Depression And Perception Of Maternal Rejection In Latency Age, African American Children Of Alcoholic Mothers

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Depression and Perception of Maternal Rejection

In Latency Age, African American Children of Alcoholic Mothers

BY

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Submitted in partial fulfillment of the requirements of the

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Abstract

Depression and Perception of Maternal Rejection in Latency Age, African American Children of Alcoholic Mothers

This study investigated differences in depression and perception of maternal rejection among 128 African American latency-age (7 to 12) males and females whose mothers were identified as either alcoholic, nonalcoholic-clinical, or nonalcoholic-nonclinical. Groups were similar on age, gender, and grade level. Participants were recruited from a major urban hospital. The dependent variables of depression and perception of maternal rejection were measured by the Children’s Depression Inventory and the Child Parental Acceptance-Rejection Questionnaire.

The results indicate that children in the alcoholic group did not demonstrate higher levels of depression than children in the control groups. In contrast, previous studies have suggested that young children of alcoholics (COAs) evidence greater levels of depression than nonCOAs. This raises the possibility that previous research, which has predominantly utilized Caucasian subjects, may not be applicable to African American children. Another conclusion that can be drawn from the findings is that clinicians meeting young African American children of alcoholic
mothers should not necessarily assume that these children evidence symptoms of depression nor that depression is an area that needs to be addressed in treatment.

As hypothesized, children of alcoholic mothers did however report significantly higher levels of overall maternal rejection \((p = .001)\) and maternal neglect and indifference when compared to children in the nonalcoholic-nonclinical group. A conclusion then, which also has treatment implications for these children, is that children should be helped to understand the effects that alcohol has regarding their parent’s memory and behavior rather than personalizing parental behavior.

Future researchers might consider comparing various ethnic groups on the dimensions of depression and parental rejection. Exploration of potential protective factors within various ethnic groups, such as the role of the extended family in caring for children, would provide useful information regarding treatment and intervention. Research might also investigate differences between children of alcoholic mothers and mothers who have other substance abuse disorders.
Acknowledgements

In sitting down to write my acknowledgments, I became aware for the first time of the numerous numbers of people who have helped me transform one of my life's goals into a reality. Foremost, I wish to express my gratitude to my chairperson, Dr. Lee, not only for her contributions toward this project, but for the genuine guidance and encouragement she has given me throughout my years at Seton Hall. I am also thankful for the insight and contributions given to me by my other committee members, Dr. Caulker, Dr. Dillon and Dr. Lewis-Chang.

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CHAPTER I

Introduction

The purpose of this study was to compare depression in latency age, African American inner-city children of single, alcoholic mothers to similar groups of children whose mothers were not alcoholic. The degree to which perceptions of maternal rejection and neglect were present in these children was also examined.

Statement of the Problem

Despite recognition of alcoholism as a systemic disease that affects the entire family (Jesse, 1989; Kaufman & Kaufman, 1992), young children of alcoholics (COAs) continue to be ignored, misdiagnosed, and under treated (Bingham & Barger, 1985) by professionals who work with them (Jesse, 1989). Mental health professionals estimate that only 5% of these children receive appropriate intervention due to problems in identifying school age COAs (Kamstra, 1986).

Jesse (1989), who has written extensively about young COA's began her work in a large urban medical center treating adults for secondary and tertiary physical manifestations of the final stage of alcoholism. "So compelling was the advanced diseased condition of the men on my ward that it did not occur to me at the time to
wonder about the status of their children" (Jesse, 1989, p. vii).

Those working primarily with children often experience the opposite phenomenon, that is, so much attention is devoted to a child's presenting problem that "professional denial" (Jesse, 1989, p. 3) keeps clinicians from seeing what is before their eyes.

While it is true that research on young COAs has contributed to our understanding of these children, much of it has focused on externalizing disorders such as Attention Deficit Disorder, Oppositional, and Conduct disorders (Reich, Earls, Frankel, & Shayka, 1993; Sher, 1997). Research literature however, has postulated that affective processes are not only fundamental to adaptation and influence one's behavior, but they also interact with cognitive processes (Rolf, Johnson, Israel, Baldwin, & Chandra, 1988).

Nevertheless, there continues to be a scarcity of research examining depression in young children of alcoholics in general. To date, research regarding depression in young African American COAs continues to be seriously lacking and unfortunately, researchers in other areas have noted a similar trend (Samuel et al., 1997). This is an important void given that the number of children
entering inner-city agencies for treatment and whose primary caretaker is involved with alcohol is very large.

Nonetheless, research conducted on young COA's has seriously ignored African American children. Woodside (1988) was one of the first authors who brought attention to this matter by encouraging future research to focus on minority children of alcoholics. To date, neither this challenge, nor the issue of the experience of maternal rejection in these children has been addressed.

Methodological issues of many of the studies focusing on depression in young COA's (National Institute of Alcohol Abuse and Alcoholism (NIAAA), 1990; West & Prinz, 1987) have been plagued by a lack of control groups and children of all ages being grouped into one sample (NIAAA, 1990). Poor or inadequate measures of depression (West & Prinz, 1987) have attracted criticism to findings as well. The present study has corrected for these limitations.

Finally, while there has been criticism about COA literature for not providing a theoretical context for explaining results (Wilson & Orford, 1978; Scavnicky-Mylant, 1984), this study utilized object-relations theory to provide some context to the issues of young COAs.
Background of the Problem

A recent report from the National Association for Children of Alcoholics (NACoA) (1998) states that there are 28.6 million children of alcoholics (COAs) in the United States, an estimated 11 million of who are under the age of eighteen. COA's also have a four-times-greater risk of developing alcoholism than children of nonalcoholics (NACoA, 1998). There is little scientific information available about low income, minority COAs (NIAAA, 1990). If parental alcoholism is a demonstrable risk factor for childhood psychopathology, these figures suggest that a large population of children are at risk.

Alcoholism has long been recognized as a problem that not only affects the alcoholic, but also their children (El-Guebaly & Offord, 1977). Indeed, over the past decade, evidence has accumulated from a large number of studies suggesting that young COA's are an at-risk population for a variety of difficulties (NACoA, 1998; Roosa, Sandler, Gehring, Beals & Cappo, & 1988). A substantial amount of research reports that young COA's suffer from academic/cognitive difficulties (Bosma, 1972; Deutsch, 1982; Ringdahl, 1980), behavior problems, such as oppositional and conduct disorders (Reich et. al., 1993), and externalizing behaviors (Sher, 1997). Emotional
difficulties have also been linked to young children growing up in alcoholic families such as low self-esteem (Woititz, 1978) and anxiety (Cork, 1969; Herjanic, Herjanic, Wetzel & Tomelleri, 1978; Kamstra, 1986). Claudia Black (1979) has taken a firm position that treatment of young COAs is important in not only preventing future psychological problems, but also in thwarting their potential to become alcoholic adults or to marry alcoholics.

Investigation of depressive affect, however, remains relatively ignored in the studies of young COAs (Rolf et al., 1988). West and Prinz (1987), in their review of the literature between 1975 and 1985 on the relationship between parental alcoholism and childhood psychopathology, found only eleven investigations examining the impact of parental alcoholism on children's emotional functioning. Of these, only two were related to depression in young children (Anderson & Quast, 1983; Moos & Billings, 1982). Moreover, West and Prinz (1987) concluded that the body of research they reviewed was plagued with problems, including inadequate assessment measures and poor research. Three later studies (Kamstra, 1986; Calder & Kostyniuk, 1989; Rolf et al., 1988) specifically investigated the level of depression in this population; however, none investigated
depression in inner city, latency age African American children of alcoholics.

Although depression in young COA's has not received a significant amount of attention in the literature to date, affective disorders such as depression have been a reasonably active topic in adult children of alcoholics' literature (Harter, 2000). In fact, according to Harter, depression appears to be one of the most widely studied symptoms in addition to anxiety and substance abuse itself. Furthermore, retrospective accounts of adults and adolescents raised in alcoholic families report having felt depressed as children (Booz & Hamilton, Inc., 1974). Others (Black 1979; Fujita, 1984; Middleton, 1985) have observed that children who grew up in alcoholic families tended to experience unexplainable bouts of depression in adulthood. Woititz (1985) further describes adult COA's as "chronically depressed" (p. 41) due to the loss of their childhood in that they never had the opportunity to be a child. She also attributes this depression to suppressed anger in growing up in an alcoholic family. Thus, research on depression in young COA's appears to be a needed and valid research area.

The study of depression is valuable and necessary in that it is more than simply a disorder of mood. As Reynolds
(1989) aptly asserts, depression affects multiple areas of functioning, including behavioral, emotional, somatic, and cognitive domains. Clusters of symptoms include anhedonia, lowered self-esteem, social withdrawal, fatigue, impaired school performance, as well as a host of somatic problems (American Psychiatric Association, 1994; Pozanski, 1982; Reynolds, 1992). Of even more concern is that depressed youngsters can evidence psychotic symptoms including hallucinations and delusions (Chambers, Puig-Antich, Tabrizi & Davis, 1982; Strober, Green, & Carlson, 1981). If a link between childhood depression and parental alcoholism can be established, therapeutic intervention and treatment goals could be made clearer.

Latency age (seven to twelve) COA’s comprise a particularly vulnerable group as they do not always maintain clear, realistic concepts regarding relationships (Lidz, 1968). They are prone to believing that they are directly responsible for family problems such as divorce and alcoholism. Clinical observations reveal that children do not know or believe that their parent’s alcoholism is a disease that they cannot cause, control or cure (Woodside, 1988). Often time, they think that their parent would stop drinking (Woodside, 1988) if they picked up their clothes, were better behaved, or did better in school. Latency age
children are further distressed by the disharmony, parental rejection, and fears of abandonment related to the parents drinking (Adler & Raphael, 1983).

Added to the vulnerability of latency age COA's is the suggestion that having an alcoholic mother is more harmful than having an alcoholic father (Hect, 1973; Miller & Jang, 1977; Richards, 1979; Werner, 1986). Steinhausen, Gobel, and Nestler (1984) believe that while both paternal and maternal alcoholism are deleterious, children of alcoholic mothers are more prone to develop emotional disorders. Logically, this makes sense given the fact that women remain largely responsible for raising their children, and are often the primary socializing agent. Nonetheless, little has been done to empirically examine the development of children under the care of an alcoholic, female caregiver (Jester, Jacobson, Sokol, Tuttle, & Jacobson, 2000) other than the effects of prenatal exposure to alcohol.

More critical than providing socialization for her child, however, is the understanding of the importance of the mother-child relationship and the development of the self (Cashdan, 1988). In the case of maternal alcoholism, various identificational, introjective, or mirroring functions between the parent and child is often distorted
and disrupts their bond (Hibbard, 1987). These functions, which would optimally be performed by a sober parent, become dysfunctional by an unavailable alcoholic parent.

Furthermore, the child is often left to develop under the influence of an unpredictable primary caretaker (Richards, 1979). Mahler, (1968) emphasizes the child's dependency on the accurate responsiveness of the mother in meeting basic emotional and physical needs. Therefore, if the mother is alcoholic, the mother-child relationship will be profoundly impaired due to the mother's primary emotional involvement with alcohol (Beletsis & Brown, 1981). The appropriate physical care and nurturing will also be absent from their relationship (Beletsis & Brown, 1981) leading to subsequent feelings of emotional instability and depression (Cashdan, 1988) in these children. In general, parents who are rejecting, whether by being indifferent and or neglectful, usually induce their child to feel unloved and unwanted (Rohner, 1991).

**Hypotheses**

**Hypothesis 1:** African American children of alcoholic mothers will demonstrate higher levels of depression on the CDI than children whose mothers are nonalcoholic-clinical, or nonalcoholic-nonclinical.

**Hypothesis 2:** African American children with
alcoholic mothers will report higher levels of maternal rejection on the Child PARQ than will children of nonalcoholic-clinical or nonalcoholic-nonclinical mothers.

Hypothesis 3: African American children of alcoholic mothers will report lower levels of maternal warmth and acceptance as well as higher levels of aggression/hostility, neglect/indifference, and undifferentiated rejection on the Child PARQ than will children of nonalcoholic-clinical or nonalcoholic-nonclinical mothers.

Definition of Terms

The following terms are defined as they are used within the context of the study.

Alcoholic mother: An alcoholic mother is an individual who currently meets the criteria, as defined by the Family History-Research Diagnostic Criteria (FH-RDC) instrument (Endicott, Anderease, & Spitzer, 1978). Mothers in this study are single parents.

Depression: Depression is more than a disorder of mood, and it affects multiple areas of functioning, including behavioral, emotional, somatic, and cognitive domains (Reynolds, 1989). For the purpose of this study then, depression is operationally defined by a score on a children's self-report measures of depression:
The Children's Depression Inventory (Kovacs, 1992). This measures taps the subjective experience of depression in the child and is not contaminated by perceptions and/or projections of the alcoholic mother or teacher.

