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EXAMINING THE SOCIAL AND EMOTIONAL
IMPACT OF SUBSTANCE USE ON THE USERS'
FAMILY MEMBERS

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Bachelor of Arts

The University of Northern Iowa

December, 2005

Submitted in partial fulfillment of requirements for the degree

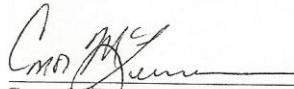
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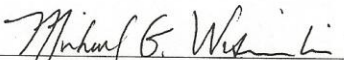
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EXAMINING THE SOCIAL AND EMOTIONAL IMPACT OF SUBSTANCE USE ON
THE USER'S FAMILY MEMBERS

STEVEN BEYER

ABSTRACT

Alcohol use is a multibillion dollar problem in the United States that has been linked to higher rates of anxiety, depression and maladjustment within families. Most studies examining the impact of alcohol use in these areas focus on individuals within treatment facilities. This study extended that research to examine the effects of social and emotional effects of alcohol use on a greater sample of the population, the family members of alcohol users. This study examined the relationships between family alcohol use and higher rates of depression, anxiety, and maladjustment. The data was expected to follow one of two general patterns. First, that as reports of family alcohol use increased greater symptoms of anxiety, depression and maladjustment would be reported. Second, that the data would fit the J-shaped function often seen in medical outcomes for alcohol users in which there is a down trend between non-users and moderate users followed by increasing negative outcomes as use increases. The data collected from 177 undergraduate students at Cleveland State University fit the second model for self reports of anxiety and depression, with no significant results observed between the levels of use and adjustment. The data indicates that individuals reporting minimal and moderate levels of family alcohol use have significantly lower levels of anxiety and depression compared to those reporting high levels of alcohol use, which is consistent with the literature. More significantly, the data suggests that participants reporting minimal and moderate levels of family alcohol use experience lower levels of anxiety and depression

than those reporting no family alcohol use. More research is needed to determine if low levels of alcohol use are beneficial or if confounding factors contribute to non-users higher levels of negative outcomes.

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CHAPTER I

INTRODUCTION

Alcoholism and addiction are prevalent within the American culture. Addiction is an affliction that is not bound by location, income, education, or race. Over half of all Americans over the age of 12, an estimated 126 million people, are current alcohol users, having had a drink in the past month according to the National Household Survey on Drug Use and Health (2005). Over a fifth of the population reports binge drinking, consuming five or more alcoholic beverages in a single incident, within the past month (Substance Abuse and Mental Health Services Administration, 2005). Due to the prevalence of alcohol use, this study endeavored to examine the social and emotion impacts of alcohol use within families. Depression, anxiety, and adjustment were all examined to determine if any of these areas are negatively affected by family substance use.

Substance abuse, chemical dependency, and alcoholism are all used to describe the condition of addiction. This condition, regardless of the substance used, is often characterized by a maladaptive pattern of use leading to clinically significant impairment or distress (American Psychiatric Association [APA], 2000). There is often a significant

loss of control over the substance that is used. The substance that is being used often begins to occupy large amounts of the user's time in obtaining, using, and recovering from the substance use. The occupation with the drug and loss of control of its use lead to increases in the amount of the drug that is used. In many cases, the increased use leads to the development of tolerance, a process by which more of a substance is needed to produce the same effect of a drug that was previously experienced with a smaller amount. Many addicts who have developed a tolerance to a drug will experience withdrawal symptoms if use of the drug has stopped. Addicts often experience a period of time in which they unsuccessfully attempted to reduce the amount of the drug that is used or to abstain from use. A final defining characteristic of an addict is continued use despite repeated negative consequences (APA, 2000). The continued use is often accompanied by a lack of insight into the problems that are being caused by the drug and a denial of the harmful effects.

The high level of substance use in the United States has lead to high costs for the country. Substance use has been a burden on the economy (Monge, Fulk, Parnassa, Flanagan, Rumsey, & Kalman, 1999, p.229). Money is spent at all levels of the government for substance abuse related issues. A major expense to the government is prosecuting and imprisoning drug offenders. Over 50% of all inmates in federal prisons, and almost 20% of all state prisoners are being held on drug charges (Harrison & Beck, 2006). The average daily cost per state prison inmate per day in the United States in 2005 was \$67.55, costing states approximately \$16,948,295 per day to imprison drug offenders, or \$6,186,127,675 per year” (American Correctional Association, 2006; Harrison & Beck, 2006). Furthermore, treating and preventing addictions also has a

significant financial impact in the United States. In 1998 the economic cost of drug abuse was 246 billion dollars, 60% (148 billion dollars) of which was spent on alcohol abuse and alcoholism (Kirkcaldy, Siefen, Surall, Bischoff, 2004).

CHAPTER II

THE IMPACT OF SUBSTANCE USE ON SOCIAL ADJUSTMENT

The staggering economic impact of addictions in the United States often overshadows the social impact of drug use and abuse. Substance abuse can lead to a maladaptive pattern of behavior that can be disruptive to everyone close to the user. The maladaptive behaviors exhibited by substance abusers can have a negative social impact on their family members. The family environment of substance users has been described as being primitive, less cohesive or organized, and more angry and conflicted than families without drug addiction (Stanton & Shadish, 1997). The dysfunctional family dynamics of drug users often leads to increased problems both for the family and for the users themselves. These dynamics are characterized by parental over involvement or outright rejection, leading to disruptive marital relationships in which these characteristics are often carried over (Bidokhti, Yazdandoost, Birashk, Schottenfeld, 2006). The disruptive family dynamics of substance users can lead to a lack of cohesion within their families and increase the likelihood of substance abuse by the children in an addict's household. "Adolescent drug abusers in a residential drug treatment center viewed their parents as

emotionally constricted, distant, and critical, and their parents had difficulties balancing the autonomy and emotional-expressive needs of their offspring” (Searight, Manley, Bider, Krohn, & Russo, 1991). Substance use has been demonstrated to have a negative impact on all the relationships within a family, leading to a less cohesive family dynamic. The disruptive impact of substance abuse on family cohesion is most evident in the families of heavy drug users (Piercy, Volk, Trepper, Sprenkle, & Lewis, 1991).

There has been dispute over the cause of the impact of substance abuse in families (Hogan, 1998). It has been debated in the literature whether substance abuse itself or a range of contributing variables such as environmental stressors and increased mental disorders that often accompany substance abuse leads to disrupted family functioning and poor parenting skills (Suchman & Luthar, 2000). While the data collected in this study will not resolve this debate, current results will address components of the debate, such as the correlation between substance abuse and decreased social and family adjustment. While the primary factors contributing to poor parenting skills and a disruptive family environment in families of substance abusers have not been established, it is clear that these families’ environments are often unstable and often chaotic places where drugs and other criminal activity occur on a frequent basis (Barnard, 2001). People growing up in a household with a substance abuser have been shown to be at higher risk for behavior problems (Gabel & Shidledecker, 1992; Hawley, Halle, Drasin, & Thoma., 1995) and social isolation (Dore, Nelson-Zlupko, & Kaufmann, 1999). Substance abuse in families presents many environmental stressors that contribute to a wide range of social and emotional maladjustments for children and significant others living with a substance abuser (McKeganey, Barnard & McIntosh, 2002)

The household environment of an addict, be it the addiction per se or the environmental conditions the addiction elicits, has been shown to have a detrimental impact on family members and significant others. Family members and significant others of alcoholics have been found to experience unique and extensive physical, behavioral, and psychological problems (Moos & Moos, 1984). While the majority of the research on addiction has been focused on alcoholism, studies have shown that the detrimental effects documented in the family members of alcoholics are also present in the family members of other substance abusers (Friedmann, McDermut, Solomon, Ryan, Keitner & Miller, 1997).

One study by Hudson et al. (2002) examined the level of social adjustment in parents and partners of substance users. The 70 participants in this study completed a baseline assessment that included the Social Adjustment Scale-Self Report (SAS-SR) (Weissman & Bothwell, 1976). This study determined that both parents and significant others of substance users had poorer overall social adjustment compared to a community sample. The study also found that partners exhibited a statistically significant lower level of social adjustment than parents. When age and race were controlled, the statistically significant difference between parents and partners was no longer observed, suggesting that regardless of an individual's relationship to a substance user, as a family member or significant other, the individual will be suffer significant impairments in social adjustment. Additionally this study examined the relationship between the current living situations of parents and partners of substance abusers, those living with and apart from the substance abuser, and social adjustment. No significant differences were found between parents and partners currently living with substance abusers and those who were

not currently living with the substance abuser. This study by Hudson et al. (2002) is effective in demonstrating the impact of substance use on the level of social adjustment in the family members of substance users, regardless of the family member's current living situation. This suggests that the impact due to substance use may still cause detrimental effects in the life of the family member or significant other after the individual has left the substance users household.

CHAPTER III

THE EMOTIONAL IMPACT OF SUBSTANCE USE

Mood and anxiety disorders are two of the most commonly diagnosed categories of disorders (Bumberry, Oliver & McClure, 1978; Reyno, Stewart, Brown, Horvath & Wiens, 2006). In addition, many connections have been made between mood and anxiety disorders and substance abuse. The mood disorder most commonly associated with substance abuse is depression. To be diagnosed as having a depressive episode, an individual must exhibit five of the symptoms of depression and either a depressed mood or a loss of interest or pleasure in a previously enjoyable activity. The other symptoms of depression are: weight loss or weight gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue, feeling of worthlessness; diminished ability to concentrate; and recurrent thought of death or suicidal ideation. Depression is commonly comorbid with substance use, and is caused by the substance use in the case of the diagnosis substance induced mood disorder (APA, 2000). Substance intoxication and withdrawal can also mimic symptoms of depression (Ferrando, 2005).

