SAVING GRACE: THE RELATIONSHIP BETWEEN SPIRITUALITY AND MENTAL HEALTH IN ADULT CHILDREN OF ALCOHOLICS

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Approved: 
Date: 2-19-2015

Committee Chair

Approved: 
Date: 8/6/2014

Committee Member

Approved: 
Date: 7/25/2014

Committee Member

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Approved: ____ Dr. Karen Stinson ______ Date: __2/19/2015_____

Committee Chair

Approved: ____ Dr. Jovan Hernandez ______ Date: __7/25/2014_____

Committee Member

Approved: ____ Dr. Travis Nelson ______ Date: __8/05/2014_____

Committee Member
SAVING GRACE: THE RELATIONSHIP BETWEEN SPIRITUALITY AND MENTAL HEALTH IN ADULT CHILDREN OF ALCOHOLICS

Approved: Dr. Karen Stinson, Thesis Chair
Date: 5-5-2015

Approved: Dr. Jovan Hernandez, Committee Member
Date: 5-11-15

Approved: Dr. Travis Nelson, Committee Member
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ABSTRACT

SAVING GRACE: THE RELATIONSHIP BETWEEN SPIRITUALITY AND MENTAL HEALTH IN ADULT CHILDREN OF ALCOHOLICS

Amanda L. Schroeder
Under the Supervision of Dr. Jovan Hernandez and Dr. Karen Stinson

Background: Alcohol use affects thousands of individuals and families each year. The surviving child of an alcoholic home, an adult child of an alcoholic, often experiences difficulty including psychological distress and relationship difficulties. The current study attempted to identify how religious coping and an individual’s image of God might relate to levels of distress, help-seeking attitudes, and overall psychological well-being.

Methods: Ninety individuals participated in the research consisting of assessment instruments designed to collect data reflecting psychological distress, help-seeking attitudes, religious coping styles, and image of God. Two-way ANOVAs were used to explore the relationship between the independent variables, identified as belief in either an engaged God or an angry God, and the dependent variables, including all subscales of psychological well-being, depression, anxiety, stress, help-seeking attitudes, positive religious coping, and negative religious coping.

Results: The two-way ANOVAs revealed several significant main effects. God’s engagement was associated with more favorable help-seeking attitudes, more prevalent use of positive religious coping, higher levels of personal growth, and greater overall psychological well-being. God’s judgment (belief in an angry God) was associated with more prevalent use of negative coping skills/higher spiritual struggle, higher levels of stress, higher levels of anxiety, and higher levels of depression.
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CHAPTER 1
INTRODUCTION

This chapter provides first a brief introduction to the negative effects of alcohol use in the United States. Second, some general background information about understanding adult children of alcoholics, the dysfunction faced in the home, and the impending psychological distress is presented. Third, a brief explanation is provided about the role of religion and God as coping mechanisms. Lastly, significant terms used within this paper are defined.

Background Information

Research on alcohol use disorders in the United States indicates that in 2012, nearly 17 million adults over the age of 18 had an alcohol use disorder with 1.4 million adults receiving treatment at a specialized treatment center (National Institute on Alcohol Abuse and Alcoholism, n.d.). The National Institute on Alcohol Abuse and Alcoholism cites that high levels of alcohol use, whether during one instance or over time, can lead to changes in the brain and medical complications in the liver, pancreas, heart, immune system, and potentially contribute to the development of cancer. This impact becomes even greater when examining the effects of alcohol use disorders on family and loved ones.

Adult child of an alcoholic

Parental alcoholism affects millions of children every year and has been linked to poor psychological development across the lifespan (Hall & Webster, 2007). The surviving child of an alcoholic home, referred to as an adult child of an alcoholic (ACOA), often experiences feelings of distrust, a severely increased sense of responsibility, and frustration, in addition to anxiety, stress, and depressive symptoms (Hall & Webster, 2007; Beesley & Stoltenberg, 2002; Chassin, Pitts, DeLucia, & Todd, 1999). These afflictions can permeate nearly every aspect of an
individual’s life. While psychological distress and lower levels of psychological well-being might be apparent in some ACOAs, not all members of this group will experience this.