Latency-age, African American children: The latency period of development is referred to as elementary school years of seven to twelve years of age (Sarnoff, 1987).

Maternal Rejection: For the purpose of this study rejection is operationally defined by a score on the Parental Acceptance-Rejection Questionnaire. This instrument measures a child's perceptions of parental acceptance and rejection.

Nonalcoholic-Clinical mother: A nonalcoholic-clinical mother is described as an individual who, based on the Family History-Research Diagnostic Criteria (FH-RDC), is believed to have a nonalcoholic-related mental health disturbance such as a general mood disorder.

Limitations of the Study

The generalization of the present study's findings to the population of African American latency-age children of alcoholic mothers at large was restricted to its design. This included the absence of other minority children, as well as children of alcoholics residing in urban areas. The study suffers from some limitations inherent in the
self-report measures and, therefore, in these instruments, such as the willingness to self-disclose as well as on the subjects' personal perceptions. In addition, subjects were recruited from one of several, large inner city hospitals servicing the entire city. It is therefore possible that children's responses to the self-report measures were affected by various social, environmental or demographic factors that are not operating in other neighborhoods. These factors may include socio-economic status, quality of education, living conditions, and access to community resources.
CHAPTER II
Review of the Literature

Young children of alcoholics have been long been ignored, misdiagnosed, and under treated (Bingham & Barger, 1985; Jesse, 1989). This may in part be attributable to the fact that historically, alcoholism has not been conceptualized as being the primary problem for an individual and his or her family. As Brown (1990) points out, it is extremely difficult to accord legitimacy to the problems of children that were experienced as a direct result of living with an alcoholic parent if the addiction is not recognized as being central to the families functioning.

Another factor is the observation that when working with families alcoholism has generally been missed or minimized by mental health professionals. Additionally, this phenomenon has been paralleled to the process of denial, which strongly operates in the addicted individual and family, and thereby can be seen to operate in the mental health professional (Black, 1981; Brown, 1990). Furthermore, since the reality of parental alcoholism was denied, minimized, or diverted, mental health professionals have been unable to recognize that parental alcoholism not only constitutes a chronically traumatic environment
(Brown, 1990); the parent's addiction becomes a central factor in a child's development (Jesse, 1989).

Family therapy and the concept of alcoholism as a family disease that affects all family members (Brown, 1988; Fox, 1962; Jackson, 1954) did much to contribute to the understanding of the impact of parental alcoholism on children. Nonetheless, without a clear understanding of how alcohol affects the developmental psychology of the individual, little progress can be made clinically or theoretically (Rivinus, 1990). Rivinus in his review of the psychoanalytic literature found few authors who commented on the fact that alcoholism runs in families or who spoke to the effects of a child being raised by an alcoholic parent.

To this end, chapter II will highlight the emotional impact of the alcoholic parent and the developing child and the nature of that parenting. Empirical research on depression in alcoholic families will also substantiate this perspective. This groundwork will set the stage for a discussion of the development of depression in young children of alcoholics from a psychodynamic perspective with an emphasis on object relations theory.
Impact of the Alcoholic Parent on the Developing Child

One of the first attempts to gain a deeper understanding of young children of alcoholics and their family relationships and environments were made by Cork (1969). In her seminal work, The Forgotten Children, she carefully collected data from interviews with 115 school age children between the ages of ten and sixteen years of age. An interesting finding, especially from a psychodynamic point of view, was that most of the children felt a lack of attachment to either parent, that is, there was a clear separation in the parent-child relationship. The majority of children felt unloved and rejected by one or both parents. In addition, another dramatic finding was that the child's life did not improve significantly with parental abstinence, nor did the parent-child relationship evidence much healing under these conditions.

Although conducted in Sweden, Nylander's (1960) comprehensive studies of young children of alcoholics shed light on the prolonged emotional stress these children endure. This study examined the effects of parental abstinence on 229 children, ages 4 to 12, whose fathers were chronic alcoholics undergoing treatment. Nylander's findings suggest that children's difficulties were not alleviated by the father's abstinence. Even when the length
and duration of the father's drinking was considered, there were no differences in the frequency of emotional symptoms of the children. Furthermore, in all the children, there appeared to be a disturbed relationship with the nonalcoholic mother.

These early, detailed studies (Cork, 1969; Nylander 1960) indicate that there are deleterious effects upon the children of alcoholics and that they have a disturbing influence on the life of a child. Work by Jesse (1989) helps to explain what these researchers revealed in their works; that the absences of important caregiving functions become a part of a child's intrapsychic reality. While these functions are necessary for the emotional well being of all children, they are virtually lacking for the child of an alcoholic.

Object relations theorists have long held the belief that the need for other human beings does not simply subserve other needs, but it is motivational in its own right (Cashdan, 1988). Theorists such as Fairbairn (1954), Kohut (1971, 1977), and Winnicott (1971) contend that of all the various relationships that make up the human drama, by far the most important one is the early caregiving relationship with the mother. Therefore, pathology is seen to arise from early object-relation deficiencies such as
maternal abuse, chronic separation, and abandonment (Cashdan, 1988). If the mother is alcoholic, the mother-child relationship will be impaired in that the mother's primary emotional involvement is with the alcohol, not the child (Beletsis & Brown, 1981) and consequently, a milieu of abandonment and rejection is created (Jesse, 1989).

A chemically dependent parent is by definition, a narcissistic parent, especially at those times when the parent is preoccupied with getting, using, and recovering from their addiction (Rivinus, 1990). In this cycle, the alcoholic or addicted parent has scant time for nurturing a relationship with their child and the remaining parent, who may not be addicted, and who is likely to be crippled by their relationship with the addicted partner.

It is rare that the addicted parent can consistently meet the psychological needs of their child. The child's needs are also narcissistic and dependent placing a great demand on the alcoholic parent who cannot delay the satisfaction of their own needs and impulses to meet those of the child (Rivinus, 1990). Much of the damage of growing up in an alcoholic or other substance abusing family revolves around the fact that basic human needs are not met, are disregarded, or are minimized (Rivinus, 1990). A deep narcissistic wound for all children (Jesse, 1989) who
witness a parent chose an addiction as the primary relationship has devastating consequences.

Moore-Russell and Saraf (1992) perhaps best summarizes how profound the effects of alcoholic parenting is on the developing child by underscoring the inescapable fact that alcohol and other drugs impair the parent's ability to parent. These substances alter one's perceptions, attention, rationality, and memory as well as a myriad of other functions. As a result, parental alcoholism is more than incidental to the child; the child's daily competence, organization of ego functions, how the child thinks, feels, and acts in the world will be influenced by the alcoholic's thinking and emotionality. The child's personality evolves in the context of an addicted parent's behavior. Moore-Russell and Saraf (1992), explain:

The infant, of course, does not know that his mother is an alcoholic (or coalcoholic) any more than he knows she is a woman. As the child grows, however, his representation of her (the first "object" in object relations theory) will grow and change as her alcoholism waxes and wanes with the changing internal and external pressures in her life. His memory, then, even preverbally, records the history, his story of her alcoholism and the vicissitudes of her alcoholic
mothering. So too the child's developing identity, competence and emotional structure will be affected by the alcoholism (or coalcoholism) of the father, whether or not he is still present in the home (p.8).

From the beginning, early developmental issues around attachment such as the establishment of basic trust, symbiotic bonding, and emerging autonomy are seriously affected by the realities of a chaotic, uncertain, and out-of-control environment as well as the nature of the parent-child relationship (Brown, 1990).

Logue and Rivinus (1991) acknowledge the importance of mother-infant attachment and how this first relationship serves as a prototype for other relationships in the child's life such as peers, teachers, and others. The mother's alcoholism or preoccupation with another's consumption interferes with the mother's capacity to respond consistently to her baby's needs and thus jeopardizes the quality of the attachment. Fox (1962) also pointed out this inconsistency in that infants of alcoholic mothers are at risk for neglect while the mother is intoxicated, yet are overindulged when the mother is sober and remorseful.

O'Connell, Sigman, and Brill (1987) studied the attachment behavior of infants of middle class mothers with
drinking problems. They reported that a significant amount of these babies exhibited a disorganized/disoriented attachment pattern. Advances in attachment theory postulate that children who display this particular pattern often evidence later role reversal and depression (Logue & Rivinus, 1991).

In recognition of research that has suggested that parents who abuse alcohol or other drugs are emotionally unavailable to their children, Moser and Jacob (1997) sought to compare parent-child interactions as related to the gender of the alcoholic parent. Their study assessed parent child interactions, as measured by an abbreviated version of the Marital Interaction Coding System, an instrument that is intended to record verbal and nonverbal behaviors of family members in a problem-solving situation. The Child Behavior Checklist was also completed by parents. Interactions were observed in families in which there was an alcoholic father, an alcoholic mother, two alcoholic parents, or no alcoholic parents. Families were primarily Caucasian and children were between ten and seventeen years of age. Their findings suggested that dual and mother-only alcoholic families exhibited the most impaired interactions although child problem behavior was not significantly different across the three groups of alcoholic parents.
A more contemporary article, Drug/alcohol addictions and mothering (Eliasen & Skinstad, 1995), raises several relevant points regarding the literature concerning alcoholic mothering. They reviewed empirical literature from 1980 to 1995 regarding women who were both alcoholics and drug addicts. They report that very little is currently known about the motherhood or mothering skills of these women. Several barriers to effective mothering in addicted mothers are discussed, such as depression, limited resources, poor role models, temporary cognitive deficits, and overall traumatic childhood’s, all of which have been associated with impaired parenting.

Alcoholism establishes a family context for ongoing and repetitive psychological maltreatment of a child (Jesse, 1989). Garbarino’s (1987) discussion summarizes the forms that this maltreatment can take.

1. Rejecting: The parent refuses to acknowledge the child’s worth and the legitimacy of the child’s needs.

2. Isolating: The child is removed from important social experiences, leading the child to experience himself as alone, without friends.

3. Ignoring: The adult is physically present, but is emotionally and psychologically absent, ignoring the child’s needs.
4. Terrorizing: The parent assaults the child with words instilling fear, and bullies or frightens the child, leading the child to experience the world as a hostile place.

5. Corrupting: The adult "mis-socializes" the child, or over-stimulates the child, or leads the child to engage in destructive behavior, and reaffirms the child's deviance, creating an individual who is unfit for normal social experiences.

Research on the maltreatment of children (Farber & Egeland, 1987), which encompasses physical abuse, hostile/verbal abuse, psychological unavailability and neglect, indicates that psychological unavailability can be just as devastating as physical abuse. The Minnesota Mother-Child Interaction Research Project (Erickson, Egeland & Pianta, 1989), an ambitious, longitudinal, prospective study of 267 women and their children, describes the effects of different types of maltreatment of children. Due to economic disadvantage, subjects were considered to be at risk for maltreating their children. Detailed and comprehensive multiple assessments of child and parental competence began at birth and have continued at regularly scheduled intervals through the early school years. Data characteristics of children, parents, child-
parent interactions and the environment had also been extensively collected. Their findings were based on comparisons of children experiencing various types of maltreatment and a control group of normal treated children for the same high-risk sample, provide evidence that maltreated children have significant social and emotional problems well beyond the problems related to low socioeconomic background. However, while the outcomes for all groups of maltreated children were severe, the consequences of psychologically unavailable patterns of parenting were most striking. These children showed a notable decline in competence during the early years of life. The authors conclude that the caregiver's lack of emotional responsiveness is a devastating form of abuse (Farber & Egeland, 1987).

Similarly, Rohner (1980, 1991) who has written extensively on the consequences of parental rejection defines rejecting parents as those who generally view the child as a burden. Rejection as defined is manifested in two primary ways: One is in the form of parental hostility and aggression; the other is in the form of parental indifference and neglect. The latter is characterized by lack of concern or interest in the child and general unresponsiveness to the child's physical and emotional
needs. In addition, broken promises and inattention to the
details that contribute to a child's well-being and
happiness, are commonly recognized (Rohner, 1980). The
rejected child thus comes to devalue the self, has low
self-esteem, and develops a sense of inadequacy (Rohner,

Although the association between parental alcoholism
and the child's feelings of rejection have not been well
researched by direct measurement, these parental failures
are believed to run rampant in the alcoholic family since
the parent's own self-centeredness and narcissism
interferes with the child's developmental needs (Jesse,
1989). Interview data, such as that collected by Jesse
(1987) suggest that children raised in alcoholic homes felt
unloved and rejected. Jesse utilized projective tests to
study perceived parental support among twelve latency age
children of alcoholics. She found evidence that these
interviewed 115 children, ages ten to sixteen, and reported
that approximately 98% described feeling unloved while
approximately 84% reported that they perceived their
alcoholic parent to lack interest in them. Therefore, the
author concluded that COA's often experience feelings of
parental rejection. The retrospective accounts of adult
COA's revealed that many of them recalled feeling rejected by their parents in childhood (Booz & Hamilton, Inc., 1974).

