Are Adult Children of Dysfunctional Families With Alcoholism Different From Adult Children of Dysfunctional Families Without Alcoholism? A Look at Committed, Intimate Relationships

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Investigating the validity of classifying adult children of dysfunctional families with alcoholism (ACDFAs) as a unique population, this study compared ACDFAs with adult children of dysfunctional families without alcoholism (ACDFs) and adult children of functional families (ACFFs) on current relationship satisfaction. Participants (N = 126) were from a community sample. No significant difference between the ACDFAs and the ACDFs was found; however, both ACDFAs and ACDFs displayed significantly more difficulty with problem-solving communication than the ACFFs. Regression results indicated that dysfunction in the family of origin is significantly related to global distress and difficulties with problem-solving communication in current intimate relationships. Results do not lend support to the utility of classifying ACDFAs as a unique population.

Adult children of dysfunctional families with alcoholism (ACDFAs), typically referred to as adult children of alcoholics (ACOAs), have numerous resources available that are based primarily on the assumption that they possess certain maladaptive characteristics. Investigations of these characteristics, however, have yielded mixed results. Some researchers have failed to find differences between ACOAs and non-ACOAs (Fulton & Yates, 1990; Tweed & Ryff, 1991; Wright & Heppner, 1991, 1993), whereas other researchers have found significant differences between the two groups (Hinz, 1990; McKenna & Pickens, 1983; Webb, Post, Robinson, & Moreland, 1992). One explanation for the contrasting findings lies in the method of sampling. Studies finding differences between ACOAs and non-ACOAs have used clinical populations, whereas studies using community-nonclinical populations have typically found no significant differences between the groups. Furthermore, it is unclear whether findings from studies using undergraduates (Wright & Heppner, 1993) generalize to noncollege populations. Prior studies comparing ACOAs and non-ACOAs have also, for the most part, neglected to consider the real likelihood that other types of dysfunction (i.e., physical abuse and sexual abuse) were present in the non-ACOA group.

Given the contradictory findings relating to ACOA characteristics, many researchers are questioning the validity of classifying ACOAs as a unique group (Beidler, 1989; Fulton & Yates, 1990; Goodman, 1987; Seefeldt & Lyon, 1992). To address this issue, some researchers have used a comparison group of adult children of dysfunctional families (ACDFs) in their studies. These studies have consistently shown no significant difference between ACOAs and ACDFs, yet they have shown that ACOAs and ACDFs display significantly more symptomology than adult children of functional families (ACFFs; Baker & Williamson, 1989; Fisher, Jenkins, Harrison, & Jesch, 1993; Jenkins, Fisher, & Harrison, 1993). A major limitation of past studies is the criterion used to categorize a participant as an ACDF. Participants in past studies have been categorized as ACDF on the basis of the presence of a traumatic event such as abuse, divorce, or death of a parent. Presence of a traumatic event, however, does not necessarily equate with familial dysfunction. According to Beavers and Hampson (1990), family dysfunction is based on the interactive patterns in the family, with emphasis on how well the family can organize and manage itself. On the basis of this premise, it is critical to assess the general dysfunction within the family system rather than relying on the presence of a traumatic experience.

One area that has been clinically identified as problematic for ACOAs, yet has not been the focus of much research, is intimate relationships. Some studies have found that ACOAs report their relationships to be more problematic than do non-ACOAs (Black, Bucky, & Wilder-Padilla, 1986; Domenico & Windle, 1993; Fisher, Jenkins, Harrison, & Jesch, 1992; Kerr & Hill, 1992). Stout and Mintz (1996), for example, found that college women with alcoholic fathers reported significantly more distress arising from interpersonal problems than did non-ACOAs. Although these findings provide some support for the notion that ACOAs have difficulty in intimate relationships, they have not pinpointed which aspects of relationships are problematic and have typically assessed general relational problems rather than assessing problems in current, committed relationships. It is particularly interesting that past studies have neglected
to focus on communication skills, because communication is typically considered the basic building block of relationships. Because communication skills are learned, it seems plausible to expect that adult children raised in dysfunctional families learned dysfunctional communication patterns that may be affecting their communication in current relationships.