Substance use in a family has been linked to increased rates of depression in family members. “The most widely-reported finding is that depression is inversely related to the level of support, attachment, and approval provided by the family environment” (Sheeber, Hops & Davis, 2001, p 21). Bidokhti et al. (2006) found that due to its detrimental effects on the family environment substance use increases the likelihood for mood disorders such as depression. The rate of mood disorders is often difficult to determine in populations of substance users because the rates often change depending on the drug used, the situation in which it is used, and if the substance user is in or has completed a treatment program (Rissmiller, Biever, Mishra & Steer, 2006). The increased rate of depression in families with addictions is often attributed to maladaptive styles of parenting and an unstable family environment (Bidokhti et al., 2006).

The emotional impact of addiction in a family has multiple sources. Dore (1998) identified two sources most often cited in the literature: 1) the detrimental effect of drug intoxication on an individual’s ability to recognize the needs of those around them; and 2) the environmental factors that are affected by an individual’s substance use. The direct effects of the substance abuse as a source of dysfunction within a family are described by Dore (1998). When an individual is intoxicated, the sensitivity to the needs of others is diminished, limiting the individual’s capacity to recognize the wants and needs of others, which may contribute to inconsistent levels of care given during periods of sobriety and intoxication. Intoxication from different drugs has different effects on the body, which can lead to different reactions to others. Drug intoxication may cause an individual to lower their responsiveness to the needs of others. The negative effects of drug withdrawal may also leave an individual incapable of providing a proper response to the

needs of those around the user. Environmental factors that may have a detrimental effect on the emotional well being of an individual living with a substance user are poverty and violence within the home (Dore, 1998). These are some of the factors that contribute to decreased support and attachment which in turn increase the risk for mood disorders.

One study by Bidokhti et al. (2006) examined the relationship between the family environment of individuals recently completing opioid detoxification and anxiety and depression. Participants completed the Family Environment Scale (FES), a measure of the social environment of a family, the Beck Depression Inventory (BDI-II), and the Beck Anxiety Inventory (BAI). The scores on the BDI-II and the BAI were correlated to the scales of the FES. Two significant relationships emerged. First a significant negative correlation between BDI scores and family cohesion was obtained, indicating that lower levels of family cohesion were present in individuals with higher rates of depression. Second, there was also a significant positive correlation between family conflict and depression, indicating that household conditions that are typically associated with substance use, such as less family cohesion and increased family conflict, are also related to increased rates of depression.

The primary concern of my study is to determine the social and emotional impact of substance abuse within families. The impact of substance abuse was measured by self-reports of anxiety, depression, family and social adjustment filled out by the family members of alcohol users. It has been established that social adjustment, family adjustment, depression and anxiety disorders are more likely to occur in family members of alcohol abusers than in the general public (Bidokhti et al., 2000; Hudson et al., 2002; Reyo et al., 2006).

This study examined if this correlation between substance use and negative outcomes, reduced levels of adjustment and increases in anxiety and depression in the family members of the alcohol user, can be observed when the level of alcohol use for family members is assessed through reports completed by the participants, as opposed to being assessed through clinical assessments of alcoholism completed by the family member. If the relationship is evident, a significant positive correlation between reports of substance abuse and reports of negative outcomes is expected. Much of the literature is based on studies of individuals within drug treatment facilities and relies on the diagnosis of an assessment to categorize an individual as a substance abuser; the current study attempted to observe significant correlations when the measure of alcohol use in a family is assessed through a family report of symptoms of addiction and not through a clinical assessment.

While the literature has identified a relationship between substance use disorders within an individual's family and the individual experiencing negative outcomes (Bidokhti et al., 2000; Hudson et al., 2002; Reyo et al., 2006), these results cannot easily be generalized to the overall population. The majority of individuals in the United States who consume alcohol do not meet the criteria for alcohol abuse or dependence. My study looked at the impact of substance use in a non-clinical setting to determine if the predicted relationship between reports of outcomes and family alcohol use will be obtained even if the family members' alcohol use falls within a normal range of use. This will determine the relationship between family alcohol use and negative outcomes in the general public and not in the minority of individuals within substance abuse programs

CHAPTER IV

METHOD

The current study included multiple measures to assess levels of functioning and emotional responses, similar to Bidokhti et al. (2000); moreover, correlations were formed on these scores to examine the relationships between these variables. The current study expanded on the previous research in two ways. First, in the majority of the literature, data on levels of alcohol use and negative outcomes are gathered from self reports completed by the substance user. In the current study, the data was collected from the family members of the alcohol users. Collecting data directly from family members of alcohol users should reduce the incidence of under or over reporting symptoms. In other words the aspect of denial that is associated with substance abusers may have reduced the reliability of measures completed by alcohol abusers themselves.

Second, the participants completed a measure to assess the level of alcohol use of the heaviest user within the participant's family. Previous studies have assessed substance abuse through self report or due to admission to a drug treatment center (Bidokhti et al., 2000; Allen, Nelson, Rouhbakhsh, Scifres & Greene, 1998) or self reports of significant

others seeking treatment for a substance abuser (Hudson, Kirby, Firely, Festinger & Marlowe, 2002; Kirby, Dugosh, Benishek, Harrington, 2005). These studies have used the measures of substance use strictly to assess if an individual was a substance abuser, but the degree of the user's use was not classified to determine if the degree of use had an impact on the outcomes of other measures. This study quantified the level of alcohol use an individual is reporting for a family member, for use in the correlational analysis, using the Self-Administered Alcoholism Screening Test (SAAST). These data allowed the current study to investigate whether the levels of negative outcomes, such as higher scores on the measures of depression and anxiety and lower scores on the measures of adjustment, are correlated with reported levels of family alcohol use.

CHAPTER V

PARTICIPANTS

Two samples of participants were recruited for this study. First students attending Cleveland State University (primarily Introduction to Psychology students) were recruited. College students are often used as a baseline sample for surveys on adjustment and emotional disorders (Bumberry, Oliver, McClure, 1978; Safren, Heimberg, Lerner, Henin, Warman, Kendall, 2000). Although studies have often obtained higher rates of substance use in college students, little research has been conducted on the rates of substance use in the students' families and how family substance use may relate to emotional and social development, regardless of the students' personal substance use or lack thereof. The second sample consists of family members of individuals seeking assessment and referral services at the Lorain County Alcohol and Drug Abuse Services (LCADA). Typically individuals seeking assessment and referral services are referred to LCADA through the court system after being identified as high risk for a substance abuse or dependence disorder. These participants were recruited to participate in this study during the initial assessment for treatment services and during family group services. Not

all individuals receiving assessments are diagnosed with substance use disorders, and many individuals present for the family group services are court ordered to attend regardless of a diagnosed substance use disorder. The abusers (i.e., diagnosed clients at LCADA) themselves were not recruited and were not included as participants. While participants may have been substance abusers, individuals in treatment were not actively recruited for this study.

Participants were given a survey consisting of demographic information and personal and family alcohol and drug use histories using the Self-Administered Alcoholism Screening Test (SAAST and SAAST form II) to assess the impact of alcohol abuse. Measures of depression, anxiety, social and family adjustment were also included in the survey.

All the questions on the survey came directly from published normed measures, with only minor modifications to compensate for the measure being administered in a non-clinical setting. The measures used consisted of the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and Social Adjustment Scale-Self Report (SAS-SR). The questions on the SAAST form II regarding a family member's or significant other's alcohol use were modified to reflect that the family member is not being treated at an inpatient treatment facility by replacing the word "patient" with "family member". To compensate participants for their time, participants in the first group received extra credit from their Introduction to Psychology professors. Participants in the second group were entered into a raffle for a gift-certificate worth \$20.00.

Participants from Cleveland State University (n=177) completed the survey of family alcohol use, depression, anxiety, and adjustment. The average age of the participants was

20.4 years old. Thirty nine percent of the participants were male (n=69), 54% were female (n=96), and 12 participants (7%) did not indicate their gender. Participants indicated that they had an average of 13.3 years of education (standard deviation=1.86 years). Forth seven percent of the participants (n=84) were white, 32% (n=57) were African-American, 4% (n=7) were Hispanic, and 16% (n=29) indicated another ethnicity or did not indicate their ethnicity. Fourteen participants (7.91%) were removed from the final analyses based on scores on the SAAST form II. Scores that were greater than two standard deviations above the mean on the SAAST form II were removed. This process removed individuals who were answering in one of two patterns. First, participants with scores two standard deviations above the mean may were reporting levels of family alcohol use well above the cut off for an alcohol abuse disorder. This study examined the relationship between negative outcomes and normal levels of family alcohol use; since scores greater than two standard deviations above the mean are outside the normal level of alcohol even for heavy alcohol user, they were removed. Secondly, participants with scores two standard deviation above the mean for family alcohol use may have been answering the questions randomly, resulting in an atypically high score and were removed from the analyses. The data collected from the remaining 163 participants were used in the analyses.

CHAPTER VI

MEASURES

The Self-Administered Alcoholism Screening Test (Colligan, Davis, & Morse, 1988; Swenson & Morse, 1975) is a 35-item screening questionnaire, which includes items related to drinking behavior, consequences of drinking, friends' and relatives' reactions to drinking, and family history of drinking. The SAAST has been demonstrated to be a valuable screening instrument in assessing alcohol abuse in both patient and non-patient samples (Cohen, McKeever, Cohen, & Stimmel, 1977; Davis, Hurt, Morse, & O'Brien, 1987). Six factors of addiction were found for the SAAST: loss of control, occupationally and socially disruptive behaviors, physical consequences, emotional consequences, others' concern about the person's drinking, and family history of alcohol problems. The SAAST has two forms, Form I, which is given to the substance user, and Form II, which can be given to a person who knows the substance user (Swenson & Morse, 1975). The SAAST is scored on a scale of 0 to 35, with scores above 7 indicating addiction. The SAAST has been shown to have a high degree of validity in differentiating substance abusers and non-users (Corcoran & Fischer, 2000). The SAAST demonstrated high

sensitivity (95%), a test's ability to correctly identify a condition reducing type II error, and high specificity (96%), the test's ability to correctly identify a negative result and reduce type I error, which means that the SAAST can accurately indicate if an individual is abusing alcohol without falsely identifying non-abusers as having abuse problems (Corcoran & Fischer, 2000). The SAAST also has a short form consisting of questions 2, 4b, 8, 11, 17, 18, 25, 27, and 31 (Corcoran, Fischer, 2000). Scores on questions 4b and 18 are given extra weight when determining a total score. The short form score was administered to determine if the participant taking the survey has a substance abuse problem of their own. If sufficient participants' scores indicate abuse problems, their data was analyzed to determine if the participants' personal alcohol abuse impacts the measures of anxiety, depression or adjustment.