In their work with adult COA's, clinician's have observed the long-term consequences of alcoholic parenting on the personality structure of the adult individual (Cermak, 1984; Hibbard, 1987).

Utilizing the perspectives of theorists Kohut, Masterson, and Miller, Cermak (1991) asserts that chemical dependency in one or both parents lays the seeds from which personality pathology grow. In this context, he further proposes that codependency and narcissistic traits/disorders, the latter having a strong element in addiction (Cermak, 1991; Jesse, 1989; Kohut, 1977; Rivinus, 1990), both have their genesis in the symbiotic and separation-individuation phases of development. The context within which, defective mirroring during this phase, as well as the specific needs that are defectively mirrored, differentiates the two.

The defective mirroring specific to the development of narcissism occurs when the primary caregiver withdraws emotionally as the child begins to develop his or her own unique self (Kohut, 1977). The etiological agent for the codependent is initially the same according to Cermak
(1991). He reports that adult children from alcoholic homes (who would satisfy the criteria for codependence) often have quite vivid memories and intense feelings of times when an intoxicated parent demanded that they, as a child, attend to that parent's needs, instead of their own, lest the parent withdraw emotionally from the child. When children must supersede their investment into their relationship with a parent in order to maintain some shred of connectedness, chronic depression can result accompanied by profound feelings of inadequacy, low self-esteem, and inner emptiness. The codependent individual then, never feels entitled to be in a mutual relationship and furthermore, their only sense of human connectedness comes from being the perfect mirror to the other (Cermak, 1990).

According to Kohut (1977), the addict who has strong narcissistic issues at the core of their psychopathology must have their grandiosity constantly fueled by others. Their sense of human connectedness comes when they are being mirrored by others (Cermak, 1991). Here within lies the inextricably intertwined relationship of the narcissist, or addict, and the codependent; narcissists cannot imagine others as existing separately from themselves while the codependent cannot imagine themselves existing separately from others (Cermak, 1991). With
respect to the impact of the child in this case he writes, "As difficult as the narcissistic stance of an addict is to deal with for an adult, its power is raised exponentially for the developing children, for whom the addict is parent and primary role model" (Cermak, 1991, p. 134).

Although not specifically stated by Cermak (1991), his exploration of the dynamics which lead to the development and bonding of the narcissist/addict and the codependent partner shed light on how the addictive family system continues to perpetuate itself generation after generation.

Hibbard (1987, 1989) also noted that adult COA's display personality pathology related to developmental object relations deficits. He observed that adult COA's presented with disorders ranging from anxiety to psychotic episodes. Like Cermak (1991), Hibbard (1987) also identified that adult COA's suffer from depression.

Certainly, character disorders are not unique to adult COA's. What make them unique, however, are the recurring pathogenic mechanisms in alcoholic families, which lead to developmental and object relations deficits (Hibbard, 1987).

One of these mechanisms is that the alcoholic's behavior actually facilitates the use of splitting as a defense in the child as well as the use of overidealization
to ward off ambivalence and abandonment depression (Hibbard, 1987). In their extensive work with young children of alcoholics, Moore-Russell and Saraf (1992) found that these children produced strikingly different portraits of their parent as sober versus their parent as intoxicated.

Secondly, according to Hibbard (1987), parental alcoholism renders the parent unavailable, "or worse, distorted, for various introjective, identificational, or mirroring functions which optimally would be performed by a sober parent" (p. 784).

Beletsis and Brown (1981) also focused on the developmental impact of parental alcoholism. They state that the adult COA's that they worked with described their childhood as chaotic and unpredictable, a place where inconsistency ran rampant. This instability, coupled with the constant chiseling away of trust and confidence in the parent, interferes with the child's growing autonomy. In adulthood, difficulty separating emotionally from their families is observed and separation is experienced as abandonment.

In summary, the literature suggests that the impact of the parent's alcoholism on the developing child is significant. The disturbed relationship between the
alcoholic parent and the child is characterized by feelings of being unloved, rejected, and disregarded in the child. The parent, due to their primary involvement with alcohol, is unable to meet the child's emotional and psychological needs and remains essentially unavailable to the child. Alcoholic parenting and the relationship between the alcoholic parent and child are believed to negatively impact on the child's personality structure and defenses. Although the effects of parental alcoholism and how this type of parenting relates to the child's feelings of rejection and disregard have not been well researched, these parental failures have been documented as running rampant in these families. One possible outcome is the development of depression.

Depression in Alcoholic Families

Adult Children of Alcoholics

A sufficient number of experienced clinicians working with adults have observed the serious effects of parental alcoholism on the developing child (e.g. Beletsis & Brown, 1981; Cermak, 1991; Hibbard, 1987; Rivinus, 1990). Depression is one of the most frequently reported symptoms of this population (e.g. Black, 1983; Hibbard, 1987; Hinkin & Kahn, 1995,) as well as one of the more actively researched areas (Harter, 2000). It is also noteworthy that
African American ACOAs are a seriously ignored population in this literature (Rodney, 1996).

Black, Bucky and Wilder-Padilla (1986) compared several affective dimensions from large samples of adults who were raised in an alcoholic family with adults raised in nonalcoholic family. Data was compiled on extensive questionnaires of 409 subjects identified as being raised in a home with an alcoholic parent. In summary, the adult COA's not only reported having greater difficulty with intimacy, and expressing their needs, they also described themselves as being confused and depressed with greater regularity than the respondents in the nonalcoholic group. While this study is not truly empirical in nature (i.e., no psychometric instruments were used) one cannot discount the ACOA's perceptions of being depressed.

Other studies that utilized rating scales and more reliable assessment instruments have purported similar conclusions. Pushkash and Quereshi (1980) administered the Mitchell Adjective Rating Scale (MARS) to 50 individuals whose primary diagnosis was alcoholism. Utilizing personality assessment scales with adult male alcoholics, this group rated themselves and significant others, such as their parents, spouses, and partners, as being more unhappy than the nonalcoholic group and reported that they were
more depressed and unhappy than their male counterparts. Brown (1980) attempted to differentiate alcoholics from nonalcoholics by measuring anxiety, depression, and self-esteem. Brown (1980) concluded that adult male alcoholics were more depressed, anxious, and had lower self-esteem than social drinkers. Jones and Zalewski (1994) focused on shame and depression proneness among adult female ACOAs. Both groups of 30 females each completed a Depression Proneness Rating Scale and the Adapted Shame/Guilt Scales. They report that female ACOAs were more prone to depression than the control group but not more shame prone. These subjects were being treated in individual psychotherapy or group therapy.

Other studies have utilized assessment instruments such as the Beck Depression Scale and the MMPI. One such study administered both measures to assess depression in male alcoholics as well as perceived control using Rotter's Locus of Control Scale and found that a low level of control was significantly correlated with a high level of depression (O'Leary, Cysewski, Donovan, & Chaney, 1977). Other, more recent studies, have also used the Beck Depression Inventory (Hinz, 1990; Lyon & Greenberg, 1991) and the MMPI (Hinkin & Kahn, 1995) to measure symptoms of depression among their samples of ACOAs. Hinz (1990)
sampled 252 female and 153 male, college students who identified themselves as children of alcoholics. She found that ACOAs expressed more concern than non-ACOAs over family problems, relationship difficulties, and depression. Lyon and Greenberg's study (1991) focused more on the codependency attributes in their sample of 48 female undergraduates. Female ACOAs evidenced greater levels of depression than the control group. Hinkin and Kahn (1995) administered a variety of measures including the MMPI and the Symptom Checklist, to wives of VA patients who were married or living with an alcoholic, psychiatric, or dentistry patient. Fifty percent of the subjects had a positive family history for alcoholism. Their results suggest that there are significantly greater levels of depression, as per results of the Symptom Checklist, for subjects whose spouse was an alcoholic and who had a positive family history of alcoholism.

Two studies relied on diagnostic interviews. Sber, Walitzer, Wood, and Brent (1991) looked at a college sample of 253 COAs and 237 non-COAs and compared them on measure of alcohol and drug use, psychopathology, cognitive ability, and personality. Students of alcoholic parents showed an increased diagnosis of depression on the Diagnostic Interview Schedule. Another smaller study (Hill,
Nord, & Blow, 1992) assessed the effects of family history and environment on drinking among ACOAs who were placed into groups according to their parent's drinking status (alcohol-dependent or social-drinking parents). Subjects were assessed utilizing a diagnostic interview. Psychological symptoms, such as depression were reported more by ACOAs with social-drinking parents but not by subjects with alcohol dependent parents.

In comparing clinical-setting COAs with nonclinical-setting adult COAs and a group of children of nonalcoholics, Baxter (1990) found that clinical-setting children of alcoholics experienced higher levels of depression and relied on behavioral coping strategies more than did the other two groups. Interestingly, the clinical setting group described the least cohesion and most conflict in their family environment.

Another study (Berkowitz & Perkins, 1988) compared personality characteristics of late adolescent and young adult COAs with their peers and found that the former group, especially females, were more likely to report greater self-depreciation. Unhappiness and dissatisfaction with themselves was also greater for female COAs than male COAs.
In reviewing the literature of depression among adult children of alcoholics and young children of alcoholics, an interesting contrast can be observed. That is, empirical research on adults yields more results that are mixed.

In a study focusing on female, adult children of alcoholic fathers, Jackson (1985) hypothesized that this group would evidence greater inability to trust, guilt proneness, denial of feelings, dominant and controlling behavior, compulsive need for approval and depression than a group of daughters of nonalcoholics. Using the Sixteen Personality Factor Questionnaire, no support was found for depression.

Settle (1989) compared adult COAs with adult non-ACOAs on questionnaires assessing alcoholism, parental alcoholism, family origin health as well as other demographic data. The ACOAs differed from the other group in that they reported experiencing more physical/sexual abuse, more thoughts and behaviors that are suicidal, as well as depression. Similarly, Williams (1989) also utilized a questionnaire format, and found that depression scores were not different for the ACOA group. The use of questionnaires in these studies rather than psychometrically sound instruments may have contributed to the conflicting results.
An increasing number of recent studies are finding that adult COAs are not necessarily more depressed than their non ACOA counterparts (e.g. Dodd & Roberts, 1994; Williams & Corrigan, 1992).

Using an undergraduate population, Williams and Corrigan (1992) examined whether young adults growing up in families with an alcoholic or mentally ill parent were more likely to evidence greater symptoms of depression, as measured by the Beck Depression Inventory, than a control group. The researchers also examined dimensions of self-esteem and anxiety. They found more depression in adult children of mentally ill parents than COAs and controls.

Dodd and Roberts (1994) specifically investigated levels of self-esteem, anxiety, and depression among counselor education students. Their sample of 60 ACOA and 143 non-COA subjects completed the Beck Depression Inventory and found no difference in the symptoms of self-esteem, anxiety, or depression was found between the two groups.

**Young Children of Alcoholics**

Historically, depression in young children has been an avidly debated topic (Kazdin, 1989). This was primarily because, according to orthodox psychoanalytic principles, depression was considered contingent upon the establishment
of a well-developed superego. The advent of ego psychology allowed for the consideration that approximations of a depressive disorder could manifest themselves in childhood (Bemporad & Wilson, 1978). Changing perspectives acknowledged that depression could be experienced in childhood and theorists began the task of explaining how it was manifested in children. For example, Cytryn and McKnew (1972, 1974) espoused the idea of depressive equivalents whereby depression in children was evidenced by overt negative behaviors such as acting-out, delinquency, and temper tantrums. This perspective also meant that childhood manifestations of childhood depression were significantly different from those observed in adults (Kazdin, 1989).

The current position among researchers in the field asserts that childhood depression is manifested in a manner similar to that of adults (Cytryn, McKnew, & Bunney, 1980). This viewpoint is upheld by the DSM IV (American Psychiatric Association, 1994) categories of depressive disorders such as major depression, dysthymic disorder, and depressive disorder not-otherwise-specified. These classifications are characterized by a primary disturbance in mood accompanied by other symptoms (APA, 1994).

Theoretical explanations and clinical observations aside, little research has systematically investigated the
presence of depression in young children of alcoholics. West and Prinz (1987), in their review of the literature between 1975 and 1985 on parental alcoholism and childhood psychopathology, found eleven investigations examining the impact of parental alcoholism on children's emotional functioning. Of these, only two were related to depression in young children (Anderson & Quast, 1983; Moos and Billings, 1982) and the latter looked at children in recovering families. Three recent studies (Calder & Kostyniuk, 1989; Kamstra, 1986; Rolf, et al., 1988) specifically investigated the level of depression in this population of children. However, none investigated depression in inner city Black children of alcoholics.