In 2007, the U.S. Department of Health and Human Services and the Substance Abuse and Mental Health Services Administration (SAMSHA) identified 76 million ACOAs living in the United States (2008). The chaotic and unpredictable nature of an alcoholic home can foster psychological distress in anyone experiencing it, especially children. Although growing up in an alcoholic home does not guarantee psychological problems, there is a higher risk present with this population (Hall & Webster, 2007). While research lacks consensus about the underpinnings, data suggests that psychological distress in children in an alcoholic home may present as anxiety, depression, and stress as time progresses (Hall & Webster, 2007; Audage & Middlebrooks, 2008). While it is apparent that not every child raised in an alcoholic home will develop psychological issues in adulthood, it is critical to understand factors of resiliency that prevent psychological problems later in life.

*God and Religion as a Coping Mechanism*

The purpose of this research is to explore spirituality as a resiliency factor. More specifically, this research examines a belief in particular types of God as well as religious coping styles as factors potentially correlating with levels of anxiety, depression, stress, and overall psychological well-being. While core strivings and life principles, such as the values an individual holds, life ambitions, or their chosen lifestyle, are traditionally believed to be influenced by an individual’s view of God (Schreiber, 2011), there is additional research regarding religiousness and lower lifetime prevalence of major depression and anxiety disorders (Nurasikin, Khatijak, Aini, Ramli, Aida, Zainal, & Ng, 2012; Moreira-Almeida, Neto, & Koenig, 2006). Better psychological well-being is also associated with greater reported religiosity.
Religiosity was defined simply by having a religious perspective or orientation (Momtaz, Hamid, Ibrahim, Yahaya, & Chai, 2011). The study that examined the association with religious beliefs and behavior and psychological well-being used a definition of religious belief as a belief in a sacred or transcendent force, which could be God or any other higher power, as individually defined (Moreira-Almeida, Neto, & Koenig, 2006). However, the study examined several other research projects and reported the degree to which an individual uses religion to cope with adverse circumstances or events is valuable in understanding resiliency as well as illuminating important implications for integrating religion and spirituality into counseling psychology practices (Hebert, Zdaniuk, Schulz, & Scheier, 2009). Leondari and Gialmas (2009) propose that religion and spirituality in general contribute to a more positive mental health status by providing increased social support, creating a stronger sense of cohesiveness, expanding psychological resources, and promoting positive health practices. While religion and spirituality shed light on individual beliefs and potential resiliency factors, there is another factor that helps to bring this more into the focus of clinical work; an individual’s attitude toward seeking professional psychological help.

Help-Seeking Attitudes

Research on help-seeking attitudes has been conducted with various ethnic and cultural groups, often searching for what is influencing a specific attitude (Al-Darmaki, 2003; Al-Krenawai, Graham, Dean, & Eltaiba, 2004; Shea & Yeh, 2008). Studies have shown that help-seeking attitudes are the strongest and most consistent indicator of intentions to seek help for psychological concerns (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Vogel & Wester, 2003). There is also the concept that negative help-seeking attitudes include avoidance factors of seeking help such as social stigma, treatment fears, fear of emotion, anticipated utility and risk,
reluctance to self-disclose, lower self-esteem, and consideration of social norms (Vogel, Wester, & Larson). Examining help-seeking attitudes will provide a light into how therapists can better help ACOAs. The current study targets help-seeking attitudes in an effort to discover how more positive or negative attitudes relate to levels of psychological distress and psychological well-being. Additionally, data will be gleaned to understand where the factors of an individual’s image of God and help-seeking attitude might intersect.

Terms Defined

Adult child of alcoholic (ACOA) is a term that will be used quite frequently herein and is characterized by a unique set of characteristics defined by Woititz (1990; as cited in Hall and Webster, 2007) that includes topics of loyalty, behaviors, relationships, and judgment. For the purpose of this study, an ACOA is defined as having at least one parent or caregiver that was/is an alcoholic.