There were three main purposes of this study. One was to investigate whether ACDFAs and ACDFs have difficulty in their committed, intimate relationships and, if so, to determine which relationship aspects are problematic for these couples. The second purpose was to determine whether any difficulties, if they exist, are unique to the ACDF population or more characteristic of ACDFAs as a whole. The third purpose was to determine whether degree of dysfunction is related to difficulties with these couples. It was hypothesized that ACDFAs and ACDFs, regardless of parental alcoholism, would report higher levels of global distress, more dissatisfaction with affective and problem-solving communication, and lower levels of dyadic trust than adult children of functional families (ACFFs). The degree of dysfunction in the family of origin was also expected to be significantly related to trust, global distress, affective communication, and problem-solving communication. No significant differences between ACDFAs and ACDFs were expected. This study improved on some important methodological flaws present in past studies. Rather than relying on the presence of a traumatic event, this study assessed the level of dysfunction in the family of origin with the Self-Report Family Inventory (Beavers, Hampson, & Hulgus, 1990). Hadley, Holloway, and Mallinckrodt (1993) also used this inventory in their investigation, but to assess differences in family functioning between the ACOA and ACDF groups that were previously classified on the basis of self-identification. Results of this study indicated no significant differences between the ACOA and ACDF groups on family functioning or the other variables investigated. Instead of relying on self-identification as an ACDF or ACFF, as past studies have done, this study used Self-Report Family Inventory scores to classify individuals as being raised in functional or dysfunctional families.

Method

Participants

The sample consisted of 126 participants (45 men and 81 women) ranging in age from 19 to 75 years ($M = 37.96$, $SD = 12.24$). The sample was predominantly Caucasian (88%), 6% were African Americans, 4% were Hispanic, and 2% represented other racial groups. The most prevalent religious affiliation in this sample was Christian, with 54% indicating Catholic as their religion and 15% reporting Protestant as their religion. Most of the participants were married (71%), 15% were engaged and not living with their partner, 10% were engaged and living with their partner, and 4% were living with their partner. The mean length of participants' current relationship was 13.51 years ($SD = 12.61$, range = 5 months to 52 years).

Instruments

Children of Alcoholics Screening Test. This widely used self-administered inventory (Jones, 1991) contains 30 items designed to identify individuals who have lived with an alcoholic parent. It assesses (a) psychological distress associated with parental drinking, (b) perceptions of drinking-related marital discord between parents, (c) attempts to control parental drinking, (d) efforts to escape from alcoholism, (e) exposure to drinking-related family violence, (f) tendencies to perceive parents as being alcoholic, and (g) desire for professional counseling. A Spearman–Brown split-half reliability coefficient of .98 was found for an adult population (Jones, 1991). Clair and Genest (1992) reported a test–retest reliability coefficient of .88 over a 2-month interval. The test manual reported on two validity studies conducted, both of which showed that clinically diagnosed children of alcoholics and self-reported children of alcoholics scored significantly higher on the Children of Alcoholics Screening Test than did controls (Jones, 1991).

Self-Report Family Inventory. The Self-Report Family Inventory (Beavers et al., 1990) is used to assess the level of competency versus dysfunction within a family. This instrument consists of 36 items with 3-point scales. There are five subscales: Family Health, Family Conflict, Family Cohesion, Directive Leadership, and Expressiveness. Participants completed the entire inventory, but the Health–Competence scale was used in this study. The Health–Competence scale addresses themes of happiness, optimism, problem solving, negotiation skills, family love, strength of parental coalitions, autonomy, and minimal blaming patterns. Scores on this scale range from 19 to 95, higher scores being characteristic of dysfunctional families.