Anderson and Quast (1983) administered the Personality Inventory for Children to the nonalcoholic parent (usually the mother) of children (six to twelve years old) whose other parent was in treatment for alcoholism. The nature and extent of the treatment program is unknown and no control group was utilized. As a group, children and alcoholics scored significantly higher than test norms on the Anxiety and Adjustment scales and the scores on the Depression scale approached significance. No other data was provided with respect to group demographics.
Moos and Billings (1982) compared three groups of children and adolescents of relapsed, recovered and control families. The functioning of children in each family was determined from the mother's responses to yes/no questions about her children's health regarding five dimensions of mood (e.g. feeling sad, anxiety, nightmares). These tape-recorded answers contributed to the framework for determining "emotional problems." The authors concluded that emotional problems, especially anxiety and depression, were more evident in children of relapsed alcoholics than children in the control families were. The researchers reported that the children in the recovery group were not only functioning as well as the control group, but that they were also less depressed than the control group. The parents in the recovery group had been abstinent for two years, were primarily Caucasian (about 80%) and were considered to have stable marriages. The specific ages of the subjects were not given, nor were the sex of the relapsed or recovered parents.

Another study (Rolf et al., 1988), compared male and female youths (ages six to eighteen) from alcoholic and nonalcoholic families. The results indicated significant group differences on both maternal and youth ratings with more depressive symptoms shown for the offspring of
alcoholics. Subjects were Caucasian and middle class. The
mother completed the NIMH Center for Epidemiological
Studies Depression Scale (CES-D) and the Child Behavior
Checklist (CBCL). Youths up to fifteen years old completed
the Children's Depression Inventory (CDI) while those over
fifteen were administered the Beck Depression Inventory. A
second rating of depressive symptoms was also obtained from
the Youth Self Report of the CBCL, but for eleven-to-
eighteen year-olds only.

In investigating the personality profiles of sixty-two
children of alcoholics, ages six to sixteen, Calder and
Kostyniuk (1989) collected data using the Personality
Inventory for Children (PIC). The PIC was completed by
parents who were involved in treatment for an average of
fourteen sessions to address alcohol-related problems.
Scores were then compared with the norm population on the
PIC. The researchers report that the children of alcoholics
had elevated scores, more than one standard deviation above
those on the norm population, on the Family Relations,
Delinquency, Depression, and Withdrawal scales. Children of
alcoholics, despite the wide age range, were considered to
be one group. Furthermore, children were not administered
any measures themselves, thereby complicating the meaning
of the results. The researchers offered no demographics.
One study, conducted by Reich, Earls, Frankel, and Shayka (1993) found no differences in rates of depression among children with one or two alcoholic parents. They collected data on 158 children between the ages of 6 and 18 years of age. Ethnic demographics were not identified. Data was obtained via the Diagnostic Interview for Children and Adolescents, the Home Environment Interview for Children. Children were rated utilizing the Child Behavior Checklist.

Although most studies support an association between parental alcoholism and depression in children, several limitations exist which weaken their conclusions as well as their applicability to a Black, inner-city population of children.

Three of the three studies mentioned above (Anderson & Quast, 1983; Calder & Kostyniuk, 1989; Moos & Billings 1982) relied on parental responses. A substantial amount of research indicates that children's self-report measures do not generally correlate well with measures obtained from other sources such as parents and teachers (Doerfler, Felner, Rowlison, Raley, & Evans, 1988; Kazdin, Esveldt-Dawson, Unis, & Rancurello, 1983; Saylor, Finch, Baskin, Furey, & Kelly, 1984). The correlations are occasionally significant but their magnitude typically ranges between .00 and .30 (Kazdin, 1989). This may be reflective of the
fact that self-reports of depression draw on traits and states within the child; dysphoria, feelings of worthlessness or hopelessness, focus on internal states. Parental reports, on the other hand, tend to focus on social behavior and affect related expression (Kazdin, Esveldt-Dawson, Sherick, & Colbus, 1985). Although the results of the studies by Anderson and Quast (1983) and Moos and Billings (1982) suggest the presence of depression in children of alcoholics, their results were based on parent's reports which do not necessarily reflect the subjective experience of the child. The present study will concern itself with the child's subjective account of his affective state.

Another area of difficulty in three of the studies (Anderson & Quast, 1983; Calder & Kostyniuk, 1989; Rolf et al., 1988) was their inclusion of both children and adolescents in one group. This made it impossible to determine the extent to which depression in latency-age children of alcoholic parents existed. These studies did not consider developmental factors. Clinical observations reveal children do not know or believe their parent's alcoholism is a disease, which they cannot cause, control, or cure. Children ages seven to twelve often believe that they are directly responsible for parental problems such as
divorce or alcoholism (Lidz, 1968) and they think that if they picked up their clothes, were better behaved, or did better in school, their parent would stop drinking (Woodside, 1988). Whereas parental alcoholism affects children of all ages, latency-age children present a particularly vulnerable group (Bingham & Bargar, 1985; Morehouse & Richards, 1983). It is this age group that is the focus of the current study.

Other, often ignored variables are the sex of the alcoholic parent and the intactness of the family. Current research suggests that children reared with alcoholic mothers are at greater risk for a wide spectrum of psychological difficulties then alcoholic fathers (Miller & Jang, 1977; Richards, 1979). Logically, this makes sense given the fact that women remain largely responsible for raising their children and are often the primary socializing agent. In addition, Booz and Hamilton, Inc. (1974) found that adolescents and young adolescents who lacked a supportive parental figure reported feeling twice as depressed as those who perceived a supportive parent did. Based on the above information, latency-age children of single, alcoholic mothers would seem to be at considerable risk for depression. This appears to be particularly so because inner-city families are frequently
headed by single mothers. Nonetheless, the sex of the alcoholic parent and intactness of the family is rarely controlled for in the research. The current study focuses on alcoholic mothers of single parent households.

Kamstra’s (1986) research appears to have transcended many of the difficulties inherent in the current literature. Her study investigated the differences in anxiety, depression, and perception of parental rejection among latency age children. Three groups were utilized: one was comprised of children whose alcoholic father and nonalcoholic mother had received less than four weeks of psychotherapy for familial alcoholism. A second group consisted of children from families where the mother had received psychotherapy for nonalcohol related problems. The last group served as a control group. Depression was measured by the Children’s Depression Inventory. The results suggested that children in the first group, whose father was alcoholic, were significantly more depressed than the other two groups. It is not clear however, why the second group was comprised of latency age children whose mother’s were in psychotherapy.
Development of Depression in Young Children of Alcoholics

Depression has been a reasonably active topic in the literature about adult COAs. Evidence from clinical work with ACOAs reveals that complaints of depression is often cited from these individuals (e.g. Cermak, 1991; Cotton, 1979; Hibbard, 1987; Scavnicky-Mylant, 1984). In addition, retrospective accounts of adults and adolescents raised in alcoholic families report having felt depressed as children (Booz & Hamilton, Inc., 1974). Many clinicians have also commented on this phenomenon and have offered some explanations.

Whether intentional or not, most of the well known writers in the field of addiction have paid homage to the fact that the relationship between the child and the alcoholic mother is extremely important in the development of pathology. As Beletsis and Brown (1981) summarize, if the mother is alcoholic, the mother-child relationship will be impaired as her primary emotional involvement is with the alcohol and not the child. Jesse (1989) concurs adding that a foundation of abandonment is thus created. From an object relations perspective, pathology is seen to arise from early object-relations deficiencies such as maternal abuse, chronic separation, and abandonment (Cashdan, 1988).
Historically speaking, Karl Abraham is believed to be the psychoanalyst who postulated the original psychoanalytic theory of depression (Gaylin, 1983) in which a comparison between grief and melancholy became crucial. For Abraham, the differentiating factor was that, while both were a response to a loss, the reaction to the lost love in melancholia is heavily tinged with anger. Freud (1917) also conceptualized that mourning and melancholia were a reaction to the loss of a loved object, the difference being that in grief, there is an actual loss of the object, while in melancholia, there is usually an emotional loss of the object due to disappointment or other similar factors. He further added that in melancholia, the loss might be real or imagined. Freud (1917) also recognized that anger was a critical feature of depression, or melancholia. The depressed person’s deflated self-esteem and self-punishing behavior was explained as the patient’s attempt to punish the abandoning love figure with whom he or she had identified via the process of narcissistic identification. Rado (1928) also believed that depression was precipitated by an actual or imagined loss, but added that in addition, the individual believes that in some way, the loss endangers his or her security as well. Thus far, the common thread is the lost love object in the etiology
of depression as well as ambivalent feelings, aggressive energy, and guilt.

The importance of object loss in depression continued to remain pivotal in subsequent theories of depression, however, depression as a clinical disorder in children had, for decades, been widely and avidly disputed. This was primarily due to the fact that, psychoanalytically speaking, depression was seen to result from aggression directed towards oneself, guilt, and low self-esteem, all of which were not possible without the well-developed superego of late latency (Arieti & Bemporad, 1978; Kazdin, 1989). Important contributors such as Spitz (1946) and Bowlby (1961; 1963) however, continued to forge ahead building on some of the concepts that came before.

Again, focusing on the impact of the loss, such as that of the primary caretaker, Spitz (1946) described an entity known as "anaclitic depression" which appeared in infants who were separated from their mothers. He described their reaction as withdrawn and sad looking, characterized by weight loss, insomnia, and a lack of responsiveness to others. Bowlby (1961; 1963) followed, advancing that once the child formed a tie to the mother in infancy, separation would lead to grief and a process of mourning. Bowlby delineated three stages in the mourning process. First is
the stage of protest in which the distressed infant cries, screams, and thrashes about in what is seen as an attempt to be reunited with its mother. The yearning that colors this stage may persist long after this phase is over, giving rise to feelings of sadness, depression, and longing for the lost object. In the second stage, mourning is characterized by despair. The infant appears to maintain a hope of being reunited with his mother, and a sense of quiet depression prevails. In the final stage, the child appears to overcome his loss, has detached, and begins responding to others. In highlighting the importance of the tie to the mother, Bowlby has explained that when a child is subjected to repeated losses or rejections and has experienced repeated anger and yearning, intense ambivalence toward love-objects may ensue.

Breen (1985) and Black (1981) noted the similarity between children of alcoholics and those facing the loss of someone close to them. The difference however, is that the child of an alcoholic is confronted with and "altered grief" (Breen, 1985, p. 86) that is repressed for an alcoholic parent who is psychologically absent but physically alive. Breen (1985) refers to this concept as a "subterranean grieving process" that may not manifest
itself overtly, but festers within the child, adolescent, or adult child of an alcoholic.

Borrowing from Kubler-Ross's stages of bereavement (1969), Black (1981) reports that children of alcoholics experience the same stages of grief, as do normal individuals. Denial, the first stage in dealing with the death of a loved one, is considered to be a healthy, first response to this situation however, the COA may become perpetually fixated at this point, continually denying the alcoholism and/or, as Breen (1985) points out, denying the severe emotional consequences they endured.

In the course of dealing with loss, the second stage, anger, is experienced as the individual expresses anger toward the lost object for leaving (Kubler-Ross, 1969). This is a thwarted stage for the COA's, who frequently internalize the anger and in turn, experiences a sense of guilt (Breen, 1985). Breen believes that during this stage, young COAs frequently believe that if they had done something different, such as making good grades or not talking back, the alcoholic parent would not have gotten drunk.

Bargaining, the third stage in Kubler-Ross's model (1969), is characterized by the person's "bargaining" for the dying loved ones recovery into health. This is often
reflected in the spiritual sphere of prayer for a granting of this wish. Again, for the COA, a different form of this stage is seen and a form of grandiosity often emerges: "If I say my prayers more faithfully..., or go to church more regularly..., or read the Bible more often, Dad will stop or lessen his drinking" (Breen, 1985, p. 86-87). The sad truth, that one's prayers cannot stop the alcoholic from drinking, can be devastating to the COA (Breen, 1985). The fourth stage, depression (Kubler-Ross, 1969) is the most crucial stage for COA's and the most painful. While the normal individual and the COA both experience the helplessness and sadness of their situation, the alcoholic parent remains a perpetual reminder of how powerless the child is in stopping the alcoholism. Unlike the child of a dying parent, where the loss becomes a concrete reality, "the child of an alcoholic must endure the endless uncertainty of the alcoholic parent's continued disease" (Breen, 1985, p. 87).

This is what makes the last stage, acceptance (Kubler-Ross, 1969), so out-of-reach for the COA. There is always the physical presence of the alcoholic parent, the ongoing reminder of the child's ineffectiveness in saving the alcoholic parent. What must take place then, according to Breen (1985), is the acceptance that the parent is
psychologically lost, however he also aptly points out that this is difficult to achieve because of the physical presence of the parent and the tantalizing hope that this loss can somehow be repealed.

The British school of object-relations theorists, however, began to recognize the reality of grief and mourning in early childhood and to conceptualize psychopathology in new ways. Clinical experience, however, also made it clear that depression was not always precipitated by the loss of a love object (Gaylin, 1983).

