children” (Cork, 1969) because clinicians and researchers focused so narrowly on the alcoholic member, they often ignored the children in such families. Although Cork (1969) drew unavoidable attention to these children, it was not until the late 1970s that adult children of alcoholics received attention. An article in Newsweek (Black & Brown, 1979) sparked the popularization of the concept “adult children of alcoholics” (ACOAs) by reporting on the early research of Brown and Black. Both described and labeled “adult children of alcoholics as a new, unrecognized, legitimate population” (Brown, 1988, p. 18), who suffer the consequences of living in chaotic, inconsistent and unpredictable environments (Black, 1981, 1995, December; Brown, 1992; Woititz, 1983) and thus have treatment needs of their own (Beletsis & Brown, 1981; Black, 1981; Cermak & Brown, 1982).

Ever since the publication of the Newsweek article (Black & Brown, 1979), the recognition and description of ACOAs has spread (Brown, 1988). The Children of Alcoholics Foundation
(1987), the National Association for Children of Alcoholics (1983), and a similar Canadian Association (1986) (as cited in Schneider, 1995) have been formed to provide validation and support for ACOAs, to raise public awareness, and to support research on the topic. Information on this topic now abounds. Given the widespread literature including books, articles, videos, web sites, workshops and conferences, both the mental health worker and the general public are quickly becoming educated about ACOAs.

It is the purpose of this study to further contribute to the development of knowledge about ACOAs. More specifically, the intent is to examine the appraisals and coping strategies that ACOAs utilize to deal with stress. These appraisals and coping strategies will be examined in regards to how they either perpetuate or break the cycle of alcoholism as evidenced in the ACOA.

**Adult Children of Alcoholics**

*Adult Children of Alcoholics* (ACOA) is a term that was first coined by Claudia Black in 1977, during the initial phases of the concept's development. Since that time, "the phrase and its acronym have moved through a variety of changes" (Black, 1990, p. 4). Today, few authors and researchers are willing to define the term. Numerous sources, however, offer elaborate descriptions of the concept (e.g., Black, 1981, 1990; Brown, 1988, 1992; Wegscheider, 1977; Woititz, 1983). The phrase *adult children of alcoholics* points to the importance of the family as a unit. It focuses on understanding and exploring the individual's experience within the context of the family environment which is riddled with the overriding factor of alcoholism. This "family focus [...] assigns primacy to the alcoholism [within the home] and therefore suggests that a child's development can be understood in relation to it" (Brown, 1992, p. 7).
Hence, the term *adult child* does not imply that the adult-aged individual behaves like a child, but rather refers to the child within the adult who was affected by their parent's use of alcohol (Black, 1990). The phrase attempts to acknowledge the neglect, abuse, chronic loss and trauma these individuals experience as children, and the emotional vulnerability they experience as adults (Black, 1992, 1993; Brown, 1992).

One of the few recent attempts at defining the term *adult children of alcoholics* refers to “the adult person who was raised in a family affected by parental chemical dependency and codependence” (Black, 1990, p. 3). Although the term chemical dependency refers to both drug (legal and illegal) and alcohol abuse, the majority of research on ACOAs focuses on the children of alcoholic parents as opposed to those of drug addicted parents. Given that alcohol is legally and socially sanctioned in North America, as compared to drug use (including prescription drug abuse), alcohol is more widely used in Canada. This study examines how ACOAs cope with stress in relation to alcoholism. Although growing up in a drug using/abusing environment may also lead to adverse adult effects, the scope of this study will focus on those ACOAs who grew up in alcoholic homes, excluding any other form of “parental chemical dependency”.

**Characteristics of ACOAs**

In an attempt to provide further legitimacy to ACOAs as a group, there have been numerous attempts to describe the similarities among these individuals (e.g., Black, 1990; Brown, 1990; Woititz, 1983, 1984). Appendix B provides three lists of the putative characteristics that three leading ACOA clinicians have drawn from their observations. Although some of these items of clinical observations have been empirically supported, others have been refuted. These lists may provide a starting point for the understanding of ACOAs, however, they do not provide a
sufficiently exhaustive profile. To date, there is not sufficient evidence to suggest that these descriptions can be used as checklists for the assessment of ACOAs.

Between these lists (refer to Appendix B), there are contradictory characteristics. For example, Black (1990) maintains that ACOAs become addicted to excitement, while Woititz (1983) states they have a difficult time having fun and take themselves very seriously. Even within these conceptualizations, there are numerous contradictions. Woititz describes ACOAs as either super responsible or super irresponsible, and Black states ACOAs are either victims or rescuers. These contradictions further complicate the ACOA profile rather than clarify it.

Brown (1992) however, attempts to resolve these inconsistencies by maintaining ACOAs are “black or white”, “all or nothing” individuals, therefore maintaining that such polar traits are central characteristics of ACOAs.

Intuitively, some of these qualities and traits appear to be characteristic of ACOAs. However, upon close examination many of the characteristics may also be observed in almost all adults at some point in time. In order to confirm that these characteristics are representative of ACOAs, empirical research must be conducted. In a national sample of 624 female ACOAs and 585 female non-ACOAs, Ackerman (1989) attempted to compare these women on each characteristic delineated by Woititz (1983) via a self-administered survey. He found ACOAs reported experiencing each characteristic more often than non-ACOAs (p < .01). Ackerman (1989) however, did not report the procedure for sample selection, nor did he provide information regarding the content or format of the survey. One is left to assume that Ackerman (1989) administered a 5-point Likert type itemed survey including Woititz’ (1983) characteristics along with two sets of questions related to Rigidity and Fear of Failure. However, this is not
clarified. Given the vagueness with which this study is reported, caution must be used when interpreting these results.

Black, Bucky, and Wilder-Padilla (1986) attempted to empirically test Black's clinical observations. They studied 588 self-reported ACOA and non-ACOA volunteers, recruited via magazine and journal advertisements. They examined emotional and interpersonal difficulties, including difficulty in trusting others, trouble with emotional expression, difficulty with intimacy, problem solving and issues of responsibility. Their study also examined ACOAs and non-ACOAs in terms of reported difficulty with dependency, expressing needs and putting themselves first, and increased feelings of depression. According to Black et al., the results confirmed Black's (1981) earlier conceptualization of ACOAs, and illustrated the importance of treating ACOAs as a special population. However, as suggested elsewhere (e.g., Burk & Sher, 1988) these conclusions are overstated.

The sample in the Black et al. (1986) study was composed of volunteers who responded to a request for subjects advertised in two addiction focused journals and one family journal. Therefore, this sample was biased with individuals who are likely to have a high degree of interest in ACOA related issues. This conclusion may be confirmed via the pattern of subject response. That is, of the 725 questionnaires mailed to the ACOAs, 461 were returned (63.6%), while only 185 questionnaires were returned from the 756 questionnaires that were mailed to the non-ACOA subjects (24.5%). In light of this return rate, one must question whether the reported differences between ACOAs and non-ACOAs regarding emotional and interpersonal problems really exist. Therefore, these difficulties may not be unique to ACOAs suggesting the necessity for further investigation.
Other efforts to better understand ACOAs focus on similarities and differences between ACOAs and non-ACOAs on personality characteristics, traits and styles of behaviour. A few of the more commonly researched characteristics include self-depreciation and self-esteem, independence, autonomy and the need for social support, intimacy, eating disorders, shame, hopelessness, depression and anxiety (Berkowitz & Perkins, 1988; Clair & Genest, 1987; Harrington and Metzler, 1997; Jarmas & Kazak, 1992; Kashubeck & Christensen, 1992; Mintz, Kashubeck, & Tracy, 1995; Reich, Earls, Frankel, & Shayka, 1993; Stout & Mintz, 1996; Wood, 1987; Wright & Heppner, 1991, 1993). Despite the breadth of literature examining these concepts, the results are mixed and unclear. Research indicates inconclusive evidence as to whether ACOAs are more likely than non-ACOAs to display these characteristics and traits.

ACOAs and Alcohol

Even for the most widely researched characteristic of ACOAs -- alcohol use and abuse -- there are inconsistent findings (Burk & Sher, 1988; Cotton, 1979; El-Gueblay and Offord, 1977, 1979; Mintz, Kashubeck, & Tracy, 1995; Rodney, 1994; Schuckit, 1994; Sher, 1991; Wright & Heppner, 1991, 1993). In a study of 50 ACOAs and 50 non-ACOAs who where selected from a college class roster and paid to complete a battery of tests, both groups were compared in terms of family of origin functioning, perceived availability of social support, academic development, and alcohol use (Rodney, 1994). Upon examination of the factor which best distinguished the two groups, it was noted that ACOAs drink significantly more alcohol than non-ACOAs (Rodney, 1994).

This difference in the amount of alcohol consumed was not noted in a study of 40 ACOA and 40 non-ACOA freshmen university students who volunteered to complete a package of
questionnaires for extra credit (Wright & Heppner, 1991). Within each group were 20 males and 20 females. Upon examining alcohol use between ACOAs and non-ACOAs, and between males and females, no significant differences were found. It was concluded that ACOAs and non-ACOAs were equally adjusted, as were males and females. However, the finding of no differences between these groups may be due to the small sample size. As well, freshmen university students is a population which is suspected to consume more alcohol than average, thus providing for increased similarities between these groups in terms of alcohol consumption.

Similar sampling procedures and instruments were used in a later study by Wright and Heppner (1993). Forty ACOAs and 40 non-ACOAs were examined to determine whether there were differences in alcohol use between the two groups with family functioning as a second independent variable. They found ACOAs from both functional and dysfunctional families were at significantly more moderate and high risk for alcohol use than were the non-ACOAs. “[T]he results of this study contradict the Wright and Heppner (1991) study, in which the same instruments and a very similar sample were used” (Wright & Heppner, 1993). These contradictory findings despite the use of similar procedures, suggests that the presence of alcoholism in ACOAs is a complex phenomenon. The presence of alcoholism may be better understood by examining mediating or suppressor variables such as appraisal and coping.

Further research has noted significant differences between ACOAs and non-ACOAs, and gender differences for alcohol use. A study of 84 ACOA and 123 non-ACOA undergraduate university students, with approximately equal numbers of males and females in each, examined the presence of alcohol abuse between these groups (Jarmas & Kazak, 1992). These students were recruited from two introductory psychology courses and a university newspaper
advertisement. An increased propensity for substance abuse was noted among male ACOAs, as compared to female ACOAs and non-ACOAs. Jarmas and Kazak (1992) suggest male ACOAs may be at high risk for alcohol abuse due to biological and cultural factors which lead them to use alcohol as a way of coping. Similar gender differences have been noted in the literature (e.g., Light, Irvine & Kjerulf, 1996; Schissel, 1993).

Much of the literature that examines alcohol use among ACOAs focuses generally on males and females somewhat equally. Gender differences have been noted in the literature (Jarmas & Kazak, 1992; Light et al., 1996; Schissel, 1993) and females have been found to be at less risk for alcohol abuse. The present study further examined adult females to better understand alcoholism among female ACOAs and non-ACOAs.