The Beck Depression Inventory-II (Beck, Steer & Brown, 1996) is a 21 item self-report measure that assesses cognitive, affective, and somatic symptoms of depression. For each item, respondents chose from a group of sentences the one that best describes how they have been feeling in the previous two weeks. Research supports the reliability and validity of this depression measure (Dozios, Dobson, & Ahnberg, 1998; Steer, Ball, Ranieri, & Beck, 1997).

The Beck Anxiety Inventory (Beck & Steer, 1990) is a 21-item self-report measure that assesses symptoms of anxiety. This measure requires the respondent to rate the degree they were bothered by each symptom in the past week on a 4-point scale that ranges from 0 (not bothered at all) to 3 (severely bothered). Research supports the reliability and validity of this measure (Osman, Kopper, Barrios, Osman, & Wade, 1997).

The Social Adjustment Scale-Self Report (SAS-SR) (Weissman & Bothwell, 1976) may be the most widely used comprehensive assessment of social functioning. It is a 54-item, self-report inventory that provides an overall measure of affective and instrumental performance during the past two weeks and provides separate factor scores along seven social dimensions including: work (questions 1 to 18), social/leisure (questions 19 to 29), extended family (questions 30 to 37), marital (questions 38 to 46), parental (questions 47 to 50), family unit (questions 51 and 53), and economic (question 54). Higher ratings indicate poorer social adjustment in each of the seven dimensions as well as in the overall score (Hudson et al., 2002).

The work subscale examines time lost from one's job, impaired performance while on the job, and work-related distress in participants who work 15 hours or more per week for pay (Weissman, 1999). The work subscale is divided into three sections, work for pay, housework, and school work, with a participant only answering questions from one of the three sections. The work subscale was removed from the analysis, because the same survey was distributed to college students and family members of substance abusers at a treatment center. Due to participants only answering questions on one section of the subscale, there was the possibility of too few participants answering any one section to provide an accurate analysis.

The social/leisure subscale focuses on difficulties with the extent and quality of contact with friends, social interactions, and leisure activity involvement. The extended family subscale taps disruptions in the quality of relationships and interactions with non-nuclear relatives outside of the home. The marital subscale provides information on problematic interpersonal exchanges, lack of affection, and sexual difficulties in intimate

relationships for participants who currently have a spouse or partner. The parental subscale focuses on lack of involvement, impaired communication, and lack of affection in parenting for individuals who have children. The family unit subscale examines disruptions in the quality of relationships and interactions with one's partner or children. Finally, the economic subscale measures the adequacy or inadequacy of available finances to meet a participant's own needs and those of his or her immediate family (Hudson et al., 2002).

CHAPTER VII

ANALYSIS

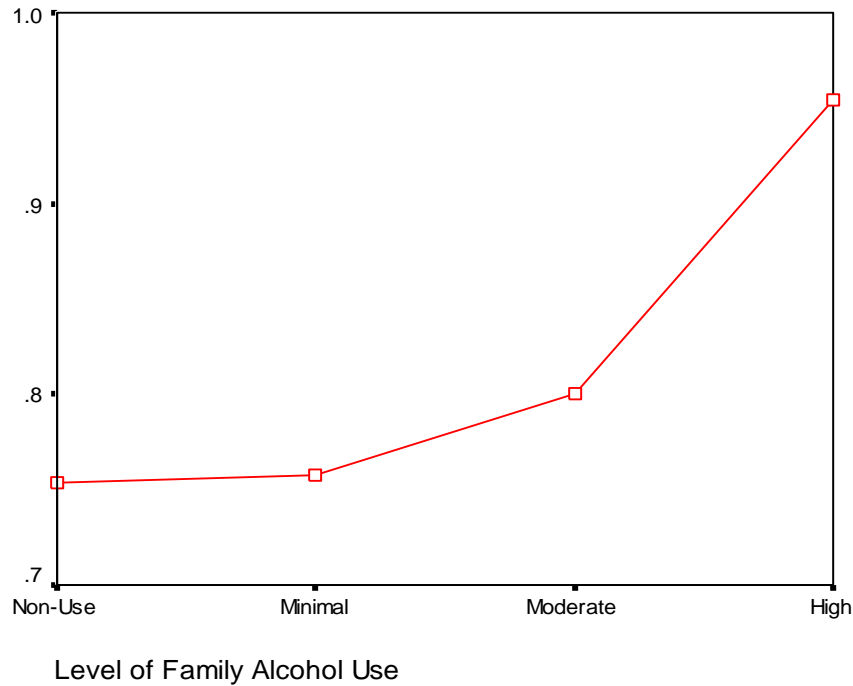
The following hypotheses were tested: reports of high levels of family alcohol use will be significantly correlated with negative outcomes on the BDI-II, BAI, and SAS-SR scales. More specifically, the degree of alcohol use was expected to be significantly positively correlated with depression, anxiety and adjustment scores, indicating higher levels of dysfunction associated with increased alcohol use. Participants reporting high levels of family alcohol use were expected to demonstrate scores on the BDI-II, BAI, and SAS-SR scales that were significantly higher than participants reporting low levels of family alcohol use (Figure 1). Finally, higher reports of negative outcomes were expected for participants reporting alcohol abuse compared to participants reporting no or minimal alcohol use. Nevertheless, a significant relationship is still predicted between alcohol use and negative outcomes even in participants reporting non-significant levels of substance use (i.e., those participants scoring lower than the cutoff of 4 on the short form of the SAAST).

Participants will have an overall score for each of the scales presented on the survey and subscale scores for each of the subscales on the SAS-SR. For the SAAST, short

forms and form II, the BDI-II and the BAI the overall score used for the analysis is the total of the questions answered, for the SAS-SR the scores that are used in the analysis are the means of the items answered for each subscale and the overall test. ANOVAs were conducted to determine if a significant difference exists between the mean scores on the BDI-II, BAI, and SAS-SR for the different levels of reported family alcohol use. Pearson correlations were then used to determine the relationship between the scores obtained on the adjustment, anxiety and depression scales with the score obtained on the SAAST form II; this determined the degree to which the reported family alcohol use is correlated with the different negative outcomes. Finally Pearson correlations were carried out for respondents from college and from clinical settings individually to determine if there were any significant differences on these measures between the two participant populations. A Bonferroni correction was done to prevent an inflated alpha level due to running multiple analyses.

Although the ANOVA and Pearson correlations are often used in the literature testing the same measures (Bidokhti et al., 2006; Hudson et al., 2002), there were several problems with these analyses. One problem was that the data categories of high and low use were not of equal size. ANOVA analyses assume that the variables are relatively equal in size. A second problem is that data may not be normally distributed. Assumptions of the statistical analyses performed were violated due to the lack of normally distributed data.

Figure 1- Example of Positive Correlation between Family Use and Negative Outcomes



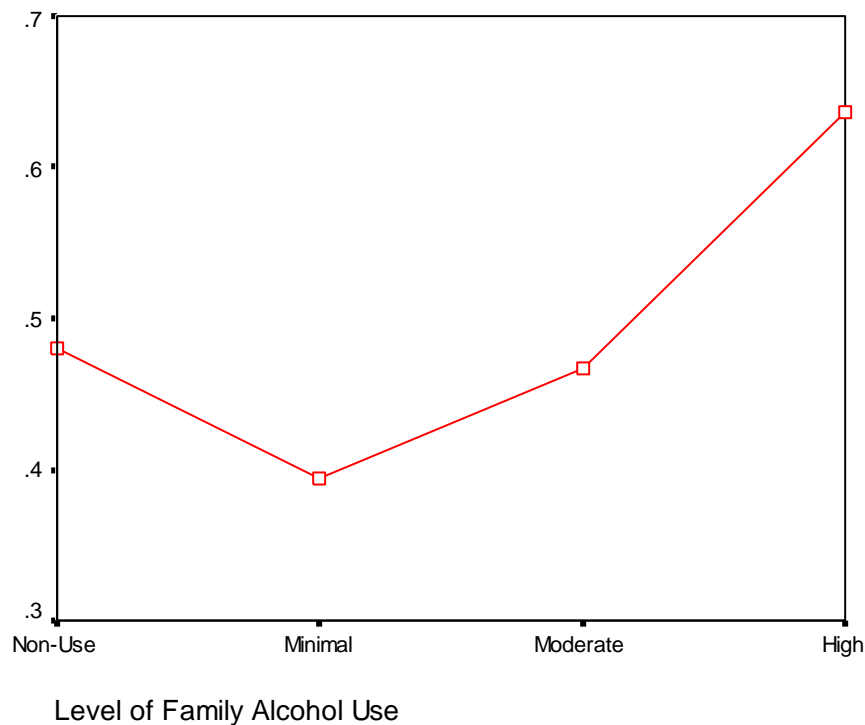
To address this issue a Chi squared tests was conducted; this test does not require continuous normally distributed data. The Chi squared test determined if the participants' reports of anxiety, depression, or adjustment are dependent upon the presence high levels of family alcohol use. The drawback to this method of analysis is that it cannot provide the direction of the relationship between the variables. A Chi squared analysis can only determine if a significant relationship exists, and was included to support the main analysis based on the ANOVAs and Pearson correlations. Significant results on a Chi squared analysis with non-significant results on an ANOVA or Pearson correlation would indicate that a significant relationship does exist, yet due to the extensive variance in the data the relationship could not be established using tests that assumed equal variance and normal distributions. Significant Pearson correlations that are not confirmed by the Chi squared analysis would indicate that the variance in the data

significantly influenced the results and further analysis is needed. In some cases a Spearman correlation was performed for ordinal data collected.