Religious coping is a somewhat vague term that is meant to describe the degree to which an individual uses religion and religious sets as a way to handle or process positive and negative events in one’s life. This is measured by a specific instrument, the Brief RCOPE, which grew out of the RCOPE developed by Pargament, Koenig, and Perez (2000). The Brief RCOPE operates under the same definitions of religious coping as does the full scale RCOPE. Pargament (1997; as cited in Pargament, Feuille, and Burdzy, 2011) defines religious coping as “efforts to understand and deal with life stressors in ways related to the sacred” (p. 52). Religious coping is defined by this scale in terms of positive and negative coping. According to Pargament et al. (2011) positive religious coping reflects a strong connection with a higher power, a feeling of spiritual connectedness with other people, and a benevolent worldview. Conversely, underlying spiritual tensions and struggles with oneself, others, and one’s transcendent force conceptualize
negative religious coping. Both positive and negative coping styles are understood to be complex and intricate concepts that involve employing methods cognitively, behaviorally, emotionally, and relationally. For this study, religious coping will be defined as Pargament posited and will be conceptualized as positive and negative styles as measured by the Brief RCOPE. The higher the number on each respective scale, positive and negative, the more reflective it is of a positive or negative religious coping style.
CHAPTER 2
LITERATURE REVIEW

Adult Children of Alcoholics

Hall and Webster (2007) have published a variety of research that aims to uncover the underpinnings of the environment of an alcoholic home. The environment in an alcoholic home includes vast inconsistencies and uncertainties. The nature of the alcoholic and the dysfunctional behaviors that often become a part of the environment are often unpredictable and potentially dangerous. Rules are often changing and are not clear, which silently encourages a child to restrain themselves from talking, feeling, or doing in an effort to protect themselves (Hall & Webster, 2007). Ruben (2001) (as cited in Hall & Webster, 2007) identified a set of eight basic rules typical in an alcoholic home:

1. “Don’t talk about family problems.
2. It is not appropriate to express feelings openly.
3. Limit communications.
4. Nothing is ever good enough, but you are still expected to strive for unobtainable perfection.
5. You have to work for the benefit of others and you can’t be selfish.
6. ‘Do what I say, not as I do.’
7. Play is not something you do.
8. Whatever else, avoid conflict” (pg. 495-496).

Ruben proposes these common themes in alcoholic homes lead to increased feelings of stress, suppressed feelings, distrust, and feelings of increased responsibility for the parent. These
themes resurface through a variety of literature on the topic of ACOAs (Lambie, 2005; Chassin, Pitts, DeLucia, & Todd, 1999; Beesley & Stoltenberg, 2002).

Due to the fact that parental alcohol abuse has been found to be a family systems issue, meaning that it affects everyone in the family, children are often put in a position to maintain an equilibrium in the home (Lambie, 2005). Children in an alcoholic home must be constantly monitoring the family climate and then precede to conduct their behaviors in a way that is designed to minimize any conflict or chaos (Beesley & Stoltenberg, 2002). In this effort, unhealthy modifications are often made at the expense of the child’s psychological and emotional well-being. This leads into the potential development of anxiety, depression, or stress as the constant control of self, others, and the environment is an overwhelming and draining task. The children often experience unrelenting frustration and an inability to relax, which often carries into adulthood (Beesley & Stoltenberg, 2002).

Research surrounding the population group of ACOAs has been circulating for decades, dating back as far as before the ACOA World Service Organization was founded. Research conducted by Emmy Werner (1986) examined characteristics of resilient offspring of alcoholics as part of a longitudinal study from birth to age 18. Results depicted males and children of alcoholic mothers as having higher rates of psychosocial problems during childhood and adolescent years as compared to females and the children of alcoholic fathers. Additionally, fewer stressful life events disrupted the family life of children who did not present serious coping problems by the age of 18 as compared to those that did develop such issues (Werner, 1986).