ACOAs and Adjustment

Although the forementioned characteristics, behaviours, and adjustment traits reflect a wide range of functioning, there is a tendency in research to focus on ACOA maladjustment. Such a negativistic perspective is prevalent among the leaders in the self-help and treatment fields (e.g., Black, 1981, 1990; Brown, 1992; Woititz, 1983). For example, even when children appear to be affected in a positive manner or not affected at all (Burk & Sher, 1988; El-Guebaly & Offord, 1977, 1979; Werner, 1985), Black (1981) maintains these children only appear well-adjusted. Black (1981) states “The bottom line is: ALL CHILDREN RAISED IN ALCOHOLIC HOMES NEED TO BE ADDRESSED. ALL CHILDREN ARE AFFECTED” (p. 27; capitalization in the original). She proposes all children develop coping strategies, including socially attractive strategies such as accepting responsibility to hide their true feelings against the stress of living in an alcoholic family (Black, 1981; Wood, 1987). Black (1981) and Woititz (1983) maintain these
“defense mechanisms” ultimately breakdown and all ACOAs eventually become dysfunctional. If such postulates hold true, this necessitates early preventative measures to be undertaken in young COAs. Such early support and therapy may be necessary to aid those who are at risk for adult maladjustment.

A few authors (e.g., Burk & Sher, 1988; El-Guebaly & Offord, 1977, 1979), however, have raised concerns regarding this focus on ACOA maladjustment and maintain that ACOAs also have strengths and competencies. Burk and Sher (1988) discuss the repercussions of falsely labelling well-adjusted ACOAs as at risk, while El-Guebaly and Offord (1977) propose that much can be learned from studies of “successes”, as opposed to directing all attention on the “casualties”. Given that the leading proponents of the self-help movement have provided such negative profiles, this increased attention on the needs of ACOAs “may have created a new group of ‘forgotten children’: those who function adaptively with parental alcoholism” (Burk & Sher, 1988, p. 286).

In order to better assist ACOAs one must consider a diverse range of functioning and adaptation. Rather than focus strictly on deleterious outcome effects, this study will examine the numerous ways in which ACOAs appraise and cope with stress in relation to alcoholism. Given that coping does not refer to negative or positive functioning, this paper will consider the diverse ways in which ACOAs cope.

Alcoholism

As noted earlier, the most widely researched characteristic of ACOAs is alcoholism. During the early 1900s alcoholism was viewed as immoral and illegal. Alcoholics were “branded as sinners or criminals and legally banned from many medical facilities” (Ciraulo & Renner, 1991,
In the 1960s alcoholism was defined more from a medical perspective, conceptualizing the alcoholic as suffering from a “syndrome of aberrant behaviours and physical symptoms” (Steinglass, Bennett, Wolin, & Reiss, 1987, p. 30) for which the alcoholic was treated.

Today, a marriage of both the moral-legal and the medical perspectives is present, however, the medical model predominates. Within the medical approach, alcoholism is often defined along three different dimensions: culturally, behaviourally, and physiologically. The British World Health Organization (BWHO) most clearly reflects the culturally based definitional approach. They propose alcoholism be defined as:

exist[ing] when the consumption of alcohol by an individual exceeds the limits that are accepted by [their] culture, if [one] consumes alcohol at times that are deemed inappropriate within that culture, or [their] intake of alcohol becomes so great as to injure [their] health or impair [their] social relationships (Kramer & Cameron, 1975 as cited in Steinglass et al., 1987, p. 31).

The behavioural approach distinguishes between alcohol use, misuse, and abuse where the differentiating factor includes the severity of alcohol related consequences. The physiological perspective with its focus on “addiction” utilizes two major diagnostic criteria: tolerance and withdrawal. Tolerance is defined as the need for increased amounts of alcohol to achieve the effects which were originally obtained with less alcohol ingestion. Tolerance is the phenomena that occurs when the effects of alcohol diminish with continued drinking of a constant amount of alcohol, thus leading to the need for increased amounts to produce similar effects. Withdrawal refers to the physiological and cognitive effects which occur when a heavy and prolonged alcohol user ceases or reduces alcohol intake. It signifies some form of equilibrium was obtained around the alcohol and cessation or reduction leads to distress and impaired functioning.
The medically oriented perspectives of North America rely more on behavioural and physiological based approaches to defining alcoholism. Both of these approaches were incorporated in the 1980 American Psychiatric Association's (APA) definition of alcoholism in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III). These perspectives have been retained through the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R) (APA, 1987). As well, concomitants of a somewhat cultural perspective and moral-legal approach have been included with these in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (APA, 1994a) criteria of alcoholism.

The APA and the World Health Organization (WHO) have recommended that the term “alcoholism” be replaced with “dependence”. The DSM-IV (1994) accounts for this change and also goes one step further in providing a distinction between alcohol dependence and alcohol abuse. Alcohol dependence refers to the loss of control over the use of alcohol to the point of interference with functioning in “important social, occupational, or recreational activities” (APA, 1994a, p. 181). It includes the continued use of alcohol despite knowledge of its persistent and recurrent adverse effects. Alcohol dependence may or may not include physiological dependence, of which tolerance and withdrawal are signs. This possibility for physiological dependence along with a greater intensity of symptoms and behaviours distinguish alcohol dependence from alcohol abuse. Alcohol abuse refers to social, legal, vocational, and possible physically hazardous consequences with continued use despite persistent or recurrent adverse effects. Alcohol abuse does not include the physiological dependence. Refer to the DSM-IV (1994) for the diagnostic criteria for alcohol dependence and abuse.
Although the distinction between alcohol dependence and abuse is an important one, the remainder of this paper will use the term alcoholism to refer to both interdependently. The more inclusive the definition / description of alcoholism, the more facilitative it is in clinical practice and research. This approach is particularly beneficial for identifying those ACOAs who are alcoholic and those who are not alcoholic, because those who are alcoholic may display alcoholism in a number of ways.

**Familial Transmission of Alcoholism**

It has been noted in numerous studies that alcoholism is transmitted intergenerationally (e.g., Cotton, 1979; Koopmans & Boomsma, 1996; Light et al., 1996; Sher, 1991), thereby placing ACOAs at risk for alcoholism (Burk & Sher, 1988; Sher, 1991). The main area of controversy in this domain regards the form of transmission of alcoholism, with a focus on genetic, environmental (familiarily cultural influence of parental behaviour on the behaviour of children), and gene by environment interactional factors.

In the effort to sort genetic and environment (cultural) effects, 43,809 adults completed the National Health Interview Survey, 1988 Alcohol Supplement (NHIS-88A) (Light et al., 1996). It was found that the odds of being alcohol dependent increased when second or third degree relatives were alcoholic. The odds almost doubled for those individuals with alcoholic first degree relatives, and doubled again for alcohol dependent individuals with first, second and third degree relatives. These results indicate genetic factors play a role in alcoholism. They do not suggest, however, that every member of a family is necessarily at risk. Other studies of ACOAs and their relatives have found similar results (Lucero, Jensen & Ramsey, 1971; Merikangas, 1990; Winokur, Reich, Rimmer, & Pitts, 1970).
In a study of 1,700 Dutch families with twins aged 12-24 the effects of genetic and environmental (cultural transmission) factors were examined in relation to alcohol use in twin children (Koopmans & Boomsma, 1996). Slightly more than half of the twin sample were female. Both the parents and the twins indicated whether they used or had used alcohol. Structural equation models were used to test “whether parent-offspring correlations could be explained by cultural transmission or by genetic inheritance or by both” (Koopmans & Boomsma, 1996). The best fitting models indicated shared environment explained between 58% and 88% of individual differences in 15-16 year olds. In twins aged 17 and older, 43% of individual differences were attributable to genetic factors, while only 37% were attributable to shared environment factors. According to this study, the results suggest that shared environment plays less of a role in older children, with genetic effects accounting for greater explanation of alcohol use as the COA ages. Two classic twin studies noted similar findings supporting the genetic transmission of alcoholism in adults (Kajj, 1960; Partanen, Bruun, & Markkanen, 1966), while others (i.e., Prescott et al., 1994a, b) have evidenced increasing genetic influence as the ACOA ages.

Gender differences have also been noted in alcohol abuse studies. While Clifford, Hopper, Fulkner, & Murray (1984) noted an almost equal contribution of genetic (37%) and environmental (42%) effects for the quantity of alcohol consumed by both genders, Prescott et al. (1994a, b) found genetic factors influenced the quantity of alcohol consumed by men and women (particularly among men) with environmental factors influencing only women. Again, alcohol abuse was genetically influenced in men while genetic influences for women met with contradictory findings (Prescott et al., 1994a, b). These results suggest males may be genetically
at high risk and women may be socially susceptible for alcoholism. These findings indicate that
both need to cope with alcoholism although in different ways. Adoption studies have noted
similar gender differences (Light et al., 1996).

The study of the transmission of alcoholism has met with mixed results. At best, the
research suggests there is a significant genetic effect on alcoholism, particularly among males.
There is debate, however, as to the size of this effect (Light et al., 1996). Age differences in the
expression of alcoholism suggest that as the ACOA ages, the equal gene and environment effects
give way to increasing genetic effects. Finally, alcohol abuse appears to be influenced more
strongly by genetic effects for males and environmental factors for females. Gene by
environment interactions have not been extensively researched (Light et al., 1996).

Regardless of the mechanism(s) by which alcoholism is transmitted, the ACOA must cope
with alcoholism. Although there is much research regarding gender differences for alcoholism,
there is little research which focuses specifically on adult females. This study will examine
alcoholism among female ACOAs as compared to female non-ACOAs. Given that not all
ACOAs are alcoholic, much can be learned from those who are not alcoholic, as well as from
those ACOAs who are alcoholic. This study will examine both alcoholic and non-alcoholic
female ACOAs and attempt to understand the appraisal and coping strategies which are related to
the perpetuation of alcoholism and those which are not related to alcoholism.

Stress, Appraisal and Coping

Stress

Lazarus and Folkman (1984) offer a widely accepted transactional perspective on stress,
appraisal and coping. The transactional perspective attempts to account for physiological,
psychological and sociological stress by focusing on the collective of the stimulus, response, intervening variables, and the interactional aspects of stress (Monat & Lazarus, 1991). From this perspective, stress refers to external and/or internal demands which “tax or exceed the adaptive resources” (Monat & Lazarus, 1991, p. 3) of the individual (Lazarus & Folkman, 1984). The continual transaction between the individual and the environment call great attention to the appraisal process.

**Appraisal**

In keeping with the transactional perspective of stress, Lazarus and Folkman (1984) propose a cognitive-phenomenological appraisal process. That is, the individual utilizes cognitive processes to evaluate whether or not a situation is personally stressful. The appraisal process includes three stages of cognitive evaluation: *primary appraisal, secondary appraisal* and *reappraisal*. During *primary appraisal* the individual assesses what is at stake. At this point, the individual evaluates whether the encounter is *irrelevant* to them, in which place there is no stake in the encounter, *benign-positive* in which outcomes are neutral or good, or *stressful* in which case secondary appraisals are made (Folkman & Lazarus, 1985).

Dependent upon the primary appraisal, the individual determines whether or not they need to cope with a situation, and if so they must take inventory of their available coping resources and options. Such an inventory occurs during the *secondary appraisal* process in which the individual assesses their options, and what they can do to cope with the situation, as well as how the environment may respond to the individual’s actions (Folkman & Lazarus, 1991). How one appraises or perceives these elements determines how the encounter is dealt with and which coping strategies are to be used. In order to determine which coping strategies to use, the
individual will first evaluate the encounter in terms of its *harm-loss* (whether injuries or damage has already been incurred), *threat* (whether injuries or damage are anticipated), or *challenge* (whether there is opportunity for mastery or gain) (Folkman & Lazarus, 1980, 1985). Coping efforts change the person-environment relationship, which in turn provides for a new context in which *reappraisals* are required to direct further coping efforts. This pattern of transaction and change is continuous.