Green (1989) reported reliability coefficients for the Health–Competence scale ranging from .87 to .92. The average test–retest correlation coefficient for a 1- to 3-month follow-up was reported as .85 for family health, which was significant at the $p < .01$ level. Beavers and Hampson (1990) reported that the Self-Report Family Inventory was able to discriminate clinical from non-clinical families. Significant correlation coefficients were found between the inventory and the Locke Wallace Marital Satisfaction Scale, Faces III, the Family Environment Scale, and the Family Assessment Device, with only a few of the subscales serving as exceptions (Beavers & Hampson, 1990).

Marital Satisfaction Inventory. This widely used instrument (Snyder, 1981) contains 280 true–false items with the following 11 subscales: Conventionalization, Global Distress, Affective Communication, Problem-Solving Communication, Time Together, Disagreement Over Finances, Sexual Satisfaction, Role Orientation, Family History of Distress, Dissatisfaction With Children, and Conflict Over Child Rearing. All of the subscales were administered except for the two pertaining to children; however, the Global Distress, Problem-Solving Communication, and Affective Communication scales were of particular interest in this study. Overall dissatisfaction with the relationship is assessed by the Global Distress scale. The Affective Communication scale measures one's dissatisfaction with the amount of affection and understanding expressed by one's spouse, and the Problem-Solving Communication scale assesses ineffectiveness of problem-solving communication and inability to resolve disagreements. Raw scores are converted to $t$ scores that range from 30 to 90; for the three subscales used in this study, higher scores indicate higher levels of dissatisfaction.

The reliability and validity of this instrument have been carefully evaluated. Biserial correlations of items with respective scale scores have ranged from .40 to .95 ($M = .75$), providing evidence of a moderate to high degree of internal consistency. Test–retest
received the written debriefing of the study, some general infor-
mation about family of origin issues, communication tips, and a
list of available resources in the community.

Participants were classified as ACDFAs, ACDFs, or ACFFs in part
on the basis of their scores on the Self-Report Family Inventory.
Participants scoring in the optimal or adequate categories (a score
of less than 43) along the health–competence dimension were
classified as ACDFAs. Those scoring in the midrange, borderline,
or severely dysfunctional categories (a score of 43 or greater) along
this health–competence dimension were classified as ACDFs. We
used the Children of Alcoholics Screening Test to determine
whether there was parental alcoholism and to classify an individual
as an ACDFA. A person scoring 6 or higher on this scale was
classified in the ACDFA group; a person scoring lower than 6
remained in the ACDF group. Two participants had scores of 6 or
higher but were classified as ACFFs; their data were discarded.

One hundred sixty-eight individuals from committed relation-
ships participated in this study. In 96 of the cases only one partner
participated, whereas in 72 cases (36 couples) both partners par-
ticipated. As a means of ensuring independence in the sample, the
data of one partner from each couple were randomly discarded. Six
additional packets were discarded, four because of incomplete or
missing data and two because the individuals were classified as
ACFF and ACDFA, a clinically questionable category. Thus, the
final sample size was 126.

Results

The mean Self-Report Family Inventory score was 49.83
($SD = 17.86$, range $= 21–93$), which is in the midrange
category along the health–competence dimension. Twenty-
eight individuals were classified as ACDFAs, 52 were
classified as ACDFs, and 46 were classified as ACFFs.
ACDFAs constituted 22% of the sample, which is in line
with what is expected in a community sample given that 8%
to 16% of the population is alcoholic and each person has
two parents. Chi-square values and analyses of variance
(ANOVAs) showed that the three groups (ACDFA, ACDF,
and ACFF) did not differ significantly by gender, race,
religion, income, age, or relationship length. An ANOVA
also showed no significant difference between the ACDFA
and ACDF groups on Self-Report Family Inventory scores,
indicating similar levels of dysfunction in these two groups.