Additional research postulates that ACOAs experience significantly higher levels of anxiety and depression as compared to adult children of non-alcoholics (ACONAs); however, lacking significant differences in regard to personality development and psychological well-being (Ryff
& Tweed, 1996). Additional researchers have discovered similar relationships among children of alcoholic homes and anxiety and depression (Fine et al., 1976; Moos & Billings, 1982; and Tarter et al., 1984; as cited in Corrigan & Williams, 1992). Chassin, Pitts, DeLucia, and Todd (1999) also found a slight risk for anxiety disorders and a significantly elevated risk for depressive disorders among children participating in a longitudinal study on the effects of parental alcoholism.

Research also shows how parental alcoholism permeates into several areas of functioning in a child’s life. Bosworth and Burke (1994, as cited in Lambie, 2005) identify the increased fear among children of alcoholic parents, as well as the increased prevalence of physical and sexual abuse. Kinney (2003, as cited in Lambie, 2005) concludes this often results in the development of post-traumatic stress disorder, sleep disturbance, nightmares, anxiety, and depression. This distress invades academic and social arenas as well. Children of alcoholics are more likely to have learning disabilities, be truant from school, or drop out altogether. Lower academic achievement and more cognitive deficits, such as learning disabilities are also apparent, which could result from a chaotic environment not conducive to homework and learning (Arman, 2000; Fields, 2004; Haggard & Christenberry, 1994; Kinney, 2003; NACOA, 1998, as cited in Lambie 2005). Finally, social deficits in communication, ability to trust, and ability to form interpersonal relationships due to lack of nurturing of those skills can lead to social isolation (Bosworth & Burke, 1994; Fields, 2004; Haggard & Christenberry, 1994; Kinney, 2003; NACOA, 1998, as cited in Lambie 2005).

There is greater literature on the ACOA as a child rather than as an adult, therefore this study attempts to provide greater information on the adult population. Additionally, ACOA literature often examines the risk factors for future alcohol or drug dependence relative to the
substance abuse exhibited by parents, as well as relationship satisfaction and success. Several studies used sample sizes that were very specific, such as those lacking ethnic diversity or small sample sizes. While this yields highly specific results, it limits the external validity in being able to generalize to the greater population. One study examined differences between ACOAs and non-ACOAs on levels of self-esteem, depression, and anxiety (Dodd & Roberts, 1994). The data for this study was gathered from volunteers at a large university in Texas. The participants were enrolled in undergraduate and graduate counselor education courses, primarily Caucasian, and the majority (70%) were non-ACOAs. The results indicated a difference in levels of self-esteem, depression, and anxiety not specific to the presence of alcohol in the home, rather the presence of any sort of dysfunction. Individuals raised in what participants self-reported as a dysfunctional home consistently reported lower self-esteem, and higher rates of depression and anxiety. The participant’s perception of dysfunctional is curious in this study, as it does not appear that the level or description of dysfunction provided by researchers is supported by research. For example, the article states that if an individual answers affirmatively to believing he or she was raised in a dysfunctional home, the statements they choose from to describe their situation include inflexible and controlling parents, physically abusive parents, sexually abusive parents, mentally disabled parents, physically disabled parents, or divorced parents (Dodd & Roberts, 1994). Additionally, the lack of presence of diversity in this study creates difficulty when attempting to generalize to the larger population.