In general, British object relations theory contends that the infant's early relationship with the mother (or primary caretaker) is the primary determinant of personality formation and pathology (Cashdan, 1988; Scharff & Scharff, 1992). In traditional Freudian theory, an "object," whether human, animate or otherwise, was the target of libidinal drives. The need to be in a relationship with another was the fundamental driving force of human beings, according to British object relations theorists, and one's relationships with these objects are of equal importance (Cashdan, 1988). In addition to the emphasis on the mother-child relationship, other significant contributions of this theory include the role of the pre-oedipal period of development (Cashdan, 1988).
and the assumption that when children, adolescents, or adults meet new people, they will meet them with the expectations of past previous relationships (Scharff & Scharff, 1992). Another hallmark of most object relations theories are their attempt to explain how the young infant and child constructs his or her world, via the process known as splitting. Cashdan (1988) explains how this process of partitioning experiences into "good" (gratifying) and "bad" (frustrating) has important implications for later functioning.

Fairbairn's work (1954; 1963) represented one of the purest departures from the structural drive model to that of a relational based model (Greenberg & Mitchell, 1983). He believed that psychopathology was reflective of disturbances and interferences in relations with others, primarily the mother. Fairbairn (1963) conceptualized the existence of three types of internal object relations: the exciting object relationship, the rejecting object relationship, and later, the ideal object relationship. The sorting and organizing of these different experiences is largely done through the mechanisms of splitting and repression. The infant, when confronted with the experience of a frustrating mother, took in a rejecting image of her through a process known as introjection. His works
carefully detail how these processes operate. This image of the unsatisfying object is repressed into unconsciousness where it is further divided into possible categories, namely that of the rejecting object or that of the exciting object. Along with the repression of the image of the object, the part of the ego that relates to the object is split off, as well the affect associated with the painful relationship.

The repressed, rejecting object relationship then includes part of the ego (anti-libidinal ego), the rejecting object, and the affects of anger, rage and sadness. The child, through interactions with a mother who is experienced as hostile and withdrawing, comes to feel unloved and unwanted, and that his love for her is not valued by her. Fairbairn postulated that this eventually resulted in psychopathology of a schizoid nature.

The other category, the exciting object relationship, is made possible through interactions with a mother who is experienced as tantalizing, teasing, or otherwise need-exciting. The affects of insatiable longing, anxious arousal, and desperation are repressed in this scenario and the result is a child who feels chronically frustrated and empty. The libidinal ego is tied to the exciting object along with its associated affects, colored by images of
unfulfilled promises, enticements, and a sense of deprivation. Fairbairn suggested that this lead to depressive dynamics.

Jacobson (1954, 1964) wrote extensively on the subject of depression emphasizing the role that self-esteem plays. She states that the primary goals of human development are the establishment of stable boundaries between self and others, and the formation of a firm self-image (identity). These goals, including self-esteem, are best achieved in an environment of parental care and affection where frustrations occur in tolerable doses. Severe disappointments however, result from the lack of fulfillment of expectations or gratification from an object. In essence, disappointment is the feeling a child has when he fails to get the love and affections he expects.

Jacobson also described two types of mothering experiences. Excessive frustrations, which taxed a developing ego beyond its capacity, were seen to result in feelings of inferiority and self-disparagement, and of being unloved and unwanted. The other style, overgratification, delayed the establishment of firm boundaries and retarded independence.
Jacobson (1954, 1964) gave considerable thought to the development of ego identifications, which she envisioned as spanning three distinct stages. In the first stage, during infancy, the child is not aware of the distinction between himself/herself, and the mother. As the child grows and develops the capacity to speak and move about, his or her ego activities are now more involved in the activity of imitation, or being like his mother. Learning to tolerate ambivalence is also an important component of this stage as well as wishful fantasies and feelings of omnipotence. In the last stage, the child's efforts are directed toward becoming like his or her parent's through the more advanced process of identification.

During the second stage, the pre-oedipal child is sensitive to the frustration and disappointing experiences suffered at the hands of his or her love objects and may experience fleeting hostile feelings, thoughts, or impulses. If these are too pronounced, they can jeopardize the establishment of self-esteem. Jacobson believed that hostile feelings could be compensated for by the pre-oedipal child's tendency to idealize his or her love-objects. Nonetheless, since the boundaries between self and object images are still hazy, devaluation of the parent will have the tendency to create self-devaluation. Early
disappointments and the subsequent devaluation of the parental images on the young child's ego, which is also experienced then as devaluation of the self, may lead to a primary childhood depression which will be repeated in later life when similar disillusionments takes place (Spitz, 1946).

Winnicott (1965) also looked to the real relationship between the mother and child, and the types of experiences a mother could provide to optimally facilitate the emergence of an infant into a person. The quality of this relationship should lead to the infant feeling secure, and a stable relationship with a mother committed to providing for his or her needs.

The mother provides a "holding environment" within which the infant is held both physically and emotionally is facilitated by the mother's devotion to mothering. Her empathic anticipation of the infant's needs and her timing gives rise to the infant's illusion that he or she is omnipotent, which is the basis for the healthy development of the self. Winnicott later compared the mother's anticipation of the child's needs and her accurate sensitivity to that of a mirror in that she provides the infant with a precise reflection of his own experiences and gestures. Imperfections in what is reflected back to the
child interfere with his or her evolving sense of self, and undercut the infant's sense of omnipotence.

The mother's failures, in manageable doses, and her interest in other areas of her life allow for the gradual diminishing of the infant's illusion of omnipotence. Deficiencies in maternal care, the failure to provide an optimal environment, and sudden or untimely withdrawal, have a debilitating impact on the emotional development of the child. By necessity, the child prematurely is forced to attune to the needs and desires of others and these deficiencies are experienced by the child as terrifying. In effect, the infant is compelled to abandon his own wishes and demands, resulting in fragmentation, or a split between a true self and a false self built on maternal expectations and needs. When childrearing demands the needs of others at the expense of the needs and desires of the self, pathology arises. Although Winnicott (1955) originally postulated three categories of mental disorders, he later came to conceptualize the false self as being the underpinnings of psychotic states, to depressive disorders.

According to current trends in object relations theory, splitting, the process of parceling experiences into "good" and "bad," is a major, yet developmentally normal dynamic that begins in infancy and extends into
adulthood (Cashdan, 1988). Abnormal splitting occurs when "bad mother" (Cashdan, 1988, p. 36) experiences are exceptionally painful and extreme, thereby leading to pathological outcomes. Hibbard (1987) indicates that one of the most pathogenic mechanisms in alcoholic families (which also differentiates them from other dysfunctional families) is that the alcoholic's behavior actually facilitates and promotes the use of splitting as a defense; "the use of overidealization to ward off ambivalence and Mastersonian-style abandonment depression" (p. 783). For example, Hibbard (1987) describes the scenario of an alcoholic mother talking warmly to her child, only to leave and return as an aggressive and menacing mother. Fox (1962) also pointed out the dichotomous aspects of the alcoholic mother who is neglectful while intoxicated, yet overindulgent and guilt ridden when sober. The inebriated mother may deliver sudden and harsh punishment which is determined not in regard to the child's behavior, but by the quantity of alcohol ingested, a distinction which the young child cannot make (Richards, 1979). In effect then, the mother becomes split into a good mother (sober), and a bad mother (drunk) (Richards, 1979). Thus, there are ample opportunities for the alcoholic mother to be experienced as a frustrating, rejecting object, as well as an exciting
object in Fairbairn's paradigm (1954, 1963). The exciting object relationship is facilitated by the alcoholic mother's periods of sobriety and physical presence, which as Breen (1985) has noted, leads to tantalizing hope.

In concert with the process of splitting, other object relations concepts can be observed, such as an impaired mothering attitude and the creation of the false self as described by Winnicott (1965). Jesse (1989) states that in alcoholic families, important care taking functions are virtually lacking. From simple neglect, to being unable to meet psychological needs, the alcoholic mother or parent is more preoccupied with the getting and using aspects of their addiction (Rivinus, 1990).

In summary, if the mother is alcoholic, the mother-child relationship will be impaired in that the mother's primary emotional involvement is with the alcohol, not the child (Beletsis & Brown, 1981). It would seem then, that the important functions of the mother's maternal preoccupation and the creation of a holding environment would be difficult to achieve given the above.

This type of environment would also seem to facilitate the need for a child to create what Winnicott (1965) calls a false self. Many clinician's, such as Cermak (1991), Jesse (1989) and Richards (1979) have commented on
the apparent pseudomaturity observed in young COA's. This may be the result of the child's having to act as a mother to him or herself as well as to the alcoholic mother and leads to rage, resentment, or feelings of deprivation. What is inherent in this situation is that the child is prematurely forced to give up his or her needs for that of the mother's. When the alcoholic parent repeatedly fails to meet the child's needs, the child's only recourse is to adapt the self to that which pleases the parent, and this forms the basis of the false self (Jesse, 1989). As Cermak (1991) states, these children must often supersede their investment into the relationship with the alcoholic parent in order maintain some sort of relationship with them, and this can lead to a profound chronic depression, inadequacy, and inner emptiness. Rivinus (1990b) elaborates further to assert that in the alcoholic family, not only does the child come to realize that his or her needs are secondary to the overwhelming needs of the parent for the drug, but that the child is deprived of any sort of holding environment. The child's only recourse then is to provide one for him or herself. This "self-holding environment" (Rivinus, 1990b, p. 270) often extends to become the holding environment for the addicted parent.
In summary, Hibbard (1987) contends that parental alcoholism renders the parent "unavailable, or worse, distorted, for various introjective, identificational, or mirroring functions which optimally would be performed by a sober parent" (p. 784). These deficits can also be ascribed to Kohut's theory.

Heinz Kohut (1971, 1977) also believed that interactions between the mother and child were important in the infant's construction of the self. Pathology is viewed as a consequence of disturbances in this relationship. Kohut referred to the parents and other significant objects as "selfobjects," and their importance lies in the psychological functions they provide. His concept of "mirroring" refers to all the transactions characterizing the mother-child relationship, including nurturance, empathy, and respect. Chronic failure of empathy, usually due to the parent's own pathology, undermines the healthy development of the child's self. Parental remoteness deprives the child of the much needed empathic mirroring, as well as a responsive target for the child's need to idealize the parent. Just as detrimental is the parent who cannot respond to the child's changing narcissistic needs. This is usually due the parent's own need to retain the child as part of their own self. In this case, the parent's
over-closeness "obscures the fact that neither the child's pridefully offered exhibitionism nor enthusiastically expressed idealizing needs had been phase-appropriately responded to and that the child, therefore, becomes depressed and lonesome" (Kohut, 1977, p. 275). Responses such as praise are experienced by the child as pride, while experiences of shame are experienced as guilt.

Recognizing that a child is by nature narcissistic, the child has two basic needs that he seeks to satisfy through early selfobject relationships. One is the need to be admired for his developing capacities and the other is to form an idealized image of the parents, usually the mother. These two configurations become incorporated into the child's representational world, the first being comprised of grandiose, exhibitionistic self-images resulting from interchanges with "mirroring selfobjects". The second relational configuration consists of toned down images of the self, fused with "idealized selfobjects".

Kohut's work has many implications for the child of an alcoholic mother. Jesse (1989) clearly states that in the alcoholic family system there is a "pervasive lack of empathy" (p. 75). Furthermore, the presence of alcoholism in a parent is evidence of a disordered self (Jesse, 1989; Kohut, 1977). A chemically dependent parent is, by
definition, a narcissistic parent who cannot meet the psychological needs of their child (Rivinus, 1990). Their own inability to delay the satisfaction of their needs and impulses contributes to this perception. The alcoholic parent's lack of self cohesion also prevents them from acknowledging that the child is an autonomous being; the child is actually experienced as a part of the parent's self (Jesse, 1989).

In conclusion, it has been reported that depression is a frequently cited symptom amongst adult COA's. While little research has investigated the presence of depression in young children of alcoholics, alcoholic mothering and it's impact on the child would seem to have profound consequences according to object relations theory. Given the primacy of the mother-child relationship in object relations theory, as well as the necessary ingredients for healthy development, the young COA is at risk for developing depression since these pre-requisites are virtually absent.
CHAPTER III

Method

This chapter describes the subjects, instruments, design and procedures of this study.

Subjects

Subjects of this study were 128 African American males and females between the ages of 7 and 12. These children were placed into three groups according to the status of their mothers: alcoholic, nonalcoholic-clinical, and nonalcoholic-nonclinical. Children for the alcoholic and nonalcoholic-clinical groups were recruited through a child and adolescent mental health outpatient unit at a major urban hospital in New Jersey. The center's mission is to provide a wide range of mental health services that meet the community's needs. The children for the nonalcoholic-nonclinical group came from the family practice office located within the same hospital. Information taken from routine family history regarding alcohol use and psychiatric conditions determined the child's eligibility.