A one-way multivariate analysis was used to address the
first two purposes of this study. We were interested in
whether ACDFs have difficulties in current relationships
and whether any of these difficulties are unique to the
ACDFA group. The specific relational difficulties investi-
gated were the following: trust, measured by the Dyadic
Trust Scale, and global distress, affective communication,
and problem-solving communication, all measured by the
Marital Satisfaction Inventory. With an alpha level of .05
and a .67 level of power, the omnibus hypothesis of no
difference between the groups was rejected, $F(8, 240) =
2.75, p = .01$. Scheffé’s multivariate simultaneous test
procedure for multiple comparisons revealed only one sig-
nificant difference between the groups: All ACDFAs and
ACDFs differed significantly from ACFFs in terms of
problem-solving communication. ACDFAs and ACDFs dis-
played more dissatisfaction in problem-solving communi-
cation in their intimate relationships than did ACFFs. No
significant differences between ACDFAs and ACDFs were found on any of the variables (see Table 1).

To address the third purpose of the study, we conducted a one-predictor multivariate regression analysis to find out whether degree of dysfunction in the family of origin was significantly related to difficulty in current intimate relationships. Self-Report Family Inventory scores were used as the predictor, and trust, global distress, affective communication, and problem-solving communication scores served as the dependent variables. The results revealed that Self-Report Family Inventory scores were significantly related to global distress ($\beta = .12$) and problem-solving communication ($\beta = .32$) in intimate relationships, $F(4, 121) = 3.98$, $p < .01$, $R^2 = .12$, but were not significantly related to trust or affective communication scores.

Discussion

As hypothesized, results revealed a significant difference between ACDFAs--ACDFs and ACFFs on problem-solving communication, the former displaying more dissatisfaction in this area. If problem-solving skills are not taught or if dysfunctional ways to solve problems are learned in the family of origin, then it seems only natural that future problems would exist in this area. Further supporting this notion, regression results revealed that degree of dysfunction was significantly related to problem-solving communication. It is important to note, however, that the mean scores for the problem-solving communication and other relationship dimensions were in the low to moderate range of dissatisfaction. Thus, problem-solving communication poses more difficulty for ACDFAs and ACDFs than for ACFFs; however, problem-solving communication is a source of low to moderate, but not great, dissatisfaction for these individuals.

Contrary to what was hypothesized, the present study failed to find any significant differences between ACDFAs--ACDFs and ACFFs on the other dependent variables: trust, global distress, and affective communication. Difficulty with trust, for example, has long been associated with ACOAs, yet research has not validated this assumption. Bradley and Schneider (1990) also failed to find significant differences between ACOAs and non-ACOAs on the Interpersonal Trust Scale. These findings suggest that difficulty with trust does not seem to stem from parental alcoholism or familial dysfunction. It is particularly intriguing that ACDFAs and ACDFs did not differ from ACFFs on global distress. This is contrary to the findings of Domenico and Windle (1993) and Kerr and Hill (1992), who reported that lower levels of marital satisfaction were indicated by ACOAs relative to non-ACOAs. Regression results, however, did show that the degree of dysfunction in the family of origin was significantly related to global distress. Adult children raised in families with high levels of dysfunction reported higher levels of global distress in their current relationships, whereas adult children raised in families with lower levels of dysfunction reported lower levels of global distress. Therefore, the degree of dysfunction, rather than the presence of dysfunction, appears to be related to global distress in intimate relationships. Perhaps it is more appropriate to discuss dysfunction as on a continuum rather than as a categorical variable. A closer look at the Affective Communication scale provides some insight into the lack of significant findings in this area: This scale taps dissatisfaction with the amount of affection and understanding expressed by the partner; therefore, it is actually measuring the partner's ability, rather than the ability of the participant, to express affection and understanding. Because the level of dysfunction in the partner's family of origin is unknown, conclusions about the relationship between family of origin dysfunction and the adult child's ability to understand and express affection in intimate relationships cannot be made.