A second study reflective of a similar situation is one conducted by Beesley and Stoltenberg (2002), in which researchers were aiming to uncover control, attachment style, and relationship satisfaction among ACOAs. The sample size consisted of 80 individuals enrolled in undergraduate or graduate courses, in which about 83% were Caucasian. The ability to
generalize to a more broad population is lacking in regard to diversity. Additionally, due to the small sample size, the power of the results is stunted as well. The fact that the sample size is purely individuals enrolled in college courses brings into question the idea that this subset of individuals may already have some resiliency factors in that they have been able to overcome some of the effects of parental alcoholism. The researchers proposed ACOAs would report a greater need for control, a significantly more insecure attachment style, and less satisfaction with intimate relationships as compared to non-ACOAs. The results of the study indicated the participants did report a greater need for control and a significantly more insecure attachment style in comparison to non-ACOA counterparts. However, researchers identified the inability to randomize participants for the ACOA group, leading to a word of caution on interpreting the hypotheses and results. The results do provide some interesting thoughts though in regard to mental health as well. If ACOAs present greater difficulty with control and insecurity, symptoms such as depression, anxiety, or stress might be quite easily magnified with this group. These relationships certainly deserve more attention in research.

For the purpose of this study ACOA status is defined as anyone who scores a 6 or above on the Children of Alcoholics Screening Test (CAST). Also, included is a second measure of ACOA status using a single question (as adapted from Beesley & Stoltenberg, 2002), “Do you believe that either one or both of your parents have/had a drinking problem?”

**Psychological Well-Being**

The concept and definition of psychological well-being has long been debated. Significant formulations about psychological well-being date back to work done by Bradburn (1969; as cited in Ryff & Keyes, 1995). Bradburn distinguished between positive and negative affect and found happiness to be the bridge between the two. Several researchers questioned the
validity of using merely happiness and affect alone to measure psychological well-being. Out of this, researchers began examining the concept of life satisfaction as an adequate indication of psychological well-being. Life satisfaction, as a cognitive component appeared to compliment the more affective element of positive functioning; happiness (Andrews & McKennell, 1980; Andrews & Withey, 1976; Bryant & Veroff, 1982; Campbell, Converse, & Rodgers, 1976; as cited in Ryff & Keyes, 1995). According to Ryff and Keyes (1995), researchers of this time were grappling at what psychological well-being could be, but were headed in too many different directions (big picture, but specific constructs as well) and had no theoretical framework. Even quality of life studies have been described as more data-driven than theory or concept focused (Headey, Kelley, & Wearing, 1993; as cited in Ryff & Keyes, 1995). Ryff provided significant contributions to the measurement and identification of psychological well-being. When developing the Scales of Psychological Well-Being, Ryff examined a variety of theory related to positive psychological functioning including literature in self-actualization, Roger’s views of a fully functioning person, Jung’s formulation of individuation, concepts of maturity, and life span development perspectives, as well as literature on the positive criteria of mental health (Ryff, 1989). Ryff contends that while current critiques postulate there is no significant theory to back up the claims that these researchers have made about how a person should act, there is still some value. The volume of work produced from a variety of researchers that all reflect this concept of positive psychological functioning is hard to deny. Ryff collected this research and used the underlying significant concepts to formulate a scale.

Psychological well-being has since been examined in a variety of different contexts. Some of which have focused on the link between social isolation and psychological well-being, determining that social isolation is negatively associated to psychological well-being. Research
has further attempted to isolate a factor that moderates that association, determining that after adjusting for a variety of other variables, religiosity significantly moderates the relationship between social isolation and psychological well-being (Montaz, Hamid, Ibrahim, Yahaya, & Chai, 2011). While religiosity has been studied by a variety of researchers around the globe (Prest & Keller, 1993; Ahmadi & Thomas, 2001; Melia, 2002; Sadler & Briggs, 2006; as cited in Montaz et al., 2011), there are other arenas in which psychological well-being has surfaced.