If the null hypothesis is rejected, the implication would be that substance use, regardless of its level, significantly contributes to the negative outcomes of depression, anxiety and poor adjustment in the family members of the user, further suggesting that there is no safe level of alcohol use. In the case of substantial correlations obtained between family alcohol use and negative outcomes, implications can be made regarding the need for prevention and treatment options to be extended to the family members of alcohol users. This is supported by current theories of development that indicate that psychosocial functioning is determined by interactions with family and the larger social environment (Dore, 1998). The possibility also existed for a dose response function to be present in the relationships between alcohol use and negative outcomes. In these cases it is possible for a J-shaped function to occur, in which minimal to moderate alcohol users exhibit the lowest levels of anxiety, depression and maladjustment, alcohol abstainers indicate higher levels, and high alcohol users exhibit the highest levels (see Figure 2). This pattern is often found in the relationship between alcohol and mortality and health risks (Bernner, Arndt, Rothenbacher, Schuberth, Fraise & Fliedner, 1997; Castelnuovo, Costanzo, Bagnardi, Donati, Iacoviello, de Gaetano, 2006; Evans, Kerr, Flanagan, 2006). Alcohol has been shown to be associated with increased high-density lipoprotein cholesterol levels and fibrinolysis, decreased platelet aggregation and coagulation factors, and beneficial effects on endothelial function and inflammation (Castelnuovo et al., 2006). At moderate levels of alcohol use there is an inverse association with negative medical outcomes, as alcohol consumption increases risk for health risk decreases.

However, at high levels of use higher rates of cancers, cirrhosis, and death from accidents associated with increased alcohol consumption are reported (Castelnuovo et al., 2006). This pattern indicates one of two possible patterns. First, that at low levels of use there may be physical and mental health benefits compared to abstinence, but that these benefits are lost with excessive use. Secondly, individuals who abstain from alcohol use may have additional qualities that increase their risk of physical and mental health problems. Factors such as age, abstinence due to a past addiction or health problems may contribute to higher levels of negative outcomes for individuals reporting no alcohol use. This study was unable to control for these factors; because of this a resulting J-shaped function could be interpreted as minimal alcohol use being beneficial or as non-users possessing preexisting factors that increase the likelihood of negative outcomes.

Figure 2- Example of J-Shaped Function



Alternatively, failure to reject the null hypothesis indicates that substance use may not impact users' family members' anxiety, depression, or adjustment. It may be the case that alcohol use still contributes to negative outcomes, yet only at clinically elevated levels and cannot be evidenced in non-clinical alcohol use; although given the problem of interpreting null effects, no definitive conclusions could be made. If this is the case, further research is needed to determine at which levels of family alcohol use negative outcomes begin to manifest. Furthermore, it is possible that the null hypothesis is not rejected for all conditions. With correlations across different scales, it is possible to detect a significant correlation on one scale and not another, indicating that alcohol use impacts functioning on some levels but not on others.

There are many factors that may explain why the null hypothesis is not rejected for all conditions. A measure may have a narrow range of variance, which would require a larger sample size to show significant results. There may also be the influence of a confounding variable which are unaccounted for; this may reduce the effectiveness of the given measures to determine a significant effect. This study will advance the field of psychology in the study of substance use, whether or not a significant effect is found, by establishing the impact or lack thereof of alcohol use on social and emotional expression, establishing a framework for the continued study in alcohol abuse and negating non-significant variables. Further investigation in this area of study may be needed to determine if variables such as the specific relationship between the user and participant, participant's age, gender, race, or education level contribute significantly to the relationship between substance use and negative outcomes.

CHAPTER VIII

RESULTS

The scores on the SAAST form II were used to separate participants into categories based on their reports of family alcohol use. The scores on the SAAST form II were divided into high and low use based on a mean split of the data (mean= 4.32). The high and low groups were each divided again based on mean splits of the data in each group. This process created four groups of participants based on increasing levels of reported family alcohol use; non-users (n= 77, mean= .09), minimal users (n= 34, mean= 3.26), moderate users (n= 30, mean= 8.27) and heavy users (n= 22, mean= 15.36). Participants were also classified as possible alcoholics (n=21) and non-alcoholic (n=142) based on the scores on the SAAST short form, with scores greater than the cut off score of 4 indicating alcoholism. ANOVAs were used to determine if there were significant differences between the scores on the BDI-II, BAI, and SAS-SR scales based on the participants classification of use and alcoholism.

To determine the relationship between the levels of family alcohol use, how much alcohol use the participants reported for their family members, and reports of negative

outcomes, how much anxiety, depression, and maladjustment the participants reported for themselves, ANOVAs were conducted. First, the relationship between the reports of alcohol use in the participants family members were compared to the participants reports of anxiety. A significant difference was observed between the levels of reported family alcohol use and the participants' reports of anxiety ($F(3) = 5.294, p = .002$). A significant positive correlation was also observed between the levels of reported family alcohol use and the participants' reports of anxiety (Pearson Correlation $r = .201, p = .01$). These results indicate that participants who report high levels of alcohol use within their families are experiencing greater levels of anxiety than participants who report low levels of alcohol use within their families. Post Hoc tests were conducted to examine the relationships between the different levels of reported family alcohol use and the participants' reports of anxiety. On the measure of anxiety, high levels of family alcohol use were significantly different than the levels of non-use ($p = .002$), minimal use ($p = .002$), and moderate use ($p = .003$). On the measure of anxiety there were no significant differences between participants reporting no, minimal or moderate family alcohol use.

The relationship between the reports of alcohol use in the participants family members were compared to the participants reports of depression. There was no significant difference in the overall analysis between the participants' reports of depression and the levels of family alcohol use. While there was no overall mean difference between the reports of family alcohol use and depression, there were significant differences between high family alcohol use and minimal family alcohol use ($p = .038$), and moderate family alcohol use ($p = .042$). These patterns are best illustrated by plotting the means of

depression for each of the levels of family alcohol use (shown in Figure 3). This figure indicates that there are higher rates of depression for participants reporting high family alcohol use compared to those reporting minimal or moderate family alcohol uses. Figure 3 also demonstrates a J-shaped function, in which participants reporting no family alcohol use reported higher levels of depression than participants reporting minimal family alcohol use.

The individual items on the measures of anxiety and depression each measure a different facet of the overall dimension. Because there are no subscales for these measures, such as with the SAS-SR, comparisons were planned to examine the interactions of the individual items of the scales with the level of family alcohol use if the overall interaction did not provide a significant result to determine if a specific facet of the dimension had a significant relationship with family alcohol use. Two of the 21 items on the BDI-II had significant differences along the factor of reported family alcohol use. Item 18, crying ($F(3) = 6.595, p = .001$), and item 20, agitation ($F(3) = 2.819, p = .041$), both had significant mean differences along the factor of family alcohol use. As with the measure of anxiety the level of high reported family alcohol use was significantly higher than the reported levels of no, minimal use, and moderate family alcohol use (shown in Figure 4). There were no significant relationships between the reported levels of family alcohol use and the participants' adjustment scores.

The significant differences between the reports of family alcohol use and the outcomes of participant anxiety and depression indicate that there is a connection between these variables. To determine if a relationship exists between reports of alcohol use and negative outcomes, ANOVAs were conducted between the participants' alcohol

use and negative outcomes. For the factor of addiction there were significant differences in the means of anxiety ($F = 7.779, p = .006$) and depression ($F = 14.625, p = .001$). On the measures of adjustment the only significant relationship was on the family unit subscale along the factor of alcoholism ($F = 8.613, p = .005$). For the factor of addiction there were significant correlations with depression (Pearson Correlation $r = .322, p = .001$), anxiety (Pearson Correlation $r = .215, p = .006$), and the family unit subscale (Pearson Correlation $r = .377, p = .005$). These results show that participants who are reporting personal alcohol use that indicates an alcoholic pattern of response are also reporting higher levels of anxiety, depression (see Figure 5) and family maladjustment.

Figure 3- Observed relationships between Family Use and Anxiety and Depression

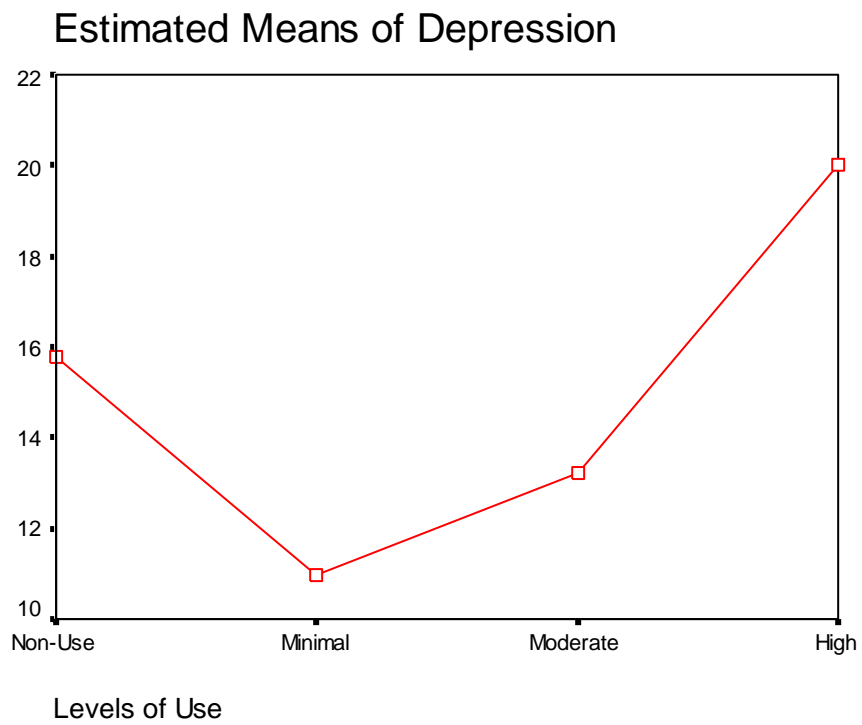
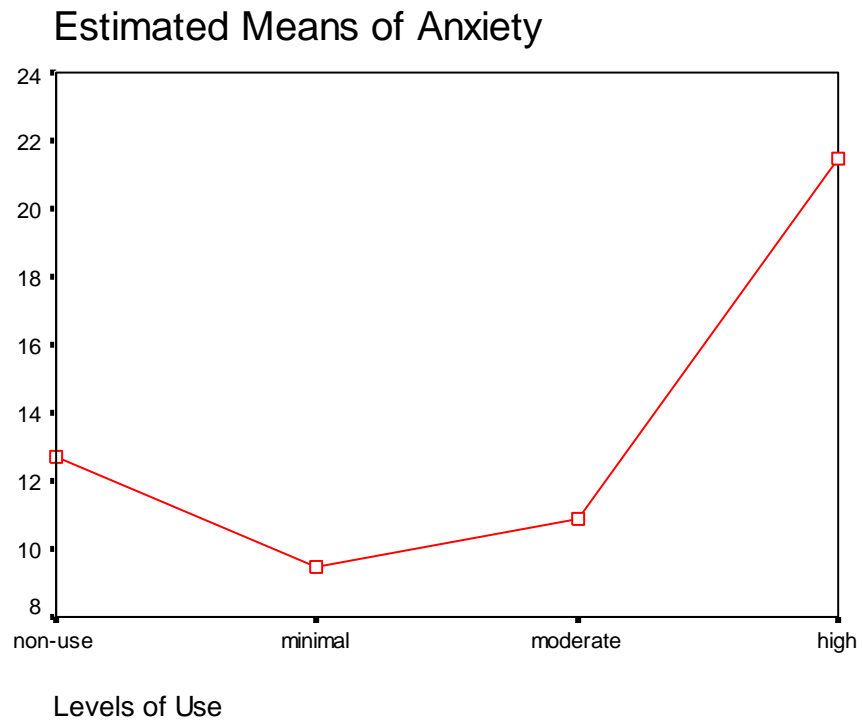