**Coping**

*Coping* refers to the cognitions and behaviours that the individual utilizes to attempt a change in the stressful encounter. The coping process therefore involves continually changing cognitions and behaviours throughout the anticipatory, confrontation and postconfrontation stages. The different forms of coping which can be utilized during confrontation influence change by either diverting attention away from the source of distress or by directing attention to it, by altering the meaning or significance of the encounter to ensure well-being, or by physically altering the person-environment relationship (Folkman & Lazarus, 1991). The changes which occur in the person-environment relationship can be viewed in terms of their direct alteration of the distressful situation (*problem-focused coping*) and/or by regulating the personal experience of emotional distress (*emotion-focused coping*).

*Problem-focused coping* involves instrumental actions which attempt to change the troubled person-environment relationship. Problem-focused coping provides for the management or alteration of the relationship and “involves strategies that attempt to solve, reconceptualize, or minimize the effects of a stressful situation” (Parker & Endler, 1996, p. 9). This strategy of coping includes confrontive and interpersonal efforts (i.e., “I stood my ground and fought for
what I wanted"), and planful problem solving (i.e., "I made a plan of action and followed it"). Refer to Appendix A.

Problem-focused coping often follows appraisals in which the individual believes a situation can be ameliorated by taking action (Folkman & Lazarus, 1980). When an individual appraises that something constructive can be done, or more information is required, problem-focused coping follows (Folkman & Lazarus, 1980). Refer to Appendix A. In short, problem-focused coping will be used following the appraisal that a situation is changeable (Folkman & Lazarus, 1985), thus providing for the management of reducing the level of stress (Wills & Hirky, 1996).

Emotion-focused coping involves cognitions and behaviours aimed at relieving the emotional impact of stress (i.e., as caused by physical or psychological disturbances). These strategies are mainly palliative for they are not focused on altering "the actual situation, but rather help assign a new meaning to it. They are not passive, but may require an internal restructuring and may cost considerable effort" (Schwarzer & Schwarzer, 1996, p. 110).

Emotion-focused coping includes the following strategies: distancing (i.e., "I tried to forget the whole thing"); escape-avoidance (i.e., "I hoped a miracle would happen"); accepting responsibility or blame (i.e., "I realized I brought the problem on myself"); exercising self-control over expression of feelings (i.e., "I tried to keep my feelings to myself"); seeking social support (i.e., "I talked to someone about how I was feeling"); and positive reappraisal (i.e., "I came out of the experience better than when I went in") (Folkman et al., 1986). Refer to Appendix A.

When a situation is appraised as having few possibilities for beneficial change, emotion-focused coping will be used (Folkman & Lazarus, 1980). When an individual appraises a
situation as having to be accepted or having to hold oneself back from acting, one will often use emotion-focused coping. In short, emotion-focused coping will be used following the appraisal of a situation as unchangeable (Folkman & Lazarus, 1985), or of oneself not having any control over the situation. Refer to Appendix A. Such appraisals and coping provide for a reduction in the level of internal emotional distress and somatic disturbance (Wills & Hirky, 1996).

This does not imply that we use one or the other type of coping exclusively, rather complex combinations of problem-focused and emotion-focused methods [are utilized] to cope with stress. The conditions determining [the use of] coping methods in particular situations are undoubtedly complex and largely unknown at this time but likely depend upon the conditions being faced, the options available, [and] personality (Monat & Lazarus, 1991, p. 6).

The ability of this approach to account for such human-environment complexities lends itself to the study of ACOAs and the intricacies of growing up in an alcoholic environment. Further, it provides a basis for the study of how ACOAs appraise and cope with daily stress and either emulate or break the cycle of familial alcoholism.

Appraisal and Coping with Stress in Relation to Alcoholism

Living in a home with "[p]arental alcoholism may be conceptualized as a form of chronic stress" (Clair & Genest, 1987, p. 345) with periods of acute exacerbation. A number of clinicians (e.g., Black, 1981, 1990; Wegscheider, 1977; Woititz, 1983) view ACOAs as the unfortunate victims of an alcoholic family environment characterized by inconsistency, unpredictability, chaos and tension. Within such an environment, these individuals are thought to experience disruption, deviant parental role modelling, inadequate parenting, and disturbed parent-child relationships (Sher, 1991). Ongoing distress and impaired functioning in COAs
and enduring adult effects in ACOAs has been attributed to the role of alcohol in the family, continuous disruption by the alcoholic parent and various adaptations employed by family members to stabilize the family process. From this clinical perspective, being an ACOA is often thought to be a problem in its own right (Sher, 1991).

Children learn in the context of the family. Often what is learned in the home shapes and guides how the child will act, think and feel as an adult. These functions develop via the roles that one assumes, the rules they adhere to and the boundaries they develop and respect. For a thorough review of how these elements interact in the alcoholic home to create a stressful environment, please refer to Black (1981, 1990), Clair and Genest (1987), Jarmas and Kazak (1992), Ullman and Orenstein (1994), Wegscheider, (1977, 1988), Werner (1985), and Woititz (1983). Appraisal systems and coping strategies are examples of important life skills which are first tested in such environments and may be perpetuated into adulthood. Given that ACOAs are at greater risk than non-ACOAs for developing alcoholism (Wright & Heppner, 1993), ACOAs must learn to cope with the stressors which may provide for the manifestation of alcoholism.

"There is a growing conviction that the way people cope with stress affect[s] their psychological, physical, and social well-being" (Folkman & Lazarus, 1980, p. 219). In keeping with the transactional, cognitive-phenomenological approach, the ACOA and their environment including the past alcoholic family environment and present daily stresses, are viewed as partaking in an ongoing reciprocal relationship, each affecting and in turn being affected by the other. Hence, dependent upon how the ACOA appraises and copes in their environment, they aid in the expression of alcoholism.

Lazarus and Folkman’s (1984) transactional, cognitive-phenomenological theory was
applied in two studies of ACOAs to examine appraisal and coping strategies in relation to the adult outcome of alcoholism (Clair & Genest, 1987; Easley & Epstein, 1991). Clair and Genest (1987) studied 70 young adult volunteers from a university and from a self-help group setting. Thirty subjects were self-reported ACOAs and 40 were self-reported non-ACOAs. The purpose of the study was to examine the moderating effects of coping in relation to aspects of adjustment which are reportedly disturbed in ACOAs (i.e., depression, and self-concept). Subjects reported the coping strategies they used to deal with two disruptive family incidents which occurred when the participant was aged 13 to 18.

Results of the study indicated that ACOAs have a greater tendency to appraise these problem situations as unchangeable or as requiring acceptance. Only 6.8% of ACOAs appraised their problems as controllable, while 22.1% of non-ACOAs appraised their problems as controllable. Non-ACOAs were noted to use emotion-focused and problem-focused coping equally. These findings are consistent with the transactional theory which posits that individuals use both types of coping somewhat equally (Folkman & Lazarus, 1980). ACOAs, however, used more emotion-focused coping than problem-focused coping (Clair & Genest, 1987). Of the emotion-focused category, ACOAs used wishful thinking and help seeking - help avoidance more than non-ACOAs, and used every avoidance-escape strategy (e.g., smoking, drinking, eating) more than non-ACOAs with the only exception being the use of medication (Clair & Genest, 1987). These avoidance coping patterns may have provided the ACOA with helpful strategies to cope in the unpredictable, inconsistent, chaotic, alcoholic environment.

Although both ACOAs and non-ACOAs appraised more situations as unchangeable than changeable, ACOAs relied on fewer coping strategies. These findings are consistent with other
results that ACOAs perceived less informative and emotional support to be available to them (Clair & Genest, 1987). That is, ACOAs may use fewer coping strategies because they do not have the information or the social support to implement different forms of coping. These findings suggest ACOAs are more restricted in their use of coping strategies.

One limitation of the above study includes the lack of examination of the stressors that the subjects reported. Perhaps ACOAs were found to use more emotion-focused coping because of the type of stressor they experienced. In a study of 100 community residing men and women aged 45 to 64, Folkman and Lazarus (1980) found the context of the reported stressor influenced whether problem-focused or emotion-focused coping was used. They noted “work was associated with higher levels of problem-focused coping, and health was associated with increased emotion-focused coping” (p. 230). In order to better understand the appraisal and coping process in relation to alcoholism, the present study will take into account the context of the stressor which participants will be asked to report.

The relationship between coping and alcoholism in ACOAs was further examined in a study of 90 clinical and non-clinical ACOAs and non-ACOAs aged 23 and older (Easley & Epstein, 1991). The purpose of the study was to examine the degree to which alcohol abuse and psychopathology were associated with self-reported family disruption, family coping and individual childhood coping.

Easley and Epstein (1991) found “a variety of individual and family coping strategies were associated with better or worse adult adjustment [i.e., alcoholism]” (p. 223). These findings are consistent with the transactional, cognitive-phenomenological theory which posits that the process between stress and the outcome includes appraisals and coping strategies such as those

A significant negative correlation was noted between individual positive reappraisal and ACOA alcoholism ($r = -0.20, p < .05$), and a significant positive correlation was found between self-reported family passive appraisal and ACOA alcoholism ($r = 0.30, p < .01$). Multiple-regression analyses revealed family passive appraisal accounted for 9% of the variance in adult ACOA alcoholism (Easley & Epstein, 1991). These results suggest passive, negative appraisals are related to the manifestation of alcoholism.

Easley and Epstein (1991) defined family passive appraisal as the perception of having little control over a stressor or appraising that the stress will go away with time. Family passive appraisal therefore appears to be a type of emotion-focused coping strategy due to the use of distancing or escape-avoidance strategies and less confrontive efforts. Refer to Appendix A. They also noted problem-solving coping was not correlated with alcoholism (Easley & Epstein, 1991). These findings suggest emotion-focused coping is related to ACOA alcoholism while problem-focused coping is not. However, as was the case with the previous study (Clair & Genest, 1987), this research did not take into account those stressors which were reported by ACOAs and non-ACOAs. The context of the stressor could have influenced the use of emotion-focused coping over problem-focused coping.

Some children of alcoholics tend to learn coping strategies within the family environment and are likely to exhibit such learned behaviours in adulthood (Beletsis & Brown, 1981). For example, the passive appraisal of alcoholism exhibited by the family (Easley & Epstein, 1991) may be perpetuated by the ACOA via the increased use of emotion-focused coping strategies such as distancing and escape-avoidance, and the decreased use of positive reappraisal (Easley &
Epstein, 1991). Such a coping process may allow for the continual tolerance and perpetuation of alcoholism.

Given that only the alcoholic has ultimate control over whether or not they drink, family members have little control over many alcohol related problems (Reddy & McElfresh, 1978). ACOAs are therefore less likely to perceive themselves as able to solve or change alcohol related problems. That is, ACOAs may be more likely to appraise interpersonal stressful situations involving the alcoholic parent as having to be accepted or as having to hold themself back from doing what they would like to do. Since such appraisals are related to emotion-focused coping (Folkman & Lazarus, 1980) (refer to Appendix A), ACOAs are also more likely to utilize emotion-focused coping than problem-focused coping, particularly in relation to such interpersonal stressful situations such as coping with an alcoholic family member.

The present study took into consideration the context of reported stressful situations to better understand the process of appraisal and coping with stress in relation to alcoholism. This study examined whether female ACOAs were more likely to be alcoholic than female non-ACOAs. It also examined whether female ACOAs differ from female non-ACOAs in terms of their appraisals of stressful situations and coping strategies used in the context of different stressful situations.
Hypotheses

In the present study it was expected that:

1. The rate of alcoholism would be higher within the ACOA sample than within the non-ACOA sample.

2.a) ACOAs would use appraisals of “I had to accept it or get used to it” more frequently than non-ACOAs when coping with interpersonal stressful situations.

b) ACOAs would use appraisals of “I had to hold myself back from doing what I wanted to do” more frequently than non-ACOAs when coping with interpersonal stressful situations.