As expected, no significant differences was found between ACDFAs and ACDFs. Because research has repeatedly failed to show characteristics that are unique to ACOAs (Baker & Williamson, 1989; Fisher et al., 1993; Hadley et al., 1993; Jenkins et al., 1993), the usefulness of this separate category is called into question. Although ACDFAs do appear to have more difficulties than ACFFs, these difficulties are characteristic of ACDFs as a whole and not unique to the ACOA population. Thus, clinicians need to be cautious in their use and interpretation of the ACOA label. These results suggest that the dysfunction in the family of origin, rather than the presence of parental alco-

### Table 1

**Mean Relationship Dimensions by Group**

<table>
<thead>
<tr>
<th>Relationship dimensions</th>
<th>ACDFAs $(n = 28)$</th>
<th>ACDFs $(n = 52)$</th>
<th>ACFFs $(n = 46)$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>42.39</td>
<td>43.25</td>
<td>46.46</td>
</tr>
<tr>
<td></td>
<td>13.18</td>
<td>10.97</td>
<td>9.56</td>
</tr>
<tr>
<td>Global distress</td>
<td>50.18</td>
<td>51.42</td>
<td>45.54</td>
</tr>
<tr>
<td></td>
<td>10.97</td>
<td>10.44</td>
<td>6.85</td>
</tr>
<tr>
<td>Affective communication</td>
<td>50.00</td>
<td>49.96</td>
<td>44.39</td>
</tr>
<tr>
<td></td>
<td>13.36</td>
<td>10.63</td>
<td>8.82</td>
</tr>
<tr>
<td>Problem-solving communication*</td>
<td>51.25</td>
<td>51.08</td>
<td>43.37</td>
</tr>
<tr>
<td></td>
<td>12.87</td>
<td>10.14</td>
<td>7.91</td>
</tr>
</tbody>
</table>

*Note.* Higher scores indicate greater levels of dissatisfaction except for trust, for which higher scores indicated a more positive response. ACDFAs = adult children of dysfunctional families with parental alcoholism; ACDFs = adult children of dysfunctional families without parental alcoholism; ACFFs = adult children of functional families.

*ACDFAs and ACDFs were significantly different $(p < .01)$ from ACFFs.*
holism, is significantly related to difficulty in intimate relationships. Werner and Broida (1991) similarly concluded that dysfunction in the family, and not the presence of alcoholism, is significantly related to lower self-esteem and a more external locus of control. Hadley et al. (1993) also reported that the degree of family dysfunction was significantly related to internalized shame, object relations deficits, presence of addictions, and emotional problems. It therefore appears that dysfunction in the family of origin may affect several domains of an individual’s life, two of which are problem-solving communication and global distress in intimate relationships. The practical implication of this finding is important, particularly in outreach and assessment. Individuals should be recruited for interventions on the basis of the presence of dysfunctional patterns in the family of origin rather than on the basis of parental alcoholism, a whole population of ACDFs without parental alcoholism is apparently being neglected in outreach endeavors. Similarly, clinicians should include questions about family of origin patterns in their assessment of the client.

This study provides insight about which aspects of intimate relationships are affected by dysfunction in the family of origin. However, there are some limitations that must be addressed. First, it is important to note that this sample was biased in that it consisted only of individuals in committed (living together, engaged, or married) relationships. Perhaps those with difficulty in intimate relationships have never been able to form a committed relationship or have dissolved a committed relationship. In addition, this sample was made up primarily of Caucasians who were Christians; thus, generalization of these findings to other populations must be made with caution. Finally, this study is subject to the same limitations as other studies relying on self-report data.

In conclusion, this study does not lend support to the utility of classifying ACDFs as a unique population. However, it does pinpoint problem-solving communication as an area in which ACDFs as a whole could use improvement. Rather than continuing attempts to find characteristics or difficulties unique to ACDFs, future research should concentrate on developing and evaluating the effectiveness of various treatment strategies based on the identified problem areas for ACDFs in general. In particular, problem-solving communication should be targeted in efforts to improve the quality of intimate relationships for ACDFs.

References
Black, C., Bucky, S. E., & Wilder-Padilla, P. S. (1986). The inter-


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