Psychological well-being has been a major underlying influence in the development of Positive Psychology. Peterson and Seligman (2004) identified six core virtue clusters: wisdom, courage, humanity, justice, temperance, and transcendence, which are then manifested by twenty-four character strengths. Peterson and Seligman perceive these virtues and strengths as a foundation for psychological health and well-being (Van der Merwe, Van Eeden, & Van Deventer, 2010). Research suggests the conceptualization of psychological well-being can be broadly categorized into two streams; hedonic and eudaimonic well-being. The hedonic approach defines the pleasant life and the good life in regard to concepts of pleasure, happiness, and life satisfaction. Diener et al. (1999; as cited in Van der Merwe et al., 2010) produced the subjective well-being model as an example of the hedonic approach. The eudaimonic approach includes the concepts of the good life and the meaningful life, where self-actualization and living a life according to personal values and virtues pushes motivation. The six-dimensional model contended by Ryff is an example of a eudaimonic approach. Seligman (2002; as cited in Van der Merwe et al., 2010) brings this together in postulating that the good life is superior to the pleasant life and the meaningful life is superior to the good life. Seligman finds psychological well-being to be tied to finding meaning in life’s challenges and creating an attachment in an entity beyond oneself, such as a good cause and/or religion. Ultimately, it could be said that
psychological well-being must encompass both sides of the spectrum, culminating with a larger piece of commitment and attachment.

The literature on psychological well-being is both objective and subjective. A variety of instruments are used to measure it and the definition and core concepts are still slightly debated in the field. This creates an issue when trying to generalize psychological well-being to a different population, as constructs are often different. However, the diversity of psychological well-being speaks to the true positive phenomena of it in regard to resiliency of various populations. The current study aims to use psychological well-being as an indicator of the role that the image of God plays in affecting the relationship between anxiety, depression, and stress. In this study, psychological well-being is operationally defined as was defined by Carol Ryff in 1989 based on psychosocial theory, as a culmination of self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. It is measured by the Scales of Psychological Well-Being (SPWB).

**Image of God/Religiosity/Spirituality**

Research related to the images of God, religion, and spirituality is quite diverse. For the purpose of this paper, the review will be limited to these concepts in relation to the character of God, mental health, and religious coping. It is important to understand that as described by Bader and Froese (2007), the struggle and conflict over the concept of God is much less about whether a God exists, such that in a random sample in America, ninety-six percent of respondents reported some level of belief in the fact that a god exists (Bader, Dogherty, Froese, Johnson, Mencken, Park, & Stark, 2006). It is much more about the underlying opinions about the character of God. According to Bader and Froese (2007), no matter if people believe that God created humans or human created God, the reality of an individual’s image of that God indicates
his or her perception of the ultimate object of their devotion. Research shows that an individual’s image of God can powerfully predict religious conservatism, levels of church attendance, frequency of religious experience, and an individual’s’ compelling need to share his or her faith with others through self-report measures of behaviors (Bader & Froese, 2006).

Research on religious coping styles has focused on an array of groups, more recently on breast cancer survivors as well as those newly diagnosed, and how that coping style can affect psychological well-being, anxiety, depression, stress, and worries about recurrence across both American and United Kingdom populations (Schreiber, 2011; Thune-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2013). Overall, the studies aimed to look at how the women perceived God and His current role in their lives and then used comparisons to determine if there was a relationship among the perception of God and religious coping styles and depression, stress, anxiety, psychological well-being, and overall adjustment. The data in both studies examined concluded that women with more favorable perceptions of God, such as God being highly engaged, or not angry or having abandoned them, displayed lower levels of anxious or depressed moods and higher levels of psychological well-being or overall adjustment. Additionally, both report that using religious/spiritual resources in the process of coping with a breast cancer diagnosis can be beneficial in overall adjustment as well as overall attainment of positive psychological well-being (Schreiber, 2011; Thune-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2013).

Mental health research looks more at how religious involvement and religious commitment can play a significant role in psychological well-being, depression, drug abuse, suicide, and coping with anxiety, fears, frustration, and anger. Research has also examined social instability resulting from a breakdown of standards, feelings of inferiority, despondency, and
isolation. Pryse (1976) and Malony (1988), (as cited by Moreira-Almeida, Neto, & Koenig, 2006) describe specific aspects of theology that are present in all religions that may promote good mental health: awareness of God, acceptance of the grace and love of God, repentance and social responsibility, faith and trust, involvement in organized religion, fellowship, ethics, and tolerance and openness to the experiences of others. Research has examined a variety of avenues relating religiousness to aspects of mental health including relationships with psychological well-being, depression, drug abuse, and suicide.