3. ACOAs would use emotion-focused coping more frequently than non-ACOAs when coping with interpersonal stressful situations.

4. ACOAs would use problem-focused coping and emotion-focused coping strategies similarly to non-ACOAs when coping with non-interpersonal stressful situations.

Although hypotheses were stated indicating an expected directional difference, all statistical tests were non-directional in nature.

To better understand the results of the hypothesis testing, exploratory analyses were conducted to examine whether there was a relationship between age and the dependent variables. As well, exploratory analyses compared alcoholic and non-alcoholic respondents for age and for each dependent variable.
METHOD

Subjects

One hundred sixty-two adult females aged 19 to 65 were recruited from social service agencies, the general public, self-help groups, a university and two social functions. All respondents participated voluntarily. Participants were excluded from the study if they indicated they were currently residing with their parents. This exclusionary criterion was in place to ensure that reported stressful situations and ways of coping with stress were not affected by the immediate influence of parental alcohol use. For the demographic description of the subjects in this study, refer to the results section.

Three hundred three surveys were distributed and 218 were returned, therefore the return rate was 72%. Of the returned surveys, 169 were completed and 49 were returned blank yielding a response rate of 56%. Three surveys were only partially completed and were therefore excluded from subsequent analysis leaving 166 scorable surveys. Four subjects indicated they were currently residing with their parents. Since this was an exclusionary criterion, these four surveys were omitted. The remaining 162 surveys were used in subsequent analyses.

Measures

The measures used in this study included an appraisal questionnaire, a coping questionnaire, a screening test to assess whether the respondent was alcoholic, a screening measure to assess whether they were ACOA, and a demographic questionnaire. Given that the measures were presented as a survey, informed consent was not necessary for this study (American Psychological Association [APA], 1994b). Instead, an introduction letter was included in the survey package to provide the participant with general information regarding the study. See
Appendix C for the survey measures.

**Appraisal Measure**

The four appraisal items were appended to the Ways of Coping Questionnaire - Subscales (WCQ-Subscales). For the purpose of this study, the participant was first prompted to record a stressful situation which occurred within the past two weeks. Participants then indicated on a 5-point Likert type scale ranging from 0 (*not at all*) to 4 (*a great deal*), the extent to which each of the four appraisal statements best described their stressful situation. The four appraisal items which were used in the present study, include:

1. I could change or do something about it.
2. I had to accept it or get used to it.
3. I needed to know more about it before I could act.
4. I had to hold myself back from doing what I wanted to do.
   (Folkman & Lazarus, 1980; Folkman, et al., 1986).

Construct validity of this measure has been assessed in a study of 100 community-residing men and women (Folkman & Lazarus, 1980). Situations in which “something could be done” and in which “more information was needed” produced higher levels of problem-focused coping than was generated by situations which “had to be accepted”. As well, situations that “had to be accepted” and in which the person “had to hold themselves back”, produced higher levels of emotion-focused coping than was generated by situations in which “something could be done”. These results support the transactional, cognitive-phenomenological perspective by providing support for the relationship among these four appraisal items and coping.

**Ways of Coping Questionnaire (Subscales)**

The Ways of Coping Questionnaire (WCQ; Folkman & Lazarus, 1988) consists of 66 items describing a broad range of cognitive and behavioural strategies which may be used to cope with
perceived stressful situations. The response format is a 4-point Likert type frequency scale where: 0 indicates does not apply and/or not used, 1 indicates used somewhat, 2 indicates used quite a bit, and 3 indicates used a great deal (Folkman & Lazarus, 1988). The frequency that each coping strategy was used was answered in relation to the previously recorded stressful situation.

In a study of 85 married couples who were interviewed 5 times over the course of 6 months, 50 items that were considered to be theoretically relevant were factor analyzed. An eight factor solution was yielded (Folkman et al., 1986). The resultant subscales may be categorized into problem-focused coping (Confrontive Coping, and Planful Problem Solving), emotion-focused coping (Distancing, Self-Controlling, Accepting Responsibility, Escape-Avoidance, and Positive Reappraisal), and a mixed category of problem- and emotion-focused coping (Seeking Social Support). Internal consistency reliabilities for the factors ranged from a Cronbach’s alpha = .66 for Distancing to Cronbach’s alpha = .79 for Positive Reappraisal. Similar subscales and factor loadings have been identified elsewhere (Folkman & Lazarus, 1985).

For the purpose of this study, only select WCQ subscales were used in an attempt to reduce the length and ensure concision of problem-focused and emotion-focused coping. First, the Seeking Social Support subscale was eliminated because it includes both emotion-focused and problem-focused coping items. Second, the Positive Reappraisal subscale was removed because it sometimes confounds with problem-focused and mixed forms of coping. Along with Seeking Social Support, Positive Reappraisal has been noted to be moderately correlated with problem-focused coping (Folkman & Lazarus, 1985). In Folkman et al.’s 1986 study as outlined above, it was noted that people who appraised situations as changeable used more problem-focused
coping strategies including Confrontive Coping, Planful Problem Solving, and Positive Reappraisal. Given that Positive Reappraisal is related to appraisals of changeable, and this is a key factor of measure in the present study, Positive Reappraisal was omitted to ensure it did not confound with appraisals of changeable.

Finally, three of the 7 items in the Self-Controlling subscale were eliminated and the remaining four items were categorized as problem-focused coping strategies. Refer to Appendix D for the Self-Controlling subscale items. Similar categorization of Self-Controlling items has been used elsewhere (Haney, 1991; Haney & Long, 1995; Tobin, Holroyd, Reynolds, & Wigal, 1989). The remaining four items include “I tried not to burn my bridges, but leave things open somewhat”, “I tried not to act too hastily or follow my first hunch”, “I went over in my mind what I would say or do”, and “I thought about how a person I admire would handle this situation and used that as a model”.

The WCQ-Subscales used in this study contained three problem-focused coping subscales (Confrontive Coping, Planful Problem Solving, and Self-Controlling), and three emotion-focused coping subscales (Distancing, Accepting Responsibility, and Escape-Avoidance). Refer to Appendix C for the items included in the WCQ (Subscales).

Short Michigan Alcoholism Screening Test

The Short Michigan Alcoholism Screening Test (SMAST; Selzer, Vinokur, & van Rooijen, 1975) is a 13-item, shortened version of the 24-item Michigan Alcoholism Screening Test (MAST) (Selzer, 1971). The SMAST is a widely used self-report, screening device used in clinical practice and in research to discriminate between alcoholics and nonalcoholics. The items tap into a wide range of alcohol related effects. “Some of the questions are sufficiently neutral
that persons reluctant to see themselves as problem drinkers may reveal their alcoholic affliction” (Selzer, 1971, p. 1654).

Respondents answer the items with “yes” or “no”. Each alcoholism-indicating response is given one point. For items 1, 4, and 5 “no” responses are given one point, while all other items receive 1 point for “yes” responses. A summed score of 0-1 identifies nonalcoholics, a score of 2 indicates possible alcoholics, and 3 or more indentifies alcoholics (Selzer, et al., 1975). For the purpose of this study those individuials who were possibly alcoholic were recategorized in a conservative manner as not alcoholic.

The MAST was completed as part of a package of questionnaires by 501 males over the age of 20 in a large northern U.S.A. city) (Selzer et al., 1975). Those items which were relevant to the SMAST were drawn out and statistical analyses of the psychometric properties of the SMAST were conducted. The internal consistency reliability was high for males who were renewing their drivers license and attending driving school, for those attending inpatient and outpatient alcohol rehabilitation programs, and for both groups combined (α = .76, .78 and .93, respectively). Product-moment correlations between the SMAST and the MAST were very high for all three groups (r = .93, .90 and .97, respectively) (Selzer et al., 1975).

Children of Alcoholics Screening Test - 6

The Children of Alcoholics Screening Test (CAST) was developed as a preventative measure for early identification of (A)COAs (Jones, 1981; 1982; 1991). This measure was designed to identify latency-age, adolescent, and adult children who are living with, or have lived with one or more alcoholic parents. This tool has been used to identify (A)COAs for both research and clinical purposes “therefore, an attempt was made to include items sampling a wide
range of the experiences of [adult children who lived] in an alcoholic home” (Hodgins, Maticka-Tyndale, El-Guebaly, & West, 1993, p. 337). A shorter version, the CAST-6 has been developed (Hodgins et al., 1993).

The CAST-6 is a 6-item self-report inventory which requires yes / no answers. Refer to Appendix C. All “yes” answers are summed to yield a total score ranging from 0 to 6 with higher scores indicating a greater likelihood of parental alcoholism. For the purpose of this study, a conservative cut-off score of 3 was used. This conservative cut-off score has been noted to minimize false positives and maximize false negatives in a population of students reluctant to disclose parental alcohol use (Hodgins et al., 1993; Hodgins, Maticka-Tyndale, El-Guebaly, & West, 1995).

The CAST-6 has been noted to have high internal consistency reliability. In a study of 131 adults seeking short-term therapeutic outpatient psychiatric services, 90 adults seeking short-term community-based substance abuse treatment, and 110 medical students, internal consistency was assessed (Hodgins et al., 1993). Internal consistency, as measured by Cronbach’s alpha, ranged from .86 to .92 across the three samples. Item-total correlations for the CAST-6 ranged from .62 to .89 across the three samples, and correlations between the CAST and CAST-6 scores ranged from .92 to .94. Similar findings have been noted elsewhere (Hodgins & Shimp, 1995).

In validity studies, the CAST-6 was found to have moderate to high concurrent validity with other measures which identify ACOAs. In a study of 55 alcoholic volunteers recruited from a residential substance abuse treatment facility for women and a similar facility for men, concurrent validity was assessed in relation to ten other methods of identifying ACOAs (Hodgins & Shimp, 1995). The association between the CAST-6 and four single identifying questions was
examined using Kappa and multiple correlation coefficients. Kappa ranged from .48 to .90, and $R = 0.69 \ (p < 0.00001)$ to $R = 0.82 \ (p < 0.00001)$. Concurrent validity between the CAST-6 and other self-report measures and an interview format yielded Pearson correlation coefficients ranging from $r = 0.93, p < 0.0001$ to multiple correlations of $R = .82, p < 0.00001$ for continuous scale measures. Kappas between the CAST-6 and dichotomous scale measures ranged from .59 to .92. Agreement between the CAST-6 and an historical research interview yielded $K = .80$. These results suggest that the CAST-6 is a moderate to highly valid tool for identifying ACOAs.

**Demographic Questionnaire**

The demographic questionnaire elicited information about the age, ethnic identity, socio-economic status, and relationship status of the participants, as well as the socio-economic status of their parents. Refer to Appendix C. It also provided an exclusionary criterion. Participants residing with parents, were omitted from the study.

**Procedures**

The participants in the present study were recruited using purposive sampling procedures in an attempt to ensure possible alcoholic indicating responses and large numbers of women. Volunteers included clients and staff from four social service agencies. Participants from the general public included respondents at an information booth regarding Drug and Alcohol Awareness Week at a public mall, women living in the researcher's apartment building, and staff and customers at a local coffee shop. Volunteers were recruited from self-help groups including Alcoholics Anonymous (AA) and Adult Children of Alcoholics (ACOA) meetings. University volunteers were recruited from four senior classes and in response
to a poster calling for subjects. As well, female volunteers were recruited from two social functions. Refer to Table 1 for the frequencies and percentages of surveys completed in each area.