Figure 4- Observed relationships between BDI-II items and Family Alcohol Use

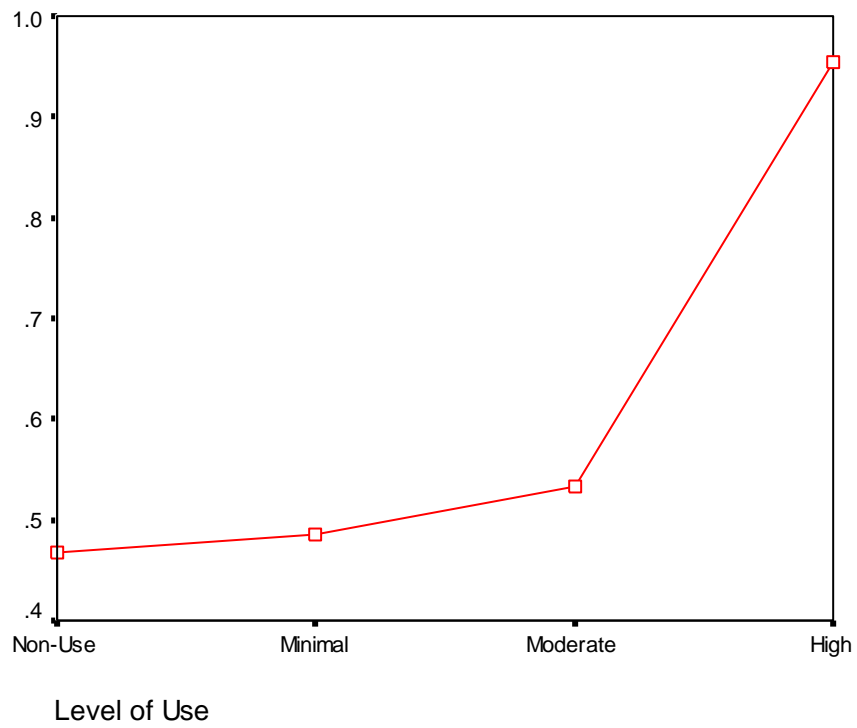
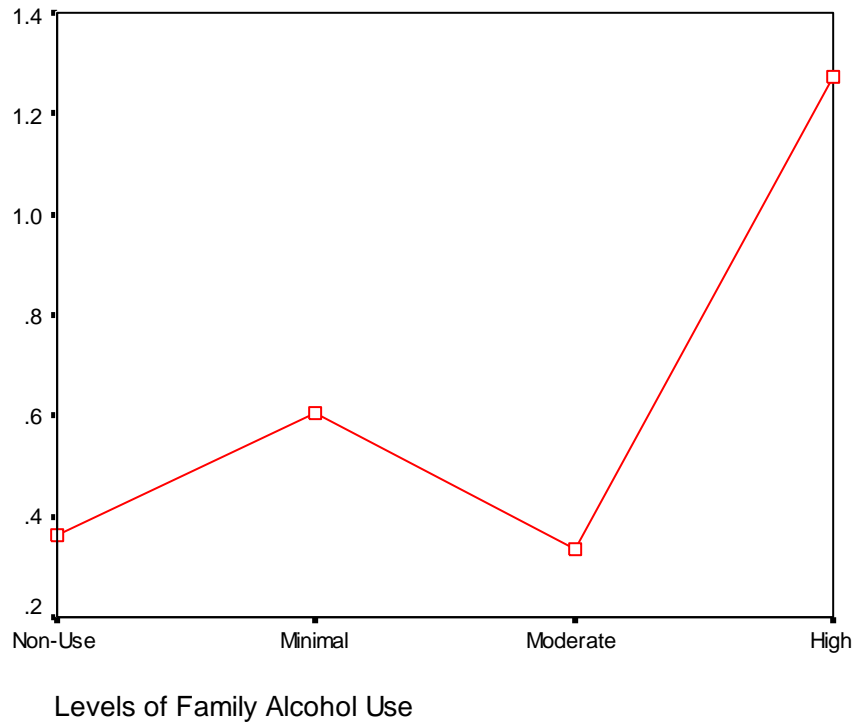
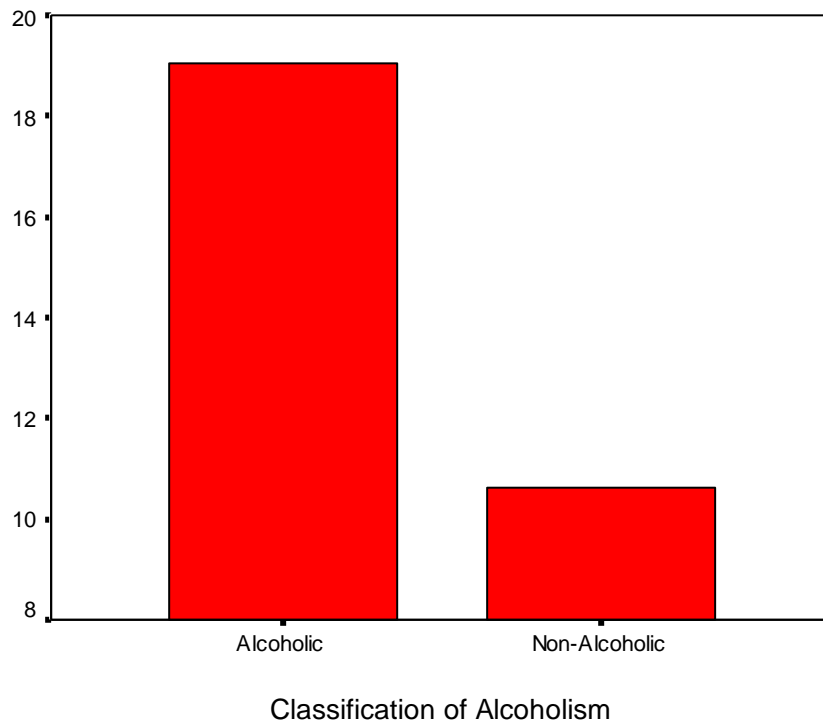
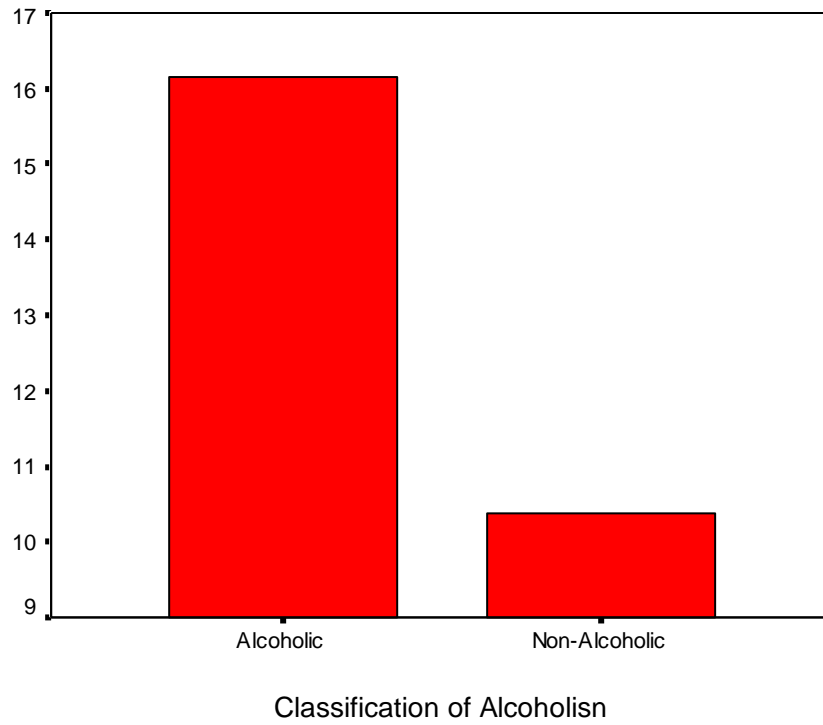


Figure 5- Observed Relationship between Alcoholism and Outcomes



CHAPTER IX

DISCUSSION

The objective of this study was to examine the relationship between reports of family alcohol use and reports of anxiety, depression and adjustment with the hypothesis that the reports of family alcohol use would be significantly positively correlated with the measures of anxiety, depression and adjustment. The data indicate that there is a significant difference between the participants' responses on the BAI for the different levels of family alcohol use, and a significant positive correlation between anxiety and the levels of family alcohol use. Plotting the mean scores of anxiety for the different levels of reported family alcohol use revealed a J-shaped function (Figure 3). This function indicates that participants reporting no family alcohol use reported higher levels of anxiety than participants reporting minimal family alcohol use. It has been established in the literature that rates of negative outcomes increase with increased personal alcohol use (Suchman & Luthar, 2000) and with increased alcohol use in an individual's family (Stanton & Shadish, 1997). This study shows that for different levels of reported family alcohol use there are significantly different reported levels of anxiety for the individual.