The alcoholic group had 27 males and 12 females for a total of 39 subjects. The nonalcoholic clinical group was comprised of 45 children (33 males and 12 females). There were 44 children in the nonalcoholic-nonclinical group, 26 of which were males and 18 were females.
**Instruments**

The Children's Depression Inventory (CDI) (Kovacs, 1992) was the instrument selected for this study, as it is clearly one of the most widely used and well researched self-report instruments to date (Doerfler, et al., 1988; Kazdin, 1989). Although significant advances have been made in developing techniques to assess depression in children and adolescents, validational research for many of these measures is still in the preliminary phase (Felner, Rowlison, Raley, & Evans, 1988). The CDI is especially useful in measuring the severity of depression given that key symptoms (e.g. sadness, feelings of worthlessness, etc.) reflect subjective feelings or perceptions (Kazdin, 1989). Furthermore, it has been used successfully with children as young as 6 years of age (Kazdin, Rodgers, & Colbus, 1986; Kovacs, 1992).

The CDI includes twenty-seven items that assess the cognitive, affective, and behavioral signs of depression. Each item presents three alternative affective statements. Children select one of three alternatives that characterize their affect within the last two weeks. For example, children are asked to select one from the following set of alternatives: (a) "I am sad once in awhile"; (b) "I am sad many times"; (c) "I am sad all the time."
Scores for each item range from zero to two. Total scores range from a minimum of zero to a maximum of fifty-four. A high score represents a large degree of depression. Kovacs (1992) reported that a criterion score of thirteen would yield the lowest number of false positive indications of nondepressed children who are mistakenly identified as depressed.

The CDI has been shown to have a high internal consistency (e.g. Chronbach's alpha .80) and moderate test-retest reliability (from one week to six months). It also has the ability to distinguish clinic groups from nonclinic groups of children (Kovacs, 1992; Saylor, Finch, Spirito, and Bennet, 1984). Doerfler et al. (1988), in their sample of 1,207 rural Southern children, 48% of whom were classified as Black, examined race differences on the CDI and found that Black children had only slightly lower scores than Caucasian children (MS 8.2 and 9.1, respectively).

The Parental Acceptance-Rejection Questionnaire (Child PARQ) is a self-report instrument designed by Rohner (1991) to measure a child's perceptions of parental acceptance and rejection. Furthermore, the Child PARQ asks children to respond about the way they feel their mothers treat them. This bipolar dimensional questionnaire conceptualizes
parental acceptance-rejection along a continuum of parental behaviors from physical affection and verbal praise (acceptance) to the absence or withdrawal of warmth and affection (rejection). Rohner (1991) described one type of parental acceptance, Warmth and Affection, and outlined three types of parental rejection:

(a) Aggression/Hostility, (b) Neglect/Indifference, and (c) Undifferentiated Rejection.

Rohner (1980) conceptualizes rejecting parents as those who dislike or otherwise resent their children, often viewing the child as a burden. The parent may manifest this rejection by being aggressive (hitting, punching, using harsh sarcasm, etc.) or indifferent and neglectful. The latter two are manifested by the parent being physically and emotionally unresponsive or absent for the child. This parent, for example, may ignore the child's cries for attention and comfort, be unresponsive to emotional needs, and otherwise show little regard to the child. These forms of parental rejection reveal an impaired parental attachment; the result being that the child feels unloved and rejected. Not surprisingly, rejected children are at risk for developing psychiatric and physical disorders.

The Warmth/Affection scale measures the child's perception of parental approval, interest in his or her
activities and well-being, and demonstrations of love and caring. The Aggression/Hostility scale refers the child's subjective perception of parental intent to harm him or her; that is, a parent who is highly critical, very impatient, ridiculing, harsh, and aggressive in behavior. A sample item of this scale is "My mother made me feel wanted and needed," and "My mother went out of her way to hurt my feelings." The Neglect/Indifference scale measures the subject's perceptions of the mother as being uninterested about them and of ignoring their needs. The statement "My mother ignored me as long as I did not do anything to disturb her" is an item from this scale. The mother may be viewed as cold, distant, and unconcerned. Finally, the last scale, Undifferentiated Rejection, refers to perceptions that the mother is withdrawing her affection from the child, but is not necessarily hostile or indifferent, nonetheless, the child interprets this as rejection. "My mother does not really love me" is an example of this type of undifferentiated rejection.

This sixty-item, self-report instrument requires the child to answer items as Almost Always True, Sometimes True, Rarely True, or Almost Never True, as to their perception of how their mother treats them.
In the validation and norming sample, which included 220 children from ages nine through eleven, the Child PARQ demonstrated sufficient reliability. Using Cronbach's alpha as a measure of reliability, the following coefficients were reported: .90 for Warmth and Affection, .87 for Hostility and Aggression, .77 for Indifference and Neglect, and .72 for Undifferentiated Rejection.

Concurrent validation techniques were used to establish the validity of the Child PARQ. Concurrent validation involves establishing validity by correlating Child PARQ scales with a measure already well researched and validated, in this case the Child's Report of Parent Behavior Inventory (Schaefer, 1964). The concurrent validation results show correlations of .83 for the Child PARQ Warmth and Affection Scale and the CRPBI Acceptance Scale, .64 for the Child PARQ Indifference/Neglect Scale and the CRPBI Hostile Detachment Scale, and .74 for the Child PARQ Undifferentiated Rejection Scale and the CRPBI Rejection Scale. Since the CRPBI did not contain a scale comparable to the Hostility-Aggression Scale of the Child PARQ, this scale was correlated with the Physical Punishment Scale of the Bronfenbrenner Parent Behavior Questionnaire (Siegelman, 1965), and a correlation coefficient of .55 was established.
The child version of the PARQ consists of sixty items that are assigned to one of four scales. The Warmth and Affection Scale consists of twenty items, the Hostility and Aggression Scale and the Indifference and Neglect Scale have fifteen items each, and the Undifferentiated Rejection Scale has ten items. While the scales can be used individually, a total composite score can also be used. Each scale is scored so that a high score represents maximum warmth/affection, maximum aggression/hostility, maximum neglect/indifference, or maximum undifferentiated rejection. As a result, in reference to the overall continuum, high scale-scores represent high levels of perceived acceptance for the Warmth/Affection scale and low scores represent perceived rejection. On the Aggression/Hostility, Neglect/Indifference, and Undifferentiated Rejection scales, high scores represent perceived rejection and low scores represent perceived acceptance. When the total composite score is used, the items in the Warmth/Affection scale must be reversed scored to keep the scale scoring pattern unidirectional so that a high composite score represents high perceived rejection and a low score represents perceived acceptance.
Design

This study investigated the following hypotheses regarding maternal alcoholism and feelings of depression and rejection in latency age African American children.

Hypothesis 1: African American children of alcoholic mothers will demonstrate higher levels of depression on the CDI than will children whose mothers are nonalcoholic-clinical, or nonalcoholic-nonclinical.

Hypothesis 2: African American children with alcoholic mothers would report higher levels of maternal rejection on the Child PARQ than will children of nonalcoholic-clinical or nonalcoholic-nonclinical mothers.

Hypothesis 3: African American children with alcoholic mothers will report lower levels of maternal warmth and acceptance as well as higher levels of aggression/hostility, neglect/indifference, and undifferentiated rejection on the PARQ than will children of nonalcoholic-clinical or nonalcoholic-nonclinical mothers.

A comparison group design was used for this study. The independent variables used for grouping purposes are the status of the mother: alcoholic, nonalcoholic-clinical, or nonalcoholic-nonclinical. As a result, subjects were
assigned to one of three groups based on the designations of the mother.

Basic descriptive statistics were generated on the subjects' demographic variables. Regarding the dependent variables, a table is presented that lists means and standard deviations for all subjects on the CDI and the composite and scale scores of the Child PARQ. Also, a Pearson correlation matrix will be presented that correlates the CDI and PARQ scales and composite score. Correlations significant at or above the .05 level will be identified.

If the correlation between the CDI and the PARQ composite score are significant, hypotheses one and two will be analyzed with a multivariate analysis of variance (MANOVA) (Tabachnick & Fidell, 1989). MANOVA is a generalization of simple analysis of variance to situations where there are multiple correlated dependent variables. The MANOVA technique will determine if the dependent variables (child depression and perceived maternal acceptance/rejection) vary as a function of the status of the mother as alcoholic, nonalcoholic-clinical, or nonalcoholic-nonclinical. The MANOVA procedure tests the null hypothesis of group differences on a multivariate
linear composite of the dependent variables as based on chance.

Should the results of the correlation between the CDI and the Child PARQ show that these scores are not significantly related, hypotheses one and two will each be analyzed with a univariate analysis of variance. ANOVA is used to test whether group differences on a single dependent variable are likely to have occurred by chance (Tabachnick & Fidell, 1989).

Regarding group difference, the PARQ scales will be analyzed with a MANOVA, for hypothesis three, if the correlations between the scales will be correlated. If they are not correlated the differences between the groups will be analyzed with univariate ANOVA's, with one ANOVA conducted for each subscale.

Procedure

1. Prior to the onset of the study, a proposal was submitted to a community-based hospital with the intent of securing permission to proceed with the research.

2. The intake process was conducted which included an intake evaluation, the Family History - Research Diagnostic Criteria (FH-RDC), and mental status.

Intake evaluations were conducted for all families seeking mental health services in accordance with the
standard procedures of the unit. At the time of the initial evaluation of the children, parents/guardians are routinely asked questions about alcohol/substance abuse, family psychiatric history, and family composition. These intakes were conducted by experienced mental health clinicians comprised of masters level social workers and psychologists.

The Family History-Research Diagnostic Criteria (FH-RDC) was also administered at the time of intake evaluations. This widely used tool is extremely useful because it provides information on the psychiatric conditions of significant caretakers including the informant (or parent, in this case), as well as on relatives of patients when the relative cannot be interviewed directly. Therefore, psychiatric diagnoses on a parent can be obtained even if the child is not in that parent’s custody as is often the case when a child is currently living with a grandparent of relative. The FH-RDC allows for the determination of the following diagnoses useful to this study: mood disorders (schizoaffective, mania, depressive and anxiety disorders, alcoholism, and "no known psychiatric mental disorder."

A mental status examination, routinely performed by mental health clinicians as part of their initial
evaluation/intake, was used to rule out the presence of major psychopathology (e.g., psychosis, suicidal/homicidal ideation) in those children being considered for this study. Children who presented with major pathology were not considered for the study.

3. Upon completion of the intake process, children were identified as being eligible to participate in this study according to the status of their mother. If the child met the criteria for inclusion in the study, the mental health clinician asked parents/guardians if their child could participate in a research project to gain more understanding on how children feel and how they feel about their families. Parents and guardians were told that their child’s participation in this study was voluntary and would not affect their treatment at the mental health center or at the family practice office.

4. Children were assigned to three groups. In the alcoholic mother group #1, the child was primarily in the care of an alcoholic mother who did not have a known psychiatric illness. The nonalcoholic-clinical group #2 the child was primarily in the care of a mother who was determined to have a nonalcoholic related mental health problem. The nonalcoholic-nonclinical mother group #3 had children who met the criteria for inclusion and who’s
mothers were not determined to have an alcohol problem or emotional disturbance. For group #2, the study limited the mother’s psychiatric disturbance to circumscribed diagnostic categories, which would include general mood and anxiety disorders and exclude severe psychiatric conditions such as schizophrenia, manic-depression, and major depression with psychotic features. The investigator did not limit the nonalcoholic-clinical group to mothers in one diagnostic category (i.e. dysthymia, generalized anxiety disorder), due to the complicating factor of genetic loading.

5. The research assistant for the department was contacted to meet with families who expressed an interest in participating and to explain the study and have all necessary consent forms signed. Informed consent forms and a letter of explanation were given to the parent/legal guardian, and to the child (subject assent form).

6. Children who had been identified as qualifying for participation in the study were administered two measures by the research assistant. The research assistant was responsible for administering the Children’s Depression Inventory (CDI) and the Child Parental Acceptance-Rejection Questionnaire (Child PARQ). Completion of the instruments took approximately 20 to 30 minutes. The research assistant
was trained in the use of the CDI and PARQ and responsible for administering the CDI and the PARQ to the participating children. The activities of the research assistant were supervised by an experienced, licensed psychologist who also served as the supervisor of the Child and Adolescent Unit. In addition, the scoring of the CDI and the Child PARQ was supervised by the same licensed psychologist.
CHAPTER IV

Results

This chapter presents the results of the analyses conducted on the data generated for this study. The chapter presents basic descriptive statistics on demographics as well as the Children's Depression Inventory (CDI), the Child Parental Acceptance Rejection Questionnaire (Child PARQ), and the and Parental Acceptance Rejection Questionnaire scales (PARQ). The results of hypothesis testing are also presented.

Subjects of this study were 128 African American males and females between the ages of 7 and 12. All children considered for participation lived in families headed by single mothers residing in the same large inner city. Subjects were divided into the following three groups according to the alcoholic or clinical status of the mother: (a) alcoholic group #1, (b) nonalcoholic-clinical group #2, and, (c) nonalcoholic-nonclinical group #3.