Table 1

<table>
<thead>
<tr>
<th>Area Data Collected From</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Service Agencies</td>
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<td>22.8</td>
</tr>
<tr>
<td>General Public</td>
<td>44</td>
<td>27.2</td>
</tr>
<tr>
<td>Self-Help Groups</td>
<td>18</td>
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<tr>
<td>University</td>
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<td>27.2</td>
</tr>
<tr>
<td>Social Functions</td>
<td>19</td>
<td>11.7</td>
</tr>
</tbody>
</table>

Participants from the social service agencies, the general public, and the social functions responded to a poster calling for female subjects to participate in the study. Refer to the poster in Appendix E. Completed surveys were placed in a sealed drop box. A contact member of an Alcoholics Anonymous group (AA) and two contact members from two different Adult Children of Alcoholic groups (ACOA) distributed the surveys to groups members following their meetings. Members were provided the opportunity to refuse to participate; as well they were provided the opportunity to return the surveys either completed or blank to the following meeting.

The researcher attended four senior university classes: one psychology and three counselling
classes. The female students were provided the opportunity to refuse to participate, or to return their surveys either completed or blank. Participants were provided the opportunity to complete the surveys in class. The researcher collected the surveys immediately following completion. Participants who responded to the poster calling for female subjects telephoned the advising supervisor who provided the researcher with information to contact these participants. These participants were provided the surveys at scheduled appointments. They completed the surveys at their own leisure and returned them to the advising supervisor's mail box.

All participants in the study were provided the opportunity to mail or leave their survey in the advising supervisor's mail box. Participants were provided with a brief introduction to the study. Refer to the Introduction Letter in Appendix C and the Poster Calling for Participants in Appendix E. Participants from the university were provided this information verbally. Any questions asked by participants were provided with like information found in the Introduction Letter.

Participants completed the survey package containing the Introductory Letter, WCQ-Subscales including the appraisal measure, SMAST, CAST-6, and demographic questionnaire. Refer to Appendix C for the survey package. The titles and scoring instructions were removed from all questionnaires prior to distribution.

The reported stressful situations were coded independently by two raters as interpersonal or non-interpersonal. Situations were coded as *interpersonal* when social distress was indicated. Interpersonal stress was defined as stress or distress that was due to social interaction or the lack of social interaction between two or more individuals; for example, "I had a fight with my partner". It also included situations in which the respondent experienced stress for someone
else’s stressful situation; for example, “My partner is overworked”. *Non-interpersonal* stressful situations included responses in which no social interaction was indicated. For example, work and health related stress which did not include distress in relation to another individual was coded as non-interpersonal, such as “The computer at work broke down”. Situations which included both interpersonal and non-interpersonal stress were coded as *interpersonal*.

**Statistical Analyses**

Descriptive statistics were calculated from the demographics questionnaire data in order to describe the sample in regards to age, ethnic identity, socio-economic status, and relationship status of the participants, as well as the socio-economic status of their parents.

Hypothesis #1 was tested using a chi-square goodness-of-fit analysis to evaluate whether the rate of alcoholism was significantly higher within the ACOA sample than within the non-ACOA sample. For the two parts of hypothesis #2, one-way ANOVAs were performed using only the interpersonal stressful situations to evaluate the differences between ACOAs and non-ACOAs for Appraisal #2 (“I had to accept it or get used to it”) and Appraisal #4 (“I had to hold myself back from doing what I wanted to do”). Hypothesis #3 was tested using one-way ANOVA for only the interpersonal stressful situations to evaluate the differences between ACOAs and non-ACOAs for emotion-focused coping. Hypothesis #4 was tested using one-way ANOVA for only the non-interpersonal stressful situations to evaluate whether ACOAs and non-ACOAs differ for emotion-focused coping and problem-focused coping.

Exploratory analyses were conducted to better understand the results of the hypotheses. Correlations were calculated in order to explore the relationship and strength of relationship among the dependent variables (four types of appraisal, total appraisal score, and the two factors
of the WCQ-Subscales) and age. Means and standard deviations were compared for alcoholic and non-alcoholic indicating respondents for age and the dependent variables.
RESULTS

Descriptive Statistics on the Demographic Variables

The female participants were 19 to 65 years old (M = 36, SD = 10.1). Eighty-six percent were White/Caucasian/European. Fifty-nine percent were married or living in a common-law relationship, and 23% were single. The respondents were predominantly of middle-class status. The modal range of current annual household income was over $55,001. The modal response of parents' highest level of education achieved was secondary school. Refer to Table 2 for the descriptive results of the demographic variables for the entire sample as well as for ACOAs and non-ACOAs.

Descriptive Statistics of the SMAST and CAST-6

The descriptive statistics of the SMAST identified 19% of the respondents as alcoholic (n = 31) and 80% as non-alcoholic (n = 129). The CAST-6 identified 38% of the respondents as ACOAs (n = 62) and 61% as non-ACOAs (n = 99).

Inter-rater Reliability

One hundred sixty-five stressful situations were scored independently by two raters to determine whether they were interpersonal or non-interpersonal. Exact agreement between the raters yielded an inter-rater agreement of 92%. The remaining 8% were resolved through discussion to result in 118 interpersonal (72%) and 47 non-interpersonal (28%) stressful situations.
Table 2

Descriptive Results of the Demographic Variables for the Total Sample, Adult Children of Alcoholics (ACOA), and Adult Children of non-Alcoholics (non-ACOA)

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Total Sample (N = 162)</th>
<th>ACOA (n = 62)</th>
<th>Non-ACOA (n = 99)</th>
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<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
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<td>37.10</td>
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<td>8</td>
</tr>
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<td>Secondary School</td>
<td>44</td>
<td>27.2</td>
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<td>Technical/ Trade School</td>
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<td>7</td>
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<td>College Diploma/ University Degree</td>
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(table continues)
Table 2. (continued)

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<td>16.2</td>
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<tr>
<td>Female Primary Caregiver</td>
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<td>10</td>
<td>16.1</td>
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<td>17.2</td>
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<td>56.5</td>
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<td>50.5</td>
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<td>9.1</td>
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<tr>
<td>Technical/ Trade School</td>
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<tr>
<td>College Diploma/ University Degree</td>
<td>29</td>
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<td>9</td>
<td>14.5</td>
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<td>20.2</td>
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<td>Master’s Degree</td>
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<td>1.9</td>
<td>1</td>
<td>1.6</td>
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<td>2.0</td>
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<tr>
<td>Male Primary Caregiver</td>
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<td>23</td>
<td>37.1</td>
<td>24</td>
<td>24.2</td>
</tr>
<tr>
<td>Elementary School</td>
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<td>21</td>
<td>33.9</td>
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<td>29.3</td>
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<tr>
<td>Secondary School</td>
<td>35</td>
<td>21.6</td>
<td>7</td>
<td>11.3</td>
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<td>28.3</td>
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<td>Technical/ Trade School</td>
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<td>College Diploma/ University Degree</td>
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</table>

**Note.** \( f \) = frequency
Test of Hypotheses

The hypotheses were tested using chi-square goodness-of-fit analysis and one-way analysis of variance (ANOVA). All statistical tests were computed using an alpha level set at .05.

A chi-square goodness-of-fit analysis was computed to determine whether the rate of alcoholism was higher among ACOAs than non-ACOAs. Nineteen percent of the total sample were alcoholic. There was a significant difference in the proportion of ACOAs who were alcoholic (26.2%) and non-ACOAs who were alcoholic (14.3%); $\chi^2(1, N = 159) = 3.50, p < .05$). This suggests that ACOAs may be more likely to be alcoholic than non-ACOAs.

A One-way ANOVA was computed to determine whether there were significant differences between ACOAs and non-ACOAs in the use of Appraisal #2 ("I had to accept it or get used to it") in the context of interpersonal stressful situations. The results indicated that non-ACOAs ($M = 2.24, SD = 1.44$) used Appraisal #2 more frequently than ACOAs ($M = 1.69, SD = 1.58$) in the interpersonal context ($F(1,109) = 3.67, p < .05$). This suggests, that non-ACOAs tend to use more appraisals of "I had to accept it or get used to it" than ACOAs in the context of interpersonal stressful situations. Refer to Table 3 for the results of the hypothesis testing.

A one-way ANOVA was computed to determine whether there were significant differences between ACOAs and non-ACOAs in the use of Appraisal #4 ("I had to hold myself back from doing what I wanted to do") in the context of interpersonal stressful situations. No significant differences were found between ACOAs ($M = 2.18, SD = 1.48$) and non-ACOAs ($M = 2.30, SD = 1.58$) in the use of Appraisal #4 in interpersonal stressful situations ($F(1,109) = .18, p > .05$). This finding suggests that ACOAs and non-ACOAs tend to use Appraisal #4 ("I had to hold myself back from doing what I wanted to do") similarly in interpersonal stressful situations.
A one-way ANOVA was computed to determine whether there were significant differences between ACOAs and non-ACOAs in the use of emotion-focused coping in the context of interpersonal stressful situations. No significant differences were found between ACOAs ($M = 15.91, SD = 10.19$) and non-ACOAs ($M = 16.58, SD = 9.27$) in the use of emotion-focused coping in interpersonal stressful situations ($F(1,109) = .13, p > .05$). This finding suggests that ACOAs and non-ACOAs tend to use emotion-focused coping similarly in interpersonal stressful situations. Refer to Table 3. However, emotion-focused coping was significantly correlated with age ($r = -.23, p < .05$) suggesting that older respondents use less emotion-focused coping. Refer to Table 4.

One-way ANOVAs were computed to determine whether ACOAs and non-ACOAs used problem-focused coping and emotion-focused coping strategies similarly in non-interpersonal stressful situations. No significant differences were found between ACOAs ($M = 21.75, SD = 5.64$) and non-ACOAs ($M = 20.80, SD = 7.28$) for problem-focused coping ($F(1,44) = .21, p > .05$). As well, no significant differences were found between ACOAs ($M = 18.94, SD = 7.40$) and non-ACOAs ($M = 17.27, SD = 8.22$) for emotion-focused coping ($F(1,44) = .46, p > .05$). These findings suggest that ACOAs and non-ACOAs tend to use problem-focused coping and emotion-focused coping similarly in non-interpersonal stressful situations. Refer to Table 3.

Exploratory Analyses

Exploratory analyses were conducted to better understand the results of the hypotheses testing. Correlations were calculated to explore the relationship and strength of relationship among age and the dependent variables. Refer to Table 4 for the correlation matrix. Since
specific relationships are to be discussed a Bonferroni-like correction was applied to the alpha level. Hence significance was claimed if $p < .007$. Mean differences and standard deviations were also explored to compare Alcoholic and non-Alcoholic indicating respondents on age and the dependent variables. Refer to Table 5.

The correlation matrix explored the relationship among age and the appraisal items and coping strategies for the total sample. Refer to Table 4. A significant negative correlation was found between age and emotion-focused coping ($r = -.23, p < .007$) suggesting that older respondents used less emotion-focused coping. The relationship between Appraisal #4 ("I had to hold myself back from doing what I wanted to do") and emotion-focused coping was significant ($r = .28, p < .007$). This finding suggests that increased use of Appraisal #4 is related to increased use of emotion-focused coping. This is in keeping with the literature (Folkman & Lazarus, 1980).