Higher rates of negative outcomes for high levels of reported family alcohol use were expected. Because levels of family alcohol use were not collected in previous studies, a downtrend in anxiety between reports of no family alcohol use and minimal family alcohol use were not previously observed. This finding is important because it shows that family members of alcohol users exhibit outcomes of anxiety in the same pattern as alcohol users experience health risks (Bernner et al., 1997; Castelnuovo et al., 2006; Evans et al., 2006), even though the differences between non-use, minimal use, and moderate use were not significant.

The means plot of depression scores for the different levels of family alcohol use shows the same J-shaped function as anxiety, with significant differences between high use and minimal and moderate uses, although the ANOVA for the overall model was not significant. In this model there were significantly higher rates of depression for participants reporting high family alcohol compared to those reporting minimal or moderate family alcohol use. However, the reports of depression for participants with no family alcohol use were high enough that they were not significantly different from participants reporting high family alcohol use (Figure 3).

Two possible explanations exist for the J-shaped function between negative outcomes and reported family alcohol use. Either moderate levels of family alcohol use contribute to a reduction of negative outcomes or no family alcohol use contributes to higher levels of negative outcomes. Individuals who drink at moderate levels are often motivated to use for social reasons (Kuntsche, Knibbe, Gmel, Engels, 2005). Individuals using alcohol at moderate levels may have more social interactions than non-users, leading to lower levels of depression and anxiety. Family members of social users may experience

reductions in anxiety and depression due to the increased levels of social interaction within their families. It has been indicated that individuals who use alcohol at moderate levels have lower risk for many health risks when compared to non-users (Bernner et al., 1997). This relationship between alcohol use and health risks may be a contributing factor to the higher rates of depression and anxiety in the family members of non-users. If non-users are experiencing more health problems than moderate users, it is possible that the family members of non-users have higher levels of negative outcomes as a result of caring for ailing relatives.

A lack of family alcohol use may contribute to higher levels of negative outcomes; this may be due to confounding factors that contribute to the family members' non-use. If participants' family members are non-users due to a past addiction, it is possible that the family members' past addictions contributed to higher rates of depression and anxiety in the participants. It is also possible that participants' family members have preexisting medical conditions that prevent them from using alcohol which in turn contribute to higher rates of depression and anxiety in the participants. Although the results of this study show that significant relationships exist between levels of family alcohol use and anxiety and depression, it is still unclear what accounts for these differences. Further research is needed to determine why family members of non-users report higher levels of negative outcomes than family members of moderate users; confounding factors need to be controlled for so that an accurate interpretation can be made of the relationship between family alcohol use and negative outcomes.

Participants indicating high alcoholic levels of personal use scored significantly higher than participants reporting normal alcohol use on the measures of anxiety,

depression, and adjustment within their family unit. This information is significant in that it demonstrates that these differences do exist between alcoholic and non-alcoholic populations; two of these three differences were observed in the family members of users. While outcomes on anxiety and depression that were significantly related to the level of a family members use were observed, significant results were not obtained between adjustment in a family unit and levels of alcohol use in the family, even though a difference was found for these variables between alcoholics and non-alcoholics. Additional research needs to be done to determine why family members are not reporting maladjustment at higher levels of alcohol use; this may be due to differences in the perception of the family environment between alcoholics and their family members.

REFERENCES

- Allen, L. M., Nelson, C. J., Rouhbakhsh, P., Scifres, S. L., & Greene, R. L. (1998). Gender differences in factor structure of the Self-Administered Alcoholism Screening Test. *Journal of Clinical Psychology*, Vol. 54(4), 439–445.
- American Correctional Association. (2006). Directory of adult and juvenile correctional departments, institutions, agencies and probation and parole authorities, 67th Edition, p. 16.
- American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th Ed., Text Revised). Washington, DC: Author.
- Barnard, M. (2001). Intervening with drug dependent parents and their children: what is the problem and what is being done to help. Glasgow: Centre for Drug Misuse Research.
- Beck, A. T., & Steer, R. A. (1990). Beck Anxiety Inventory Manual. San Antonio, TX: The Psychological Corporation.
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). Manual for the Beck Depression Inventory-II. San Antonio, TX: The Psychological Corporation.
- Bernner, H., Arndt, V., Rothenbacher, D., Schuberth, S., Fraisse, E., & Fliedner, T. M. (1997). The association between alcohol consumption and all-cause mortality in a cohort of male employees in the German construction industry. *International Journal of Epidemiology*, 26(1).

- Bidokhti, N. M., Yazdandoost, R. Y., Birashk, B., & Schottenfeld, R. S. (2006). Family environment of detoxified opiate addicts in Iran and its relationship with symptoms of anxiety and depression. *Contemporary Family Therapy*, 28(1).
- Bumberry, W., Oliver, J. M., & McClure, J. N. (1978). Validation of the Beck Depression Inventory in a university population using psychiatric estimate as the criterion. *Journal of Consulting and Clinical Psychology*, 46, 150-155.
- Castelnuovo, A., Costanzo, S., Bagnardi, V., Donati, M. B., Iacoviello, L., de Gaetano, G. (2006). Alcohol dosing and total mortality in men and women: an updated meta-analysis of 34 prospective studies. *Archives of Internal Medicine*, 166(22), 2437-2445.
- Cohen, A., McKeever, W., Cohen, M., & Stimmel, B. (1977). The use of alcoholism screening test to identify the potential for alcoholism in persons on methadone maintenance. *American Journal of Drug and Alcohol Abuse*, 4, 257–266.
- Colligan, R.C., Davis, L.T., & Morse, R.M. (1988). *The Self-Administered Alcoholism Screening Test (SAAST): A user's guide*. Rochester, MN: Mayo Clinic and Mayo Foundation.
- Corcoran, K., & Fischer, J. (2000). *Measures for clinical practice a sourcebook (Third Ed. Vol. 2 Adults)*. The Free Press, New York.
- Davis, L.J., Hurt, R.D., Morse, R.M., & O'Brien, P.C. (1987). Discriminant analysis of the Self- Administered Alcoholism Screening Test. *Alcoholism: Clinical and Experimental Research*, 11, 269– 273.

- Dore, M. M. (1998). Proceedings from protecting children in substance abusing families 1998: impact and relationship of substance abuse and child maltreatment: risk and resiliency factors what research tells us.
- Dore, M., Nelson-Zlupko, L. & Kaufmann, E. (1999). 'Friends in need': designing and implementing a psychoeducational group for school children from drug-involved families. *Social Work*, 44(2), pg. 179-90.
- Dozios, D., Dobson, K. S., & Ahnberg, J. L. (1998). A psychometric evaluation of the Beck Depression Inventory-II. *Psychological Assessment*, 10, 83–89.
- Evans, K. M., Kerr, D., Flanagan, D. E. (2006). Diabetes and alcohol: time for realistic advice based on the evidence. *Practical Diabetes International*, 23(6): 267–272
- Ferrando, S. J. (2005). Managing depression in HIV disease, viral hepatitis, and substance abuse. *The PRN Notebook*, 10, 19-23.
- Friedmann, M. S., McDermut, W. H., Solomon, D. A., Ryan, C. E., Keitner, G. I. & Miller, I. W. (1997). Family functioning and mental illness: A comparison of psychiatric and non-clinical families. *Family Process*, 36 (4), 357–367.
- Gables, S. & Schidlecker, M. (1992). Behavior problems in sons and daughters of substance abusing parents. *Child Psychiatry and Human Development*, 23(2), pp. 99-115.
- Harrison, P. M. & Beck, A. J. (2006) US Department of Justice, Bureau of Justice Statistics, Prisoners in 2005. Washington DC, US Department of Justice, p. 2-9.

- Hawley, T.L., Halle, T.G., Drasin, R. & Thoma, N.G. (1995). Children of addicted mothers: effects of the 'crack epidemic' on the caregiving environment and the development of preschoolers. *American Journal of Orthopsychiatry*, 65(3), 364-79.
- Hogan, D. M. (1998). The psychological development and welfare of children of opiate and cocaine users: review and research needs. *Journal of Child Psychology and Psychiatry*, 39(5), 609-19.
- Hudson, C. R., Kirby, K. C., Firely, M. L., Festinger, D. S., & Marlowe, D. B. (2002). Social adjustment of family members and significant others (FSOs) of drug users. *Journal of Substance Abuse Treatment*, 23, 171-181.
- Kirby, K. C., Dugosh, K. L., Benishek, L. A., & Harrington, V. M. (2005). The Significant Other Checklist: measuring the problems experienced by family members of drug users. *Addictive Behaviors*, 30, 29-47.
- Kirkcaldy, B. D., Siefen, G., Surall, D., & Bischoff, R. J. (2004). Predictors of drug and alcohol abuse among children and adolescents. *Personality and Individual Differences*, 36, 247-65.
- Kuntsche, E., Knibbe, R., Gmel, G., Engels, R. (2005). Why do young people drink? A review of drinking motives. *Clinical Psychology Review*, 25, 841-861
- McKeganey, N., Barnard, M., & McIntosh, J. (2002). Paying the price for their parents' addiction: Meeting the needs of the children of drug-using parents. *Drugs: Education, Prevention and Policy*, 9, 233-246.