Descriptive Statistics on Demographics and Scales

Demographic information was obtained on the subjects' sex, age, grade, mothers' education, and number of siblings. Basic descriptive statistics, including means and standard deviations, were generated on the demographic variables as well as the CDI, Child PARQ, and the PARQ
scales. The means and standard deviations on all variables are presented in Table 1.

Table 1

Means and Standard Deviations

<table>
<thead>
<tr>
<th>Variable</th>
<th>Nonalcoholic Alcoholics</th>
<th>Nonalcoholic Clinical</th>
<th>Nonalcoholic Nonclinical</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x</td>
<td>SD</td>
<td>x</td>
<td>SD</td>
</tr>
<tr>
<td>Age</td>
<td>9.10</td>
<td>1.53</td>
<td>9.86</td>
<td>1.61</td>
</tr>
<tr>
<td>Grade</td>
<td>3.48</td>
<td>1.58</td>
<td>3.64</td>
<td>1.59</td>
</tr>
<tr>
<td>Mother’s Education</td>
<td>10.51</td>
<td>1.57</td>
<td>10.48</td>
<td>1.93</td>
</tr>
<tr>
<td>Siblings</td>
<td>1.79</td>
<td>1.36</td>
<td>1.86</td>
<td>1.28</td>
</tr>
<tr>
<td>PARQ</td>
<td>119.30</td>
<td>31.34</td>
<td>115.53</td>
<td>29.23</td>
</tr>
<tr>
<td>Aggression</td>
<td>30.46</td>
<td>10.10</td>
<td>30.46</td>
<td>6.45</td>
</tr>
<tr>
<td>Neglect</td>
<td>32.41</td>
<td>7.49</td>
<td>29.65</td>
<td>8.66</td>
</tr>
<tr>
<td>Rejection</td>
<td>20.69</td>
<td>7.36</td>
<td>22.13</td>
<td>5.51</td>
</tr>
<tr>
<td>Warmth</td>
<td>57.95</td>
<td>16.40</td>
<td>63.74</td>
<td>12.86</td>
</tr>
</tbody>
</table>

Note. For Warmth, high scores = greater levels of warmth.

This breakdown indicates that for the total group of 128 children, about 2/3rds (67.2%) are males and 1/3rd are females (32.8%). For the children of alcoholic,
nonalcoholic-clinical, and nonalcoholic-nonclinical mothers, the percentage of males was 69.2%, 73.3%, and 59.1% respectively. The percentage of females was 30.8%, 26.7%, and 40.9% respectively. A chi² analysis was conducted to determine if a relationship exists between gender and group. A nonsignificant chi² was found \( (X^2 = 2.15, df = 2, p = .41) \) which indicates that the distribution of gender across the groups was not different from what would be found if chance alone were operating.

For each group, the ages ranged from seven to twelve years old. The mean age for groups 1, 2, and 3 were 9.10, 9.86, and 10.22 years old respectively. A one-way analysis of variance was conducted to compare the means of the groups on age. A nonsignificant F was found \( [F(1,125) = 1.08, p = .34] \), which indicates that the groups did not differ on mean age.

Subjects' grade levels ranged from 1st to 6th. The mean grade levels in indicate that for groups 1, 2, and 3, the mean grade levels were 3.48, 3.64, and 4.06, respectively. A one-way analysis of variance was conducted to compare the means of the groups on grade levels. A nonsignificant F was found \( [F(2,125) = 1.64, p = .19] \), which indicates that the groups did not differ on mean grade level.
The mothers' education levels ranged from 4th grade to high school graduates. The means on mothers' education levels show that for the alcoholic, nonalcoholic-clinical, and nonalcoholic-nonclinical mothers, the means were 10.51, 10.48, and 11.15, respectively. A one-way analysis of variance was conducted to compare the means of the groups on mothers' education levels. A nonsignificant $F$ was found [$F(2,125) = 2.32, p = .10$], which indicates that the groups did not differ on the level of mothers' education.

A breakdown on the number of siblings indicates that the number of siblings ranged from 0 to 6. The mean number of siblings for group #1 is 1.79 while it is 1.86 and 1.59 for groups #2 and #3, respectively. A one-way analysis of variance was conducted to compare the means of the groups on number of siblings. A nonsignificant $F$ was found [$F(2,125) = .58, p = .56$], which indicates that the groups did not differ on the number of siblings.

A Pearson correlation matrix is presented in Table 2, which indicates the relationships between the CDI, Child PARQ, and PARQ scales. Most interestingly, the CDI did not demonstrate a significant relationship with total PARQ scores ($r = .08, p = .32$). However, low but significant relationships were found with aggression ($r = .28, p = .001$), neglect ($r = .28, p = .001$), and rejection ($r = .35,$
A nonsignificant relationship was found between CDI and warmth and affections scores ($r = .04$, $p = .64$).

### Table 2

**Pearson Correlation Coefficients between CDI, PARQ, and PARQ Scales**

<table>
<thead>
<tr>
<th></th>
<th>CDI</th>
<th>PARQ</th>
<th>Aggression</th>
<th>Neglect</th>
<th>Rejection</th>
<th>Warmth</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDI</td>
<td>1.00</td>
<td>.08</td>
<td>.28</td>
<td>.28</td>
<td>.35</td>
<td>.04</td>
</tr>
<tr>
<td></td>
<td>(.32) (.001)</td>
<td>(.001)</td>
<td>(.001)</td>
<td>(.001)</td>
<td>(.61)</td>
<td></td>
</tr>
<tr>
<td>PARQ</td>
<td>1.00</td>
<td>.79</td>
<td>.72</td>
<td>.80</td>
<td>.58</td>
<td>.58</td>
</tr>
<tr>
<td></td>
<td>(.001)</td>
<td>(.001)</td>
<td>(.001)</td>
<td>(.001)</td>
<td>(.001)</td>
<td></td>
</tr>
<tr>
<td>Aggression</td>
<td>1.00</td>
<td>.65</td>
<td>.88</td>
<td>.49</td>
<td>.560</td>
<td>.560</td>
</tr>
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<td>(.001)</td>
<td>(.001)</td>
<td>(.001)</td>
<td>(.001)</td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td>1.00</td>
<td>.66</td>
<td>.560</td>
<td>.45</td>
<td>.45</td>
<td>.45</td>
</tr>
<tr>
<td></td>
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<td>(.001)</td>
<td>(.001)</td>
<td>(.001)</td>
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</tr>
<tr>
<td>Rejection</td>
<td>1.00</td>
<td>.45</td>
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<td></td>
<td>(.001)</td>
<td></td>
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</tr>
<tr>
<td>Warmth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.00</td>
</tr>
</tbody>
</table>

### Analysis of Hypotheses

**Hypothesis 1:** African American children of alcoholic mothers will demonstrate higher levels of depression on the CDI than will children whose mothers are nonalcoholic clinical and nonalcoholic nonclinical.

Given the fact that a nonsignificant relationship was found between CDI and PARQ scores, differences between the
groups on these variables was analyzed with an analysis of variance. The data were checked for conformance to ANOVA assumptions, including outliers, normality, and homogeneity of variance. No outliers were found and the data were normally distributed. This assumption was found to be violated however, using the Levine test to examine the assumption of homogeneity of variance. While ANOVA has been found to be robust with respect to this violation (Winer, Brown, & Michels, 1991) as such violations of this assumption have little to no effect on the F test, post hoc comparisons were conducted with the Tamhane test, which does not require this assumption to be satisfied. The results for CDI scores are presented in Table 3.

Table 3

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>1270.86</td>
<td>2</td>
<td>635.43</td>
<td>9.97</td>
<td>.001</td>
</tr>
<tr>
<td>Within</td>
<td>7961.13</td>
<td>125</td>
<td>63.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9232.00</td>
<td>127</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These results indicate that a significant difference was found \( [F(2,125) = 9.97, p = .001] \). The Tamhane post hoc comparisons, as shown in Table 4, were conducted to identify pairs of group differences show significant
findings. The post hoc analyses indicate that the CDI mean of 16.68 for the clinical group is significantly higher than the mean of 9.13 for the nonalcoholic nonclinical group. No other significant differences were found.

Table 4

<table>
<thead>
<tr>
<th>Groups</th>
<th>M difference</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic - Nonalcoholic-Clinical</td>
<td>4.0</td>
<td>.07</td>
</tr>
<tr>
<td>Alcoholic - Nonalcoholic Nonclinical</td>
<td>3.6</td>
<td>.13</td>
</tr>
<tr>
<td>Nonalcoholic - Nonalcoholic Clinical</td>
<td>7.55</td>
<td>.001</td>
</tr>
</tbody>
</table>

The results of these findings show that this hypothesis is not confirmed. The children of alcoholic mothers did not demonstrate higher levels of depression than the clinicals and nonalcoholic-nonclinical.

Hypothesis 2: African American children of alcoholic mothers will report higher levels of maternal rejection on the Child PARQ than will children of nonalcoholic-clinical and nonalcoholic-nonclinical.

An analysis of variance was used to compare the groups on total PARQ scores. All assumptions were satisfactory including outliers, normality and homogeneity of variance. The results, presented in Table 5, indicate that a
significant difference was found \([F(2,125) = 7.75, p = .001]\).

Table 5

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>15741.16</td>
<td>2</td>
<td>7870.58</td>
<td>7.75</td>
<td>.001</td>
</tr>
<tr>
<td>Within</td>
<td>126911.4</td>
<td>125</td>
<td>1015.29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>142652.6</td>
<td>127</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As a result of these significant findings, Scheffe post hoc comparisons, as shown in Table 6, were conducted to identify pairs of group differences.

Table 6

<table>
<thead>
<tr>
<th>PARQ Post Hoc Comparison Summary</th>
<th>Groups</th>
<th>M difference</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohollic - Nonalcoholic</td>
<td>Clinical</td>
<td>3.77</td>
<td>.86</td>
</tr>
<tr>
<td>Alcohollic - Nonalcoholic</td>
<td>Nonclinical</td>
<td>25.12</td>
<td>.002</td>
</tr>
<tr>
<td>Nonalcoholic - Nonalcoholic</td>
<td>Clinical</td>
<td>21.38</td>
<td>.008</td>
</tr>
</tbody>
</table>

The post hoc analyses indicated that the alcoholic PARQ mean of 119.30 was significantly higher than the nonalcoholic-nonclinical mean of 94.15. In addition, the clinical group mean of 115.53 was significantly higher than
the nonalcoholic-nonclinical mean. No other significant differences were found.

These findings show that this hypothesis is partially confirmed. The children of alcoholic mothers did report significantly higher levels of maternal rejection than the nonalcoholic nonclinical group, but not significantly higher than the clinical group. What's more, the clinical group reported significantly higher levels of maternal rejection than the nonalcoholic-nonclinical group.

Hypothesis 3: African American children with alcoholic mothers will report lower levels of maternal warmth and acceptance, as well as higher levels of aggression/hostility, neglect/indifference, and undifferentiated rejection on the PARQ than will children of nonalcoholic clinical and nonalcoholic nonclinical. As a result of the significant relationships found between the PARQ scales, a one-way multivariate analysis of variance was used to test this hypothesis. MANOVA is the statistical technique used to test mean differences between groups on multiple dependent variables that are correlated (Tabachnick and Fidell, 1989). The independent variables were the groups, and the dependent variables were the scores on the PARQ, including aggression, neglect, rejection, and warmth.
The data were evaluated for conformance to MANOVA assumptions including multivariate normality, outliers, linearity, homogeneity of variance, and multicolinearity. All assumptions were satisfactory except homogeneity of variance. The Levine test was used to determine which variables contributed to the violation of this assumption, and a significant Levine test was found for aggression \( [F(2,124) = 5.68, p = .004] \), for rejection \( [F(2,124) = 6.58, p = .002] \), and warmth \( [F(2,124) = 7.11, p = .001] \). However, as indicated previously, ANOVA has been found to be robust with respect to this violation.

A significant multivariate \( F \) was found \( [F(8, 242) = 8.242, p = .001] \) with a statistical power level of .99. These results indicate that the groups did indeed differ on the scales of the PARQ. The univariate results, presented in Tables 7 through 10 show that significant differences were found between the groups on each PARQ scale.

Post hoc analyses were conducted to pinpoint group differences. Given the violations of the homogeneity of variance assumption indicated for aggression, rejection, and warmth, the Tamhane test was used, as this test does not require homogeneity of variance to be valid. The Scheffe test was used for neglect. The post hoc analyses indicated the following:
For aggression, no significant mean differences were found between the alcoholic group and the clinical and nonalcoholic-nonclinical groups. However, the mean of 30.46 for the clinical group was significantly higher than the mean of 26.54 for the nonalcoholic-nonclinical group.