Mean differences were compared between Alcoholic and non-Alcoholic indicating respondents for the appraisal items and coping strategies. Refer to Table 5 for the resultant means and standard deviations of Alcoholic and non-Alcoholic indicating respondents in all stressful situations. Mean differences between Alcoholic and non-Alcoholic indicating respondents appear to be similar for all appraisal items and problem-focused coping. There may be significant differences, however, between Alcoholic indicating respondents ($M = 22.97, SD = 10.69$) and non-Alcoholic indicating respondents ($M = 15.47, SD = 8.03$) for the tendency to use emotion-focused coping. These differences were not tested due to the unequal size of the groups (Alcoholics $n = 30$, non-Alcoholics $n = 129$).
Table 3

**Analysis of Variance for Appraisal and Coping Between Adult Children of Alcoholics (ACOA) and Adult Children of non-Alcoholics (non-ACOA)**

<table>
<thead>
<tr>
<th>Hypothesis Number</th>
<th>Dependent Variable</th>
<th>ACOA</th>
<th>non-ACOA</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(n = 45)</td>
<td>(n = 66)</td>
<td>F-ratio</td>
<td></td>
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<tr>
<td>2.a)</td>
<td>Appraisal #2*</td>
<td>1.69</td>
<td>1.58</td>
<td>2.24</td>
<td>1.44</td>
</tr>
<tr>
<td>2.b)</td>
<td>Appraisal #4*</td>
<td>2.18</td>
<td>1.48</td>
<td>2.30</td>
<td>1.59</td>
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<table>
<thead>
<tr>
<th>Hypothesis Number</th>
<th>Dependent Variable</th>
<th>ACOA</th>
<th>non-ACOA</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>(n = 16)</td>
<td>(n = 30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Problem-focused Coping</td>
<td>21.75</td>
<td>5.64</td>
<td>20.80</td>
<td>7.28</td>
</tr>
<tr>
<td>4.</td>
<td>Emotion-focused Coping</td>
<td>18.94</td>
<td>7.40</td>
<td>17.27</td>
<td>8.22</td>
</tr>
</tbody>
</table>

*Appraisal #2 = “I had to accept it or get used to it”; Appraisal #4 = “I had to hold myself back from doing what I wanted to do”

Note. * p < .05
Table 4

Correlations of Age and Dependent Variables for the Total Sample (n = 161)

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Problem- Focused Coping</th>
<th>Emotion- Focused Coping</th>
<th>Appraisal #1</th>
<th>Appraisal #2</th>
<th>Appraisal #3</th>
<th>Appraisal #4</th>
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<td>.13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping</td>
<td></td>
<td>p = .110</td>
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<td></td>
</tr>
<tr>
<td>Emotion- Focused</td>
<td>-.23</td>
<td>.23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping</td>
<td></td>
<td>p = .003*</td>
<td>p = .004*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisal #1</td>
<td>-.03</td>
<td>.27</td>
<td>.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>p = .734</td>
<td>p = .001*</td>
<td>p = .334</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisal #2</td>
<td>-.13</td>
<td>-.05</td>
<td>.11</td>
<td>-.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>p = .112</td>
<td>p = .548</td>
<td>p = .166</td>
<td>p = .000*</td>
<td></td>
</tr>
<tr>
<td>Appraisal #3</td>
<td>.04</td>
<td>.11</td>
<td>-.06</td>
<td>.15</td>
<td>.13</td>
<td></td>
</tr>
<tr>
<td>Appraisal #4</td>
<td>.06</td>
<td>.14</td>
<td>.28</td>
<td>.05</td>
<td>.03</td>
<td>.13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>p = .447</td>
<td>p = .084</td>
<td>p = .000*</td>
<td>p = .522</td>
<td>p = .744</td>
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<td>-.03</td>
<td>.22</td>
<td>.20</td>
<td>.42</td>
<td>.42</td>
<td>.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>p = .747</td>
<td>p = .006*</td>
<td>p = .013</td>
<td>p = .000*</td>
<td>p = .000*</td>
</tr>
</tbody>
</table>

Note. Appraisal #1 is "I could change or do something about it." Appraisal #2 is "I had to accept it or get used to it." Appraisal #3 is "I needed to know more about it before I could act." Appraisal #4 is "I had to hold myself back from doing what I wanted to do." *p < .007
Table 5

Means and Standard Deviations of Alcoholic and non-Alcoholic Indicating Respondents for Age and Dependent Variables

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Alcoholic</th>
<th>Non-Alcoholic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (n = 30)</td>
<td>M (n = 128)</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>SD</td>
</tr>
<tr>
<td>Age</td>
<td>34.97</td>
<td>36.59</td>
</tr>
<tr>
<td></td>
<td>10.16</td>
<td>10.08</td>
</tr>
<tr>
<td>Appraisal #1</td>
<td>1.53</td>
<td>1.64</td>
</tr>
<tr>
<td></td>
<td>1.36</td>
<td>1.43</td>
</tr>
<tr>
<td>Appraisal #2</td>
<td>2.57</td>
<td>2.19</td>
</tr>
<tr>
<td></td>
<td>1.45</td>
<td>1.48</td>
</tr>
<tr>
<td>Appraisal #3</td>
<td>1.37</td>
<td>1.33</td>
</tr>
<tr>
<td></td>
<td>1.54</td>
<td>1.47</td>
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<tr>
<td>Appraisal #4</td>
<td>2.63</td>
<td>2.13</td>
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<tr>
<td></td>
<td>1.33</td>
<td>1.52</td>
</tr>
<tr>
<td></td>
<td>(n = 30)</td>
<td>(n = 129)</td>
</tr>
<tr>
<td>Problem-Focused Coping</td>
<td>22.43</td>
<td>21.88</td>
</tr>
<tr>
<td>Emotion-Focused Coping</td>
<td>22.97</td>
<td>15.47</td>
</tr>
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<td></td>
<td>7.56</td>
<td>6.97</td>
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<tr>
<td></td>
<td>10.69</td>
<td>8.03</td>
</tr>
</tbody>
</table>

Note. Appraisal #1 is "I could change or do something about it." Appraisal #2 is "I had to accept it or get used to it." Appraisal #3 is "I needed to know more about it before I could act." Appraisal #4 is "I had to hold myself back from doing what I wanted to do."
DISCUSSION

Upon testing the first hypothesis it was expected that the rate of alcoholism would be higher within the ACOA sample than within the non-ACOA sample. Results suggest that there was a significantly higher proportion of alcoholic ACOAs (26%) than alcoholic non-ACOAs (14%). Although these results indicate that the rate of alcoholism is higher within the ACOA group than within the non-ACOA group, these findings must be reviewed with caution due to the use of a small sample size (alcoholic ACOAs, \( n = 16 \); alcoholic non-ACOAs, \( n = 14 \)).

These findings are contradictory to those of Wright and Heppner (1991) who studied 40 ACOA college freshmen (20 male and 20 female) and 40 non-ACOA college freshmen (20 male and 20 female). They found no differences between ACOAs and non-ACOAs for drug and alcohol use. In a follow-up study however, Wright and Heppner (1993) used a similar sample of college freshmen, 40 ACOAs and 40 non-ACOAs, and similar testing measures. They found ACOAs were at significantly higher risk for moderate and high substance use than non-ACOAs. Given these mixed results, these findings suggest that the presence of alcoholism is a complex phenomenon. The presence of alcoholism may be better understood by examining mediating or moderating variables such as appraisal and coping.

Past researchers (e.g., Cotton, 1979; Schuckit, 1984) have found ACOAs at increased risk for alcoholism as compared to non-ACOAs however, these studies have mainly researched clinical samples of ACOAs. More current research suggests that ACOAs and non-ACOAs do not differ in alcohol use (Mintz, Kashubeck, & Tracy, 1995; Wright & Heppner, 1991). These more current studies, however, have examined predominantly college freshmen samples. Freshmen college students comprise a population that is suspected to consume more alcohol than
age related peers, thus providing for increased similarities between ACOAs and non-ACOAs in alcohol consumption. As well, the literature suggests that college ACOAs are more resilient than clinical samples of ACOAs (Kashubeck & Christensen, 1992) therefore providing the possibility of increased similarities between college student ACOAs and non-ACOAs.

The present study attempted to correct for the earlier trend of using predominantly clinical samples as well as the more current trend of using predominantly freshmen college and university students, by recruiting female participants from a number of diverse locations throughout a rural community. Refer to Table 1 for the areas of data collection. This method of data collection provided for greater ecological validity. The present findings using this diverse female sample indicated that ACOAs may be more likely to be alcoholic than non-ACOAs.

For the first part of hypothesis #2, ACOAs and non-ACOAs were compared to examine differences in the use of the appraisal “I had to accept it or get used to it” when appraising interpersonal stressful situations. It was expected that ACOAs would use appraisals of “I had to accept it or get used to it” more frequently than non-ACOAs because earlier literature suggests ACOAs appraise more problem situations as uncontrollable (Domenico & Windle, 1993) or unchangeable and requiring acceptance than non-ACOAs (Clair & Genest, 1987). Results of the present study suggest that non-ACOAs used appraisals of “I had to accept it or get used to it” more frequently than ACOAs when appraising interpersonal stressful situations. This finding is contradictory to previous research (Clair and Genest, 1987; Domenico & Windle, 1993). In a study of 30 ACOAs and 40 non-ACOAs recruited by newspaper and poster advertisements at a university, an institute of applied arts and technology, and through contacts at Alcoholic Anonymous, Al-Anon meetings, and throughout the community, ACOAs were found to have a
greater tendency to appraise problem situations in their alcoholic family as unchangeable or requiring acceptance (Clair and Genest, 1987). That is, the majority of ACOAs (93.2%) were found to appraise problem situations as having to be accepted or gotten used to. They appraised these problem situations as uncontrollable.

The study conducted by Clair and Genest (1987), however, includes a major limitation. It limited the respondent to report only stressful situations that occurred within the family. As well, it did not take into account the specific stressful situation that was reported. In a study of 100 community residing men and women, it was found that context and appraisal are significantly related (Folkman & Lazarus, 1980). For example, health related stressful situations are most often appraised as having to be accepted, while work related stressful situations are appraised as permitting one to do something constructive (Folkman & Lazarus, 1980). Therefore, it is of great importance to consider the context of the stressful situation when attempting to examine differences between ACOAs and non-ACOAs in regards to the amount of appraisal used.

Unlike the study conducted by Clair and Genest (1987), the present study took into account the reported stressful situation and found that non-ACOAs tended to report more frequent use of appraisals of having to accept or get used to interpersonal stressful situations than ACOAs. This suggests that ACOAs perceive interpersonal stressful situations as controllable or changeable more frequently than do non-ACOAs. That is, ACOAs experience a sense of controllability over interpersonal stressful situations more so than do non-ACOAs.

For the second part of hypothesis #2, it was expected that ACOAs would use appraisals of “I had to hold myself back from doing what I wanted to do” more frequently than non-ACOAs in
the context of interpersonal stressful situations. The results of the present study did not support this hypothesis. Rather, ACOAs and non-ACOAs were found to use this appraisal similarly in interpersonal stressful situations.

This finding is similar to that found by Clair and Genest (1987). They found no significant differences between ACOAs and non-ACOAs in regards to the amount of the appraisal “I had to hold myself back from doing what I wanted to do” in problem situations. Together with the findings of the present study, this suggests that ACOAs are similar to non-ACOAs in their use of the appraisal “I had to hold myself back from doing what I wanted to do”.

As noted earlier appraisal and context are significantly related (Folkman & Lazarus, 1980). Since ACOAs and non-ACOAs reported similar use of interpersonal and non-interpersonal stressful situations, this may contribute to the similarities between these two groups on the use of the appraisal “I had to hold myself back from doing what I wanted to do”.

For the third hypothesis it was expected that ACOAs would use emotion-focused coping more frequently than non-ACOAs when coping with interpersonal stressful situations. It was found that ACOAs and non-ACOAs use emotion-focused coping similarly. This finding suggests that ACOAs do not cope differently from non-ACOAs in regards to using emotion focused coping in interpersonal stressful situations, indicating that ACOAs are no less adaptive in using this form of coping than non-ACOAs.