- Monge, P., Fulk, J., Parnassa, C., Flanagan, A., Rumsey, S., & Kalman, M. (1999). Cooperative interagency approaches to the illegal drug problem. *International Journal of Police Science and Management*, 2(3), 229–241.
- Moos, R. H., & Moos, B. S. (1984). The process of recovery from alcoholism: III. Comparing functioning of families of alcoholics and matched control families. *Journal of Studies on Alcohol*, 45, 111 – 118.
- Osman, A., Kopper, B. A., Barrios, F. X., Osman, J. R., & Wade, T. (1997). The Beck Anxiety Inventory: Reexamination of factor structure and psychometric properties. *Journal of Clinical Psychology*, 53, 7–14.
- Piercy, F. P., Volk, R. J., Trepper, T., Sprenkle, D. H., & Lewis, R. (1991). The relationship of family factors to patterns of adolescent substance abuse. *Family Dynamics Addiction Quarterly*, 1, 41–54.
- Reyno, S. M., Stewart, S. H., Brown, C. G., Horvath, P., & Wiens, J. (2006). Anxiety sensitivity and situation-specific drinking in women with alcohol problems. *Brief Treatment and Crisis Intervention*, 6, 268-82.
- Rissmiller, D. J., Biever, M. Mishra, D., & Steer, R. A. (2006). Screening detoxifying inpatients with substance-related disorders for a Major Depressive Disorder. *Journal of Clinical Psychology in Medical Settings*, 13, 311-17.
- Safren, S. A., Heimberg, R. G., Lerner, J., Henin, A., Warman, M., & Kendall, P. C. (2000). Differentiating anxious and depressive self-statements: combined factor structure of the Anxious Self- Statements Questionnaire and the Automatic Thoughts Questionnaire-Revised. *Cognitive Therapy and Research*, 24, 327-44.

- Searight, H. R., Manley, C. M., Bider, A. F., Krohn, B. J., & Russo, J. R. (1991). The families of origin of adolescent drug abusers: perceived autonomy and intimacy. *Contemporary Family Therapy*, 13, 71–81.
- Sheeber, L., Hops, H., & Davis, B. (2001). Family processes in adolescent depression. *Clinical Child and Family Psychology Review*, 4, 19-35.
- Stanton, M. D., & Shadish, W. R. (1997). Outcome, attrition and family-couples treatment for drug abuse: A meta analysis and review of the controlled, comparative studies. *Psychological Bulletin*, 122(2), 170–191.
- Steer, R. A., Ball, R., Ranieri, W. F., & Beck, A. T. (1997). Further evidence of the construct validity of the Beck Depression Inventory-II with psychiatric out patients. *Psychological Reports*, 80, 443–446.
- Substance Abuse and Mental Health Services Administration. (2006). Results from the 2005 National Survey on Drug Use and Health: National Findings (Office of Applied Studies, NSDUH Series H-30, DHHS Publication No. SMA 06-4194). Rockville, MD.
- Suchman, N.E. & Luthar, S.S. (2000). Maternal addiction, child maladjustment and socio-demographic risks: implications for parenting behaviors. *Addiction*, 95(9), 1417-28.
- Swenson, W. M., & Morse, R. M. (1975). The use of a Self-Administered Alcoholism Screening Test (SAAST) in a medical center. *Mayo Clinic Proceedings*, 50, 204–208.
- Weissman, M. M. (1999). SAS-SR question booklet. North Tonawanda, NY: MHS.

Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of General Psychiatry*, 33, 1111 – 1115.

APPENDIX

AGE _____ RACE/ETHNICITY _____ YEARS OF EDUCATION _____ Male/Female
 Yes No

1. Do you feel you are a normal drinker or drug user? (That is you do not use more than		
2. Do close relatives ever complain about your drinking or drug use?		
3. Are you always able to stop drinking or using when you want to?		
4. Has your drinking or drug use ever created problems between you and your spouse, parents, or other near relative?		
5. Do you drink or use in the morning?		
6. Have you ever felt the need to cut down on your drinking or using?		
7. Have you ever been told by a doctor to stop drinking or using?		
8. Has drinking or drug use ever been part of a problem that resulted in your		
9. Have you ever been arrested, even for a few hours, because of driving while		

1. How many friends have you seen or spoken to on the telephone in the last two weeks?

- 1. Nine or more friends
- 2. Five to eight friends
- 3. Two to four friends
- 4. One friend
- 5. No Friends

2. Have you been able to talk about your feeling and problems with at least one friend during the last two weeks?

- 1. I can always talk about my innermost feeling
- 2. I usually can talk about my feelings
- 3. About half the time I felt able to talk about my feelings
- 4. I usually was not able to talk about my feelings
- 5. I was never able to talk about my feelings
- 8. Not applicable; I have no friends

3. How many times in the last two weeks have you gone out socially with other people? For example, visited friends, gone to movies, bowling, church, restaurants, inviting people to your home?

- 1. More than three times
- 2. Three times
- 3. Twice
- 4. Once
- 5. None

4. How much time have you spent on hobbies or spare time interests during the last two weeks? For example, bowling, sewing, gardening, sports, reading?

- 1. I spent most of my spare time on hobbies almost every day
- 2. I spent some time on hobbies some of the days
- 3. I spent a little time on hobbies
- 4. I usually did not spend any time on hobbies but did watch TV
- 5. I did not spend any spare time on hobbies or watching TV

5. Have you had open arguments with your friends in the past two weeks?

- 1. I had no arguments and got along very well
- 2. I usually got along well but had minor arguments
- 3. I had more than one argument
- 4. I had many arguments
- 5. I was constantly in arguments
- 8. Not applicable; I have no friends

6. If your feelings were hurt or offended by a friend during the last two weeks, how badly did you take it?

- 1. It did not affect me or it did not happen
- 2. I got over it in a few hours
- 3. I got over it in a few days
- 4. I got over it in a week
- 5. It will take me months to recover
- 8. Not applicable; I have no friends

7. Have you felt shy or uncomfortable with people in the last two weeks?

- 1. I always felt comfortable
- 2. Sometimes I felt uncomfortable but could relax after a while
- 3. About half the time I felt uncomfortable
- 4. I usually felt uncomfortable
- 5. I always felt uncomfortable
- 8. Not applicable; I have no friends

8. Have you felt lonely and wished for more friends during the last two weeks?

- 1. I have not felt lonely
- 2. I have felt lonely a few times
- 3. About half the time I felt lonely
- 4. I usually felt lonely
- 5. I always felt lonely and wished for more friends

9. Have felt bored in your spare time during the past two weeks?

- 1. I never felt bored
- 2. I usually did not feel bored
- 3. About half the time I felt bored
- 4. Most of the time I felt bored
- 5. I was constantly bored

Are you a single, separated, or divorced person not living with a person of opposite sex

- 1. Yes- Answer questions 10 and 11
- 2. No- Go on to question 12

10. How many times have you been with a date these last two weeks?

- 1. More than three times
- 2. Three times
- 3. Two times
- 4. Once
- 5. Never

11. Have you been interested in dating during the last two weeks? If you have not dated, would you have liked to?

- 1. I was always interested in dating
- 2. Most of the time I was interested
- 3. About half the time I was interested
- 4. Most of the time I was not interested
- 5. I was completely uninterested

Answer questions 12-19 about your parents, brothers, sisters, in-laws and children not living at home.

Have you been in contact with any of them in the last two weeks?

- 1. Yes- answer questions 12-19
- 2. No- go to question 18

12. Have you had open arguments with your relatives in the past two weeks?

- 1. We usually got along very well
- 2. We usually got along very well but had some minor arguments
- 3. I had more than one argument with at least one relative
- 4. I had many arguments
- 5. I was constantly in arguments

13. Have you been able to talk about your feelings and problems with at least one friend during the last two weeks?

- 1. I can always talk about my feelings with at least one relative
- 2. I usually can talk about by feelings
- 3. About half the time I felt able to talk about my feelings
- 4. I usually was not able to talk about my feelings
- 5. I was never able to talk about my feelings

14. Have you avoided contact with your relatives these last two weeks?

- 1. I have contacted relatives regularly
- 2. I have contacted a relative at least once
- 3. I have waited for my relatives to contact me
- 4. I avoided my relatives, but they contacted me
- 5. I have no contact with any relatives

15. Did you depend on your relatives for help, money, advice, or friendship during the last two weeks?

- 1. I never need to depend on them
- 2. I usually did not need to depend on them
- 3. About half the time I needed to depend on them
- 4. Most of the time I depend on them
- 5. I depend completely on them

16. Have you wanted to do the opposite of what your relatives wanted in order to make them angry during the last two weeks?

- 1. I never wanted to oppose them
- 2. Once or twice I wanted to oppose them
- 3. About half the time I wanted to oppose them
- 4. Most of the time I wanted to oppose them
- 5. I always oppose them

17. Have you been worried about things happening to your relatives without good reason in the last two weeks?

- 1. I have not worried without reason
- 2. Once or twice I worried
- 3. About half the time I worried
- 4. Most of the time I worried
- 5. I have worried the entire time

18. During the last two weeks, have you been thinking that you have let any of your relatives down or have been unfair to them at any time?

- 1. I did not feel I let them down at all
- 2. I usually did not feel that I let them down
- 3. About half the time I felt I let them down
- 4. Most of the time I have felt I have let them down
- 5. I always felt that I have let them down

19. During the last two weeks, have you been thinking that any of your relatives have let you down or have been unfair to you at any time?

- 1. I never felt that they let me down
- 2. I felt that they usually did not let me down
- 3. About half the time I felt they let me down
- 4. I usually have felt that they have let me down
- 5. I am very bitter that they let me down

Are you living with your spouse or have you been living with a person of the opposite sex in a permanent relationship?