Table 7

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>443.44</td>
<td>2</td>
<td>221.72</td>
<td>3.23</td>
<td>.04</td>
</tr>
<tr>
<td>Within</td>
<td>8561.8</td>
<td>125</td>
<td>68.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9005.24</td>
<td>127</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For neglect, the mean of 32.41 for the alcoholic group was significantly higher than the mean of 25.04 for the nonalcoholic-nonclinical group. In addition, the mean of 29.65 for the clinical group was significantly higher than the mean of 25.04 for the nonalcoholic-nonclinical group.

Table 8

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>1159.21</td>
<td>2</td>
<td>579.6</td>
<td>8.88</td>
<td>.001</td>
</tr>
<tr>
<td>Within</td>
<td>8155.65</td>
<td>125</td>
<td>65.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>9314.87</td>
<td>127</td>
<td></td>
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</tbody>
</table>
For rejection, the mean of 22.13 for the clinical group was significantly higher than the mean of 18.95 for the nonalcoholic-nonclinical group.

Table 9

**Analysis of Variance on Rejection by Mother's Status**

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>225.26</td>
<td>2</td>
<td>112.63</td>
<td>3.11</td>
<td>.04</td>
</tr>
<tr>
<td>Within</td>
<td>4521.41</td>
<td>125</td>
<td>36.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4746.68</td>
<td>127</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

For warmth (where a high score = greater warmth) the mean of 57.94 for the alcoholic group was significantly lower than the mean of 69.79 for the nonalcoholic-nonclinical group.

Table 10

**Analysis of Variance on Warmth by Mother's Status**

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>2908.76</td>
<td>2</td>
<td>1454.38</td>
<td>8.00</td>
<td>.001</td>
</tr>
<tr>
<td>Within</td>
<td>22711.85</td>
<td>125</td>
<td>181.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25620.61</td>
<td>127</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Comparisons

Although the present study investigated levels of depression among children of African American parents, as
evident by mean scores on the CDI, analytic techniques exist that permit one to compare those scores against CDI normative data. Thus, it is possible to determine the effect of alcoholic status of African American mothers on their child’s level of depression in comparison to CDI mean scores of a normative population. The CDI norms are based on responses obtained from a random sample of 1,266 Florida public school students in grades 2 through 8. Data regarding ethnicity of the sample estimate that 77% of the children were white and the remaining 23% included American Indian, Hispanic, and African-American or Black, children. The overall mean CDI score for that sample was 9.98 with a standard deviation of 7.3 (Kovacs, 1992). Given that the current study utilized subjects that ranged in age from 7 to 12, the corresponding normative, mean score for that particular age group was used for comparison purposes. As reported, the mean CDI score for that age group was 9.81 with a standard deviation of 7.3. The mean CDI score for African American children who were in the care of an alcoholic mother with no known psychiatric illness was 12.69 with a standard deviation of 7.53. A t-test revealed that the two means were statistically different (p < .05). Moreover, by applying a comparison statistic referred to as Effect Size (Fitz-Gibbon & Morris, 1987), it was determined
that the average African American child experienced depression levels greater than 65 percent of the normative group. Hence, while the children in the alcoholic non-clinical group did not report more depressive symptoms than the nonalcoholic-clinical and nonalcoholic non-clinical groups, their scores were elevated when compared to the normative population.
CHAPTER V

Discussion and Conclusion

African American children of alcoholic mothers did not demonstrate higher levels of depression than the children in the nonalcoholic-clinical and nonalcoholic-nonclinical groups. One conclusion that can be drawn from the data is that clinicians who encounter young African American children of alcoholic mothers should not necessarily assume that these children evidence symptoms of depression nor that depression is an area that needs to be addressed in treatment. This conclusion is similar to that of several researchers (Calder & Kostyniuk, 1989; Emshoff & Jacobus, 2000; Rodney & Rodney 1996; Sher, 1997) who advocate the view that professionals working with COAs should not assume pathology based on alcoholic parentage.

The subjects in this study did not report more symptoms of depression than their non-COA counterparts. This is not consistent with the results of several studies (Anderson & Quast, 1983; Calder & Kostyniuk, 1989; Kamstra, 1986; Moos & Billings, 1982; Rolf et al., 1988) whose subjects were primarily Caucasian. Previous research in this area may in fact have limited applicability to African American children. One study (Rodney & Mupier, 1999) that specifically investigated depression among African American
COAs represented a different developmental stage. They found an association between depression and African American COA adolescents ages 12 through 19.

In addition to ethnic differences among subjects, other important differences exist between the present study and previous research on depression in young COAs. For example, three studies found an association between depression, having an alcoholic parent, and the reliance in their research design on parental responses to questionnaires (Anderson & Quast 1983; Calder & Kostynuik, 1989; Moos & Billings, 1982). A substantial amount of research indicates that children's self-report measures do not generally correlate well with measures obtained from other sources such as parents and teachers (Doerfler et al., 1988, Kazdin et al., 1983). The present study relied on children's subjective accounts of their affective state. It is possible that this study's results were at variance with those mentioned above, due to differences in self-report and parental reports of depression. Two studies (Kamstra, 1986, Rolf et al., 1988) did however, utilize the CDI and found significant group differences. Kamstra's study had a much smaller sample size. Her group of children with an alcoholic parent contained 22 subjects and the identified alcoholic parent had been in treatment for
alcoholism. Rolf et al. (1988) included children and adolescents into one group and thus, did not account for developmental differences. As stated previously, both studies utilized a Caucasian sample.

Another important difference that emerged is that the subjects’ parents in some of the studies (Anderson & Quast, 1983; Kamstra, 1986; Moos & Billings, 1982) were in treatment for alcoholism during the time those studies were conducted. None of the mothers in the current study were being treated for alcoholism. This raises an interesting question in relation to the mothers and children in the current study. Since the issue of the parent’s addiction has presumably not been openly discussed, is the child, much like the alcoholic parent, also in “denial”?

Breen (1985) compared the experiences of children of alcoholics to Kubler-Ross’s (1969) stages of bereavement. Denial is considered to be the first stage in this process. Breen points out, however, that children of alcoholics may become perpetually fixated at this stage, continually denying not only the alcoholism in the family, but the emotional consequences as well.

It is possible that the children who participated in the other studies were beginning to learn about alcoholism as a disease and to deal with the family issues around
addiction. Therefore, those subjects might not have only
been more aware of their own feelings, but also felt safer
in acknowledging them.

That children of alcoholics in this study did not
evidence more symptoms of depression than their non-COA
counterparts was supported by the results of two other
research studies. One study, conducted by Reich et. al.
(1993), found no differences in rates of depression among
children with one or two alcoholic parents. They collected
data on 158 children between the ages of 6 and 18 years of
age. Ethnic demographics were not identified. A
longitudinal study (Hunt, 1999) of 120 COAs who were
assessed at different intervals between the ages of 11 up
until age 48 found that COAs were no more likely to exhibit
depression than non-COAs.

In reviewing the present study’s results regarding
depression, an interesting consideration emerged. For many
children being seen in a large, urban mental health clinic
such as in the present study, family constellations are
often difficult to define. For example, extended family
structure is common. A mother and her children may live
with her own mother and/or father, siblings, uncle, aunt or
paramour. These types of living arrangements may vary and
are not always reported or accounted for during the time of
intake evaluations. It is therefore, difficult to establish who has and is primarily involved in caregiving functions. A supportive caregiving environment within the alcoholic family can serve a protective function; that is, risks for developing psychopathology can be reduced by the establishment of a positive and warm relationship with significant others. It may be that the children in the alcoholic mothers group experienced the mediating effects of a supportive grandparent, sibling, aunt, uncle or father figure.

Some clinicians (Garmezy, 1983; Logue & Rivinus, 1991; Rutter, 1985) have written about so called "protective factors" related to COAs. They believe that the presence of consistent or concerned adults can mediate the consequences of living in a substance abusing family. Boyd-Franklin (1989) in particular has written extensively about the special characteristic and positive attributes of the extended African American family in caring for children of distressed parents. An additional protective factor, according to Rodney (1996), is that of religious socialization which may help to mediate the adverse consequences of parental alcoholism for some Black youths. This was not assessed in the present study.
Children of alcoholic mothers reported higher levels of maternal rejection, neglect/indifference, and did not experience their mother as physically or verbally affectionate, when compared to children in the nonalcoholic-nonclinical group. This was not the case when compared to children in the nonalcoholic-clinical group. That children of alcoholic mothers have these perceptions, is consistent with previous research and clinical observations (Cork, 1969; Jesse, 1987; Booz & Hamilton, Inc., 1974; Kamstra, 1986). This finding also has important treatment implications as well.

As early as 1969 (Cork), based on her interviews of 115 children, found that 98% of her subjects described feeling unloved and perceived their alcoholic parent to lack interest in them. Other interview data, such as that collected by Jesse (1987), suggested that children raised in alcoholic homes felt unloved and rejected. Using projective tests she found evidence that latency-age children experienced unmet dependency needs. Moreover, retrospective accounts of adult COAs revealed that many of them felt rejected by their parents in childhood (Booz, et al., 1974). More recently, Kamstra’s research (1986) also found that latency age children of alcoholic parents felt
significantly more rejected than those children in her control groups.

The relationship between the alcoholic parent and child is often characterized by feelings of being unloved, rejected, and disregarded by the child (Beletsis & Brown, 1981; Hibbard, 1987; Jesse, 1989). Other authors such as Moore-Russell & Saraf (1992) and Rivinus (1990) assert that a chemically dependent parent, by definition, has little time for nurturing a relationship with their child and furthermore, is rarely able to meet the psychological needs of the child. This is underscored by the fact that alcohol and drugs impair the parent’s attention and memory; thus, effective parenting.

It has been commonly reported by the child that the alcoholic parent forgets important events in the life of their child, or that the parent is preoccupied with their addiction, rendering them unavailable to meet their child’s needs. Since alcoholism is believed to negatively impact important aspects of parenting, the children in the present study may have interpreted their mother’s behaviors as evidence of indifference and rejection. Accordingly, one conclusion revealed through this study has treatment implications for these children. It may be valuable for clinicians to help children understand the effects that
alcohol has regarding individual memory and behavior. Since Latency-age children are particularly prone to personalizing parental behavior, helping them to understand the distinction that the parent's behavior does not originate out of indifference or rejection but rather is a result of drinking behavior may help these children feel less unimportant and rejected by their mothers. In addition to having a more immediate healing effect on the mother and child relationship, this type of intervention might also help to prevent the future development of depression or other conditions in children.

Although children with alcoholic mothers did not report feeling significantly depressed, they did perceive their mother as more rejecting, indifferent, and less affectionate and warm. Rohner (1980) reasonably speculated that feelings of rejection (due to broken promises, inattention to details that contribute to a child's well being such as remembering important events) are associated, in some manner, to depression. It is possible that the children in this study were more attentive and/or gave more prominence to parental behaviors than to any internal feelings of sadness, should those feelings be present.

While not the focus of the present study, an interesting post hoc finding that emerged was that children
in the nonalcoholic-clinical group evidenced significantly higher levels of depression than the children in the nonalcoholic-nonclinical group. Children of alcoholic mothers did not show any significance. In contrast to mothers who have an emotional disorder, alcoholic mothers may have intermittent periods of relatively stable, parental functioning when they are not under the influence of alcohol. It is therefore possible that this has a mediating effect on the child’s level of depressive feelings. Perhaps genetic factors may also account for this trend. For example, according to the DSM IV (APA, 1994), depressive disorders such as dysthymia are more common among first-degree biological relatives who have major depressive disorder as compared to the general population. Similar to the alcoholic group however, these children also perceived their mothers to be more rejecting than the children in the nonalcoholic-nonclinical group.

Recommendations for Future Research

Future research might investigate differences between children of alcoholic mothers and mothers who have other substance abuse disorders. It may be that inasmuch as various drugs have differing effects on parental behavior, the child’s emotional status may also differ as a result. Similarly, differences in the severity or subtype of
alcoholism may affect the child's affective state. Perhaps a child whose parent becomes aggressive or violent when drinking evidence different profiles than children whose parent is likely to become animated and boisterous. Similarly, a parent whose drinking interferes with their daily functioning opposed to drinking on an intermittent basis, might impact children's feelings of depression and rejection.

Furthermore, future research might consider comparing various ethnic groups, cultural beliefs regarding drinking behavior, and dimensions of depression and perception of parental rejection. Important differences may exist between African American, Asian, Caucasian, Latino, and Native American populations that could benefit treatment protocols. Age may also be in factor in the expression of depression and rejection among these groups as well. Exploring potential protective factors within various ethnic groups, such as the role of the extended family in caring for children, could provide useful information regarding treatment and intervention.

Children of alcoholic mothers and mothers who have an emotional disorder, such as depression for example, may exhibit similar characteristics as well as ones that differentiate the two. Studies focusing on the more direct
comparison of these two groups may provide interesting information regarding key factors that lead to the development of depressive feelings and perception of rejection in children.
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