The founding members of the ACOA movement (e.g., Black, 1981, 1990; Brown, 1988, 1992; Woititz, 1983) suggest that ACOAs are maladjusted due to the chaos, inconsistency and unpredictability within the alcoholic home environment. They suggest that even socially attractive coping strategies eventually breakdown and become maladaptive. Clair and Genest
(1987) propose to have found support for this proposition. In a study of 30 ACOAs and 40 non-ACOAs they found ACOAs used more emotion-focused coping strategies such as wishful thinking and escape-avoidance than problem-focused coping while non-ACOAs used similar amounts of both emotion- and problem-focused coping. They conclude that the patterns of coping used by ACOAs are consistent with those modelled by alcoholic parents. However, as noted earlier a major limitation of their study, is that it did not take into account the stressful situation reported by the respondents.

The present study took into account the stressful situations which were reported and found results that are more consistent with those of El-Guebaly and Offord (1977, 1979) and Burk and Sher (1988) who found ACOAs to be as equally adjusted as non-ACOAs. The present study found ACOAs and non-ACOAs used emotion-focused coping similarly in interpersonal stressful situations. These findings suggest that ACOAs use distancing, accepting responsibility and escape-avoidance as frequently as do non-ACOAs. Together with the findings of hypothesis #2b), these results suggest that ACOAs are no less adaptive in using the appraisal “I had to hold myself back from doing what I wanted to do” and emotion-focused coping in interpersonal stressful situations.

Exploratory analyses were conducted to better understand the relationship between appraisal and coping. The literature (Folkman & Lazarus, 1980; Folkman et al., 1986) suggests there is a relationship between appraising a situation with “having to hold oneself back from doing what they want to do” and emotion-focused coping. The present study found a significant positive relationship between this appraisal and emotion-focused coping ($r = .28$, $p < .05$), indicating that the more a situation is appraised with “having to hold oneself back”, the more emotion-focused
coping is used, and vice versa. Since there were no significant differences between ACOAs and non-ACOAs for the use of the appraisal “I had to hold myself back from doing what I wanted to do” and emotion-focused coping, examined in the context of the positive relationship between this appraisal and emotion-focused coping, it is understandable that the present findings were noted. That is, more frequent or less frequent use of the appraisal may account for more frequent or less frequent use of emotion-focused coping, and vice versa. The recursive relationship between this appraisal and emotion-focused coping may reciprocate the use of the other.

For the fourth hypothesis it was expected that ACOAs would use coping strategies as frequently as non-ACOAs in non-interpersonal stressful situations. ACOAs and non-ACOAs were examined for differences in the frequency of problem- and emotion-focused coping in non-interpersonal stressful situations. It was found that ACOAs and non-ACOAs use both problem-focused and emotion-focused coping similarly in non-interpersonal stressful situations.

These findings are similar to those of Folkman and Lazarus (1980) who studied 100 community residing men and women. They found non-interpersonal stressful situations such as work are most often coped with using problem-focused coping strategies and non-interpersonal stressful situations such as health are most often coped with using emotion-focused coping strategies. The findings of the present study also suggest that non-interpersonal stressful situations are coped with in a similar manner by both ACOAs and non-ACOAs. These findings further indicate that ACOAs are as equally adjusted as non-ACOAs when coping with non-interpersonal stressful situations.

Age and Coping

Emotion-focused coping was negatively correlated with age ($r = -.23, p < .007$) suggesting
that older respondents use less emotion-focused coping. This finding is contradictory to that found by Folkman and Lazarus (1980). In a study of 100 community residing men and women, they found older respondents used less emotion-focused coping as a result of the type of stressful situation reported, and not as a direct result of ageing. For example, they found emotion-focused coping is most often used in health-related stressful situations. Since older respondents reported coping with more health-related problems, they used more emotion-focused coping. The present study did not focus specifically on health-related stressful situations but rather examined non-interpersonal stressful situations in general. It would be of benefit for future research to further examine the appraisal and coping process of ACOAs in specific stressful situations such as health-related situations.

**Alcohol Groups**

The mean differences between the alcoholic (n = 30) and non-alcoholic (n = 129) indicating respondents suggest they used similar amounts of appraisal and problem-focused coping in stressful situations. Refer to Table 5. However, alcoholic indicating respondents used more emotion-focused coping (M = 22.97, SD = 10.69) than non-alcoholic indicating respondents (M = 15.47, SD = 8.03) in stressful situations. This suggests that alcoholic indicating respondents may use more emotion-focused coping strategies such as distancing, accepting responsibility and escape avoidance when coping with stressful situations. Such strategies may enable the perpetuation of alcoholism. Due to the largely unequal group sizes, however, further research is necessary to draw more conclusive results regarding the appraisal and coping process between alcoholic and non-alcoholic respondents.
Summary

The results of the present study suggest that ACOAs may be more likely to be alcoholic than non-ACOAs, however, the results also suggest that ACOAs are equally adjusted if not better adjusted than non-ACOAs in regards to appraisal and coping with stress. ACOAs were found to appraise interpersonal stressful situations as controllable or changeable more frequently than non-ACOAs. As well, ACOAs used the appraisal “I had to hold myself back from doing what I wanted to do” and coped using problem-focused and emotion-focused coping strategies similarly to non-ACOAs.

Previous studies, particularly those of leading ACOA movement founders (i.e., Black, 1980, 1990; Brown, 1992; Woititz, 1983), have supported the uniformity myth and have posited that all ACOAs either cope in maladaptive ways or ultimately their healthy and socially valued coping strategies break down into maladaptive coping strategies. The present findings, however, suggest that the differences within the ACOA group were as variable as those within the non-ACOA group. That is, ACOAs are as well adjusted as non-ACOAs in regards to the coping process, providing support against the uniformity myth.

Implications for Therapy

The results of this study suggest that ACOAs may be at an increased risk for alcoholism than non-ACOAs. Given this possibility for increased risk for alcoholism in ACOAs, it would be of benefit if early preventive measures were put in place to support ACOAs against becoming alcoholic. Children of alcoholic parents (COA) may require further education and training against alcoholism than is presently provided in the school system. Prevention programs may include additional information, support, and training seminars in the elementary and secondary
school systems. Educators and therapists, however, are cautioned against overpathologizing COAs and ACOAs. Therefore, such programs may be most beneficial if provided to all students regardless of (A)COA status.

Since ACOAs were found to be as well adjusted as non-ACOAs in regards to appraisal and coping with stress, therapists must be careful not to make assumptions based solely on ACOA status. ACOAs did not form a uniform group based only on the presence of an alcoholic parent, rather they appraised and coped with stressful situations in much the same way as female non-ACOAs. Therefore, it would be of great benefit to the ACOA client for therapists to attend to the issues which ACOA clients bring to the therapeutic session. Therapists are cautioned against focusing on the client’s ACOA status such as the alcoholic parent or past familial history, and popular psychology stereotypes. Rather, therapists are encouraged to attend to the presenting problems and stresses presented in therapy in much the same way they would for non-ACOAs.

Implications for Future Research

ACOAs were found to be possibly at increased risk for alcoholism. It is not possible, however, to state that all ACOAs are at risk for becoming alcoholic. The sample size of the present study was too small to make such conclusions. It is recommended that future research use a much larger sample size when exploring the possibility of ACOAs becoming alcoholic. As well, future research may simply attempt to replicate the present findings using a similar sample.

Since there were no differences between ACOAs and non-ACOAs, in regards to the coping process, this indicates there is a similar amount of variability within the ACOA group as within the non-ACOA group. Such similarities may be due to having drawn the sample from a diverse range of areas (i.e., social services, the general public, self-help groups, a university setting, and
social functions). It would be of benefit in future research to continue examining from such diverse areas, and to examine for differences both within and between these areas.

The present research compared ACOAs and non-ACOAs based on the presence or absence of parental alcoholism. It may be important in future research to consider a much wider range of determining factors, "especially phenomenological factors that help elucidate the meaning attributed to [...] events" (Wright & Heppner, 1993) such as increased and decreased distress due to parental alcohol use. As well it would be of benefit to explore more specifically stressful situations that are related to differences in appraisal and coping between ACOAs and non-ACOAs. That is, participants can be prompted to report stressful situations related to specific events such as health-related stressful situations.

Finally, it was not possible to compare alcoholic ACOAs (n = 16) and alcoholic non-ACOAs (n = 14) due to the small sample size. This is an area of research that is greatly lacking. Future research aimed at larger sample sizes may be able to further clarify differences between alcoholic ACOAs and alcoholic non-ACOAs in regards to appraisal and coping.

Limitations

The present results are generalizable with caution to women aged 19 to 65 from a rural community for areas similar to those from which the present participants were recruited (i.e., social service agencies, and senior university classes). Future research may build on the present study by examining other populations (i.e., children and men), as well as by examining for possible gender differences in appraisal and coping.

The sample in the present study was drawn from locations where there was an increased likelihood of women and possible alcoholism indicating responses (i.e., social functions that
include alcohol use). This purposive sampling procedure may have provided for increased amounts of alcohol indicating responses, as well as provided for a less than random sample. Future research may benefit by using more rigorous sampling procedures from equally as large and diverse locations, to provide a more sound study.

Due to the fairly small sample size, it was necessary to use a cut-off score to distinguish between ACOAs and non-ACOAs. It may be more rigorous for larger studies to use the top and bottom quartiles of scores on the ACOA indicating measure to categorize participants into ACOA group status. As well, the use of a cut-off score does not allow for the examination of possible variability between expressed degrees of distress over reported parental alcoholism.

Although the SMAST is a widely used, credible measure of possible alcoholism, it does not distinguish between past alcohol use and current alcohol use. It would be of benefit for future studies to include distinguishing descriptors in the questionnaire to receive reports of use during either time period.

Conclusions

The present study suggests that ACOAs may be at risk for alcoholism, however, further research is necessary before such conclusions can be drawn. As well, the present study did not provide support for the uniformity myth regarding ACOAs. Rather, it was found that ACOAs are just as variable as non-ACOAs is regards to appraisal and coping. These findings suggest that therapists should guard against stereotyping ACOAs based on parental alcohol use and should attend to the issues and stresses expressed by ACOAs in much the same way they would for non-ACOAs. More research is necessary to further explore differences and similarities both within ACOA samples and between ACOAs and non-ACOAs.
REFERENCES


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Roe, A., & Burks, B. (1945). Adult adjustment of foster children of alcoholics and psychotic parentage and the influence of the foster home. In *Memoirs of the section of*
alcoholism studies, No. 3. New Haven University Press.