The research on mental health as it relates to religiousness or spirituality is somewhat challenging to interpret. Moreira-Almeida et al. (2006), in their large scale review of religiousness and mental health excludes any studies on psychological well-being that include certain scales that are strongly laden with mental health measures, contending this is the reason for the results being associated with positive health outcomes. However, in the studies used, 79 out of 100 reported at least one significant positive correlation among variables of religious practices and behaviors and indicators of psychological well-being. In a meta-analysis of 147 independent studies with over 98,000 participants, authors contend the data supports religiousness is modestly associated with lower levels of depressive symptoms. The data on drug abuse is even more significant, with some studies reporting out of all of the constructs examined, the most profound correlation was among almost all the religious dimensions examined and lower prevalence rates of nicotine, alcohol, and drug abuse or dependence (Moreira-Almeida et al., 2006). The final variable that Moreira-Almeida et al. inspect is suicide, which strongly relates to the aforementioned relationship with drug abuse and dependence and depression. Drug abuse and dependence and depression are core factors presented in the greater majority of suicide cases, therefore, the association of religious involvement with lower levels of drug use and
depression give good explanations for a negative correlation between religiousness and suicidal behaviors. Research in this arena is slightly lacking, as it is difficult to examine feelings and behaviors about an individual after he or she has completed a suicide attempt. The only information to rely on is that of family and friends. Research cautiously does report that some studies show the suicide rate among people who did not attend religious activities was as much as four times greater than individuals who had higher participation. Additionally, some studies surveyed clinical populations in regard to suicidal thoughts and behaviors and report that religiosity was associated with a lower probability of having suicidal thoughts or attempts at suicide (Moreira-Almeida et al., 2006).

An additional piece relating to religiousness and mental health rests on how religion could influence mental health. Authors Moreira-Almeida et al. (2006) postulate six different factors that religion supplies including: healthy behaviors and lifestyles, social support, belief systems and cognitive framework, religious practices, spiritual direction, idiom to express stress, and multifactorial explanation. Ultimately, through this it can be interpreted that it is not solely a belief in God that lends itself to better overall psychological health, rather it is a more complex and multifaceted approach requiring an open mind and critical awareness on the part of the believer.

While the literature on religiousness and image of God is compelling, it is somewhat difficult to grasp. The literature has such a wide scope that finding something that wholeheartedly examines how an individual feels about God or how an individual perceives the character of God is nothing short of challenging. Much of the literature pitfalls at examining denominations and differences therein, which was excluded from this research scope in a humble effort to attempt to remove such labels and stereotypes. This research study aims to remove
denominational labels and focus more wholly and fundamentally on one's perception of the character of God and how that is exemplified in his or her life. This study examines the image of God that an individual holds as a measure of the concept of spirituality. This study uses the following as operational definitions for the images of God: an engaged image of God is as defined by Bader et al. (2006) to be "the extent to which individuals believe that God is directly involved in worldly and personal affairs" (Schreiber, 2011, p. 295). An angry image of God is as defined by Bader et al. (2006) to be "the extent to which individuals believe that God is angered by human sins and tends toward punishing, severe, and wrathful characteristics" (Schreiber, 2011, p. 295).

**Attitudes toward Help-Seeking**

The literature base on attitudes toward help-seeking is also quite broad. Research has been conducted with a variety of cultural and ethnic groups, measuring attitudes toward help-seeking in comparison to other factors such as age, gender, masculinity, and social network, among several others (Ang, Lim, Tan, & Yau, 2004; Mackenzie, Gekoski, & Knox, 2006; Al-Darmaki, 2003; Al-Krenawi, Graham, Dean, & Eltaiba, 2004; Shea & Yeh, 2008; Vogel, Wade, Wester, Larson, & Hackler, 2