- 1. Yes- please answer questions 20-28
- 2. No- Go to question 29

20. Have you had open arguments with your partner in the past two weeks?

- 1. We had no arguments and we got along very well
- 2. We usually got along very well but had some minor arguments
- 3. We had more than one argument
- 4. We had many arguments
- 5. We were constantly in arguments

21. Have you been able to talk about your feelings and problems with your partner during the past two weeks?

- 1. I can always talk about my feeling
- 2. I usually can talk about my feelings
- 3. About half the time I felt able to talk about my feelings
- 4. I usually was not able to talk about my feelings
- 5. I was never able to talk about my feelings

22. Have you been demanding to have your own way at home during the last two weeks?

- 1. I have not insisted on always having my own way
- 2. I usually have not insisted on having my own way
- 3. About half the time I insisted on having my own way
- 4. I usually insisted on having my own way
- 5. I always insisted on having my own way

23. Have you been bossed around by your partner these past two weeks?

- 1. Almost never
- 2. Once in a while
- 3. About half the time
- 4. Most of the time
- 5. Always

24. How much have you felt dependent on your partner these past two weeks?

- 1. I was independent
- 2. I was usually independent
- 3. I was somewhat dependent
- 4. I was usually dependent
- 5. I depend on my partner for everything

25. How have you felt about your partner during the past two weeks?

- 1. I always felt affection
- 2. I usually felt affection
- 3. About half the time I felt dislike and half the time affection
- 4. I usually felt dislike
- 5. I always felt dislike

26. How many times have you and your partner had intercourse?

- 1. More than twice a week
- 2. Once or twice a week
- 3. Once every two weeks
- 4. Less than once every two weeks but at least once in the past month
- 5. Not at all in a month or longer

27. Have you had any problems during intercourse, such as pain, during these last two weeks?

- 1. None
- 2. Once or twice
- 3. About half the time
- 4. Most of the time
- 5. Always
- 8. Not applicable; no intercourse in the last two weeks

28. How have you felt about intercourse during the last two weeks?

- 1. I always enjoyed it
- 2. I usually enjoyed it
- 3. About half the time I did and half the time I did not enjoy it
- 4. I usually did not enjoy it
- 5. I never enjoyed it

Have you had unmarried children, stepchildren, or foster children living at home during the last two weeks?

- 1. Yes-please answer questions 29-32
- 2. No- go to question 33

29. Have you been interested in what your children are doing-school, play, or hobbies during the past two weeks?

- 1. I was always interested and actively involved
- 2. I was usually interested and involved
- 3. About half the time interested and half the time not interested
- 4. I usually was disinterested
- 5. I was usually disinterested

30. Have you been able to talk and listen to your children during the last two weeks? Include only children over the age of 2

- 1. I was always able to communicate with them
- 2. I usually was able to communicate with them
- 3. About half the time I could communicate
- 4. I was usually not able to communicate
- 5. I was completely unable to communicate
- 8. Not applicable; no children over the age of 2

31. How have you been getting along with the children during the last two weeks?

- 1. I had no arguments and we got along very well
- 2. I usually got along very well but had some minor arguments
- 3. I had more than one argument
- 4. I had many arguments
- 5. I was constantly in arguments

32. How have you felt towards your children these last two weeks?

- 1. I always felt affection
- 2. I mostly felt affection
- 3. About half the time I felt affection
- 4. Most of the time I did not feel affection
- 5. I never felt affection towards them

Have you ever been married, ever lived with a person of the opposite sex, or ever had children?

- 1. Yes- Please answer questions 33-34
- 2. No- Go to question 35

33. Have you worried about your partner or any of your children without any reason during the past two weeks, even if you are not living together now?

- 1. I never worried
- 2. Once or twice I worried
- 3. About half the time I worried
- 4. Most of the time I worried
- 5. I always worried
- 8. Not applicable; partner and children not living

34. During the last two weeks, have you been thinking that you have let down your partner or any of your children at any time?

- 1. I did not feel I let them down
- 2. I usually did not feel that I let them down
- 3. About half the time I felt I let them down
- 4. Most of the time I felt I let them down
- 5. I let them down completely

35. Have you had enough money to take care of your own and your family's financial needs during the past two weeks?

- 1. I had enough money for needs
- 2. I usually had enough money, with minor problems
- 3. About half the time I did not have enough money but did not have to borrow money
- 4. I usually did not have enough money and had to borrow from others
- 5. I had great financial difficulty

Please indicate your relationship to the individual in your family who is currently using the most alcohol and/or drugs, or has had problems in the past. **(If no member of your family has experience with alcohol and/or drugs please skip this section.)**

Drugs for which your family member has a current prescription are not being counted as drug use in this survey.

Parent		Brother or Sister		Spouse, Significant Other	
Grandparent		Aunt or Uncle		Cousin	
Other/ N/A		If other, what is your relationship to the individual:			

Please answer the following questions for the family member indicated. Yes No

1. Does the family member have a drink or use drugs now and then?		
1b. If the family member does not drink or use now did he/she stop because of problems with alcohol or drugs?		
2. Do you feel the family member is a normal drinker or drug user? (That is he/she does not use more than average)		

3. Has the family member ever awakened the morning after some drinking or drug use the night before and found that he/she could not remember a part of the evening?		
4. Do you ever worry or complain about the family member's alcohol or drug use?		
4b. Do close relatives ever complain about the family member's drinking or drug use?		
5. Can the family member stop drinking without a struggle after one or two drinks?		
6. Does the family member ever feel guilty about his/her drinking or drug use?		
7. Do friends or relatives think the family member is a normal drinker or user?		
8. Is the family member always able to stop drinking or using when he/she wants to?		
9. Has the family member ever attended a meeting of Alcoholics Anonymous (AA) because of his/her drinking?		
10. Has the family member ever got into physical fights when drinking or using?		
11. Has the family member's drinking or drug use ever created problems between the family member and you, parents, or other near relative?		
12. Have you or other family member ever gone to anyone for help about the family member's drinking or drug use?		
13. Has the family member ever lost friendships because of his/her drinking or using?		
14. Has the family member ever got into trouble at work because of his/her drinking or drug use?		
15. Has the family member ever lost a job because of his/her drinking or drug use?		
16. Has the family member ever neglected obligations, the family, or work for two or more days in a row because of his/her drinking or drug use?		
17. Does the family member drink or use in the morning?		
18. Has the family member ever felt the need to cut down on his/her drinking or using?		
19. Have there been times in the family member's life when he/she found it necessary to completely avoid alcohol?		
20. Has the family member ever been told he/she has liver trouble? Cirrhosis?		
21. Has the family member ever had delirium tremens (DTs)?		
22. Has the family member ever had severe shaking, heard voices, or seen things that were not there after heavy drinking?		
23. Has the family member ever gone to anyone for help about his/her drinking?		
24. Has the family member ever been in a hospital or treatment center because of his/her drinking or drug use?		
25. Has the family member ever been told by a doctor to stop drinking or using?		
26. Has the family member ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital? (If no, skip the next question)		
27. Was drinking or drug use part of the problem that resulted in his/her hospitalization?		
28. Has the family member ever been a patient at a psychiatric or mental health clinic or gone to any doctor, social worker, or member of the clergy for help with any emotional problem? (If no, skip next question)		
29. Was drinking or drug use part of the problem?		
30. Has the family member ever been arrested, even for a few hours, because of drunken behavior (not driving)?		
31. Has the family member you ever been arrested, even for a few hours, because of driving while intoxicated?		
32. Has either of the family member's parents ever had problems with alcohol or drugs?		
33. Have any of the family member's brothers or sisters ever had problems with alcohol or drugs?		
34. Have you ever had problems with alcohol or drugs?		
35. Have any of the family member's children ever had problems with alcohol or drugs?		

Beck Anxiety Inventory not shown.

Beck Depression Inventory not shown.

Consent for Student Research Participation

Thank you for your interest in participating in this research project. The project is being conducted by Steven Beyer, a current Clinical Psychology graduate student at Cleveland State University and Prevention Educator at the Lorain County Drug and Alcohol Abuse Services Inc. (LCADA), who can be contacted for additional information regarding this research at (216)687-3834. The purpose of the research in which you will be participating is to explore the relationships between different aspects of your life with focusing on emotions, social functioning and alcohol and/or drug use within your immediate or extended family.

There are minimal risks associated with participation in this study. You may be asked questions that you find hard to answer or are uncomfortable answering. You are under no obligation to answer every question on the survey, and you may skip any question that you find to be too sensitive or distressing. There are other research options available to students. If you are not comfortable answering the questions on this survey you may participate in a different research project for class credit. The survey should take you approximately half an hour to complete. If you are a student and can receive class credit for your participation in this survey you may receive a ½ (.5) credit. If you feel any distress due to questions on this survey please contact the University Counseling Center at (216) 687-2277.

The results of this survey will be kept anonymous. No means of identification will be collected with the survey, please refrain from putting your name or any identifiable marking on the survey materials. While your name will be on this consent no other identification will be collected and this consent form will be kept separate from the answers on the survey. These measures will ensure that it will be impossible to link you to your survey results in anyway. Your participation in this research is voluntary and you can refrain from answering any question you wish to and you may withdraw from the research at any time without any penalty. The results of this survey are anonymous; there will be no way for your family members, professors or other students to find out the results of your survey. The results of this survey or your decision to participate or not will not affect you in any way in class.

I understand that if I have any questions about my rights as a research subject I can contact the CSU Institutional Review Board at (216)687-3630. For additional information please contact Steven Beyer at (216)687-3834 or Dr. Conor McLennan at (216) 687-3750.

Participant Signature

Date

Researcher Signature

Date

Consent for Research Participation

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There are minimal risks associated with participation in this study. You may be asked questions that you find hard to answer or are uncomfortable answering. You are under no obligation to answer every question on the survey, and you may skip any question that you find to be too sensitive or distressing. The survey should take you approximately half an hour to complete. To compensate you for your time in participating in this study you will receive a raffle ticket for a gift certificate worth twenty dollars, the raffle will take place no later than 3-1-08 and if you win the gift certificate will be mailed to you.

The results of this survey will be kept anonymous. No means of identification will be collected with the survey, please refrain from putting your name or any identifiable marking on the survey materials. While your name will be on this consent no other identification will be collected and this consent form will be kept separate from the answers on the survey. These measures will ensure that it will be impossible to link you to your survey results in anyway. Your participation in this research voluntary and you can refrain from answering any question you wish to and you may withdraw from the research at any time without any penalty. The results of this survey are anonymous; there will be no way for your family members or counselors to find out the results of your survey. LCADA will not receive the results of your survey and will not have access to the results of the survey. The results of this survey or your decision to participate or not to participate will not affect you in any way in treatment.

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