APPENDIX A

Corresponding coping strategies to problem-focused and emotion-focused coping

Corresponding appraisals to problem-focused and emotion-focused coping
### Corresponding Coping Strategies to Problem-focused and Emotion-focused Coping

<table>
<thead>
<tr>
<th>coping strategies</th>
<th>Corresponding coping strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem-focused coping</td>
<td>• Confrontive Efforts</td>
</tr>
<tr>
<td></td>
<td>• Planful Problem Solving</td>
</tr>
<tr>
<td></td>
<td>• Seek Social Support*</td>
</tr>
<tr>
<td>Emotion-focused coping</td>
<td>• Distancing</td>
</tr>
<tr>
<td></td>
<td>• Escape-Avoidance</td>
</tr>
<tr>
<td></td>
<td>• Accepting Responsibility or Blame</td>
</tr>
<tr>
<td></td>
<td>• Exercise Self-Control</td>
</tr>
<tr>
<td></td>
<td>• Seek Social Support*</td>
</tr>
<tr>
<td></td>
<td>• Positive Reappraisal</td>
</tr>
</tbody>
</table>

*Seek Social Support may be conceptualized as a form of both problem-focused coping and emotion-focused coping.*
Corresponding Appraisals to Problem-focused and Emotion-focused Coping

<table>
<thead>
<tr>
<th>Problem-focused coping</th>
<th>Emotion-focused coping</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I can change or do something about it.</td>
<td>• I had to accept or get used to it.</td>
</tr>
<tr>
<td>• More information was required before I could act.</td>
<td>• I had to hold myself back from doing what I wanted to do.</td>
</tr>
<tr>
<td><strong>Appraised as Changeable</strong></td>
<td><strong>Appraised as Unchangeable, or</strong></td>
</tr>
<tr>
<td><strong>Not having any control over the situation</strong></td>
<td><strong>Not having any control over the situation</strong></td>
</tr>
</tbody>
</table>

Compiled from:


APPENDIX B

How to Recognize the Adult Child

ACOA Coping Strategies

Characteristics and Personality Traits
How to Recognize the Adult Child

- We become isolated and afraid of other people, especially authority figures.
- We are frightened by anger and any personal criticism.
- We judge ourselves harshly and have low self-esteem.
- We don’t act - we react.
- We are dependent personalities who are terrified of abandonment.
- We will do anything to hold on to a relationship. This is the way we avoid feeling the pain of our parents not having been there for us emotionally.
- We become alcoholics, marry them, or do both. Or we find another compulsive personality, such as a workaholic or an overeater, with whom we continue to play out our fear of abandonment.
- We become addicted to excitement from years of living in the midst of a traumatic and often dangerous family soap opera.
- We live life from the viewpoint of victims or rescuers and are attracted to victims or rescuers in our love, friendship, and career relationships.
- We confuse love with pity and tend to love people whom we can pity and rescue.
- We felt responsible for the problems of our unstable families, and as a result we do not feel entitled to live independent lives now.
- We get guilt feelings if we stand up for ourselves instead of giving in to others.
- We became approval seekers and lost our own identities in the process.
- We have an overdeveloped sense of responsibility toward others, but we rarely consider our responsibility to ourselves.
- We had to deny our feelings in our traumatic childhood’s. This estranged us from all our feelings, and we lost our ability to recognize and express them.

(Black, 1990, pp. 4-5)

ACOA Coping Strategies

- Denial
- Dichotomous all-or-none thinking
- The need for control (overly controlling).
- A fear of feelings which leads to a preponderance of negative feelings, and a rigid, negative view of the world.
- Difficulty dealing with and/or expressing anger.
- Self-blame and the assumption of responsibility for others.

(Brown, 1992)
Characteristics and Personality Traits

- Guess at what “normal” is.
- Have difficulty following a project through from beginning to end.
- Lie when it would be just as easy to tell the truth.
- Judge themselves without mercy.
- Have difficulty having fun.
- Take themselves very seriously.
- Have difficulty with intimate relationships.
- Overreact to changes over which they have no control.
- Constantly seek approval and affirmation.
- Feel they are different from other people.
- Are either super responsible or super irresponsible.
- Are extremely loyal, even in the face of evidence that the loyalty is undeserved.
- Are impulsive

(Woititz, 1983, pp. 4-5)
APPENDIX C

Introduction Letter

Ways of Coping Questionnaire (Subscales) and Appraisal Measure

Short Michigan Alcoholism Screening Test

Children of Alcoholics Screening Test - 6

Demographic Questionnaire
Thank You, for agreeing to complete the following survey.

The research topic of this thesis concerns how people handle stress, and how the use of alcohol is related to the ways we handle stress.

As a participant you will be asked to fully complete the following survey.

All surveys will be kept strictly anonymous, and you will never be asked to give your name, or any other identifying information.

If you have any questions or concerns please feel free to ask or call me, Tammy Skomorowski or my thesis supervisor Dr. Colleen Haney (960-5639). Please leave a message and indicate which of us you would like to return your call.
Ways of Coping Questionnaire (Subscales) and Appraisal Measure

Please take a few moments to think about the most stressful situation you have experienced in the past 2 weeks. Please describe the event.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Keeping in mind the stressful situation, please indicate the extent to which you experienced the following.

<table>
<thead>
<tr>
<th></th>
<th>Not at All</th>
<th>Somewhat</th>
<th>A Bit</th>
<th>Quite a Bit</th>
<th>A Great Deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I could change or do something about it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I had to accept it or get used to it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I needed to know more about it before I could act.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I had to hold myself back from doing what I wanted to do.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Below is a list of ways people can respond to stressful events. Please read each statement carefully and indicate, by circling the appropriate number, the extent to which you used it in the stressful situation you first described.

<table>
<thead>
<tr>
<th>No.</th>
<th>Statement</th>
<th>Not used</th>
<th>Used somewhat</th>
<th>Used quite a bit</th>
<th>Used a great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I just concentrated on what I had to do next – the next step.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>I did something which I didn’t think would work, but at least I was doing something.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3.</td>
<td>I tried to get the person responsible to change his or her mind.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4.</td>
<td>I criticized or lectured myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5.</td>
<td>I tried not to burn my bridges, but leave things open somewhat.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6.</td>
<td>I hoped a miracle would happen.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7.</td>
<td>I went along with fate; sometimes I just have bad luck.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8.</td>
<td>I went on as if nothing had happened.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9.</td>
<td>I tried to keep my feelings to myself.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10.</td>
<td>I looked for the silver lining, so to speak; I tried to look on the bright side of things.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11.</td>
<td>I slept more than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12.</td>
<td>I expressed anger to the person(s) who caused the problem.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>13.</td>
<td>I tried to forget the whole thing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14.</td>
<td>I apologized or did something to make up.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15.</td>
<td>I made a plan of action and followed it.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
16. I let my feelings out somehow.  

17. I realized I brought the problem on myself.  

18. I tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.  

19. I took a big chance or did something very risky to solve the problem.  

20. I tried not to act too hastily or follow my first hunch.  

21. I changed something so things would turn out all right.  

22. I generally avoided being with people.  

23. I didn’t let it get to me; I refused to think too much about it.  

24. I kept others from knowing how bad things were.  

25. I made light of the situation; I refused to get too serious about it.  

26. I stood my ground and fought for what I wanted.  

27. I took it out on other people.  

28. I drew on my past experiences; I was in a similar situation before.  

29. I knew what had to be done, so I doubled my efforts to make things work.  

30. I refused to believe that it had happened.  

31. I promised myself that things would be different next time.
32. I came up with a couple of different solutions to the problem.  
33. I tried to keep my feelings from interfering with other things.  
34. I wished that the situation would go away or somehow be over with.  
35. I had fantasies or wishes about how things might turn out.  
36. I went over in my mind what I would say or do.  
37. I thought about how a person I admire would handle this situation and used that as a model.  
38. I tried something entirely different from any of the above.  
(Please describe it below).
## Short Michigan Alcoholism Screening Test

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. Do you feel you are a normal drinker? (By normal we mean you drink less Than or as much as other people.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Does your wife, husband, a parent, or other near relative ever worry or Complain about your drinking?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Do you ever feel guilty about your drinking?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Do friends or relatives think you are a normal drinker?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Are you able to stop drinking when you want to?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Have you ever attended a meeting of Alcoholics Anonymous because of your drinking?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Has drinking ever created problems between you and your wife, husband, Partner, a parent, or other near relative?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Have you ever gotten into trouble at work or school because of your drinking?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10. Have you ever gone to anyone for help about your drinking?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11. Have you ever been in a hospital because of your drinking?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12. Have you ever been arrested for drunken driving, driving while intoxicated, Or driving under the influence of alcoholic beverages?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13. Have you ever been arrested, even for a few hours, because of other drunken behaviour?</td>
</tr>
</tbody>
</table>
Children of Alcoholics Screening Test - 6

Yes  No  Question

1. Have you ever thought that one of your parents had a drinking problem?
2. Did you ever encourage one of your parents to quit drinking?
3. Did you ever argue or fight with a parent when he or she was drinking?
4. Have you ever heard your parents fight when one of them was drunk?
5. Did you ever feel like hiding or emptying a parent’s bottle of liquor?
6. Did you ever wish that a parent would stop drinking?
Demographic Questionnaire

All your answers are strictly confidential. Please feel free to answer all questions as accurately and honestly as possible.

1. **How old are you:** ______ (years)

2. **What is your ethnic identity:** (Please circle one)
   1. White/ Caucasian/ European
   2. Black/ African Canadian
   3. Hispanic/ Latin Canadian
   4. First Nations/ Native Canadian
   5. Asian Indian
   6. Asian Canadian
   7. Other _________________

3. **What is the last grade you have completed:** (Please circle one)
   1. Elementary School
   2. Secondary School
   3. Technical or Trade School Diploma
   4. College Diploma or University Undergraduate Degree
   5. Master’s Degree
   6. Doctoral Degree

4. **What is your current employment status:** (Circle all that apply)
   1. Full Time Work
   2. Part Time Work
   3. Full Time Student
   4. Part Time Student
   5. Retired
   6. Unemployed

5. **What is your current household income:** (Please circle one)
   1. under $10,000
   2. $10,001 - $30,000
   3. $30,001 - $50,000
   4. over $50,001
6. What is your present marital status: (Circle all that apply)
   1 Single
   2 Cohabiting/ Common-law
   3 Married
   4 Divorced/ Separated
   5 Widowed
   6 Other ____________________

When answering the following questions please keep in mind the family that you spent most of your time growing-up in.

7. What is the highest level of education that your parents/ primary caregivers have attained:

   Mother/ Stepmother/ Female Caregiver:
   1 Elementary School
   2 Secondary School
   3 Technical or Trade School Diploma
   4 College Diploma or University Undergraduate Degree
   5 Master’s Degree
   6 Doctoral Degree

   Father/ Stepfather/ Male Caregiver:
   1 Elementary School
   2 Secondary School
   3 Technical or Trade School Diploma
   4 College Diploma or University Undergraduate Degree
   5 Master’s Degree
   6 Doctoral Degree

8. Are you currently living with your parents?
   1 Yes
   2 No
APPENDIX D

Problem-focused and Emotion-focused Coping Items of the Self-Controlling Sub-scale
Problem-focused and Emotion-focused Coping Items of the Self-Controlling Sub-scale

<table>
<thead>
<tr>
<th></th>
<th>Self-Controlling Sub-scale Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem-focused Coping</strong></td>
<td>I tried not to burn my bridges, but leave things open somewhat.</td>
</tr>
<tr>
<td></td>
<td>I tried not to act too hastily or follow my first hunch.</td>
</tr>
<tr>
<td></td>
<td>I went over in my mind what I would say or do.</td>
</tr>
<tr>
<td></td>
<td>I thought about how a person I would admire would handle the situation and used that as a model.</td>
</tr>
<tr>
<td><strong>Emotion-focused Coping</strong></td>
<td>I tried to keep my feelings to myself.</td>
</tr>
<tr>
<td></td>
<td>I kept others from knowing how bad things were.</td>
</tr>
<tr>
<td></td>
<td>I tried to keep my feelings from interfering with other things too much.</td>
</tr>
</tbody>
</table>
APPENDIX E

Poster Calling for Participants
Are you female, 24 or older and not living with your parents?

Would you like to contribute to understanding more about alcohol and coping with stress?

I'm a student in the Masters of Education - Counselling at UNBC. My thesis is on alcoholism and coping with stress.

The survey for my thesis takes 15-20 minutes to complete.

If you are interested in helping to learn more about this topic, please call me (Tammy) at 960-5639 to request a survey. Any further concerns may be directed to my thesis supervisor Dr. Haney (960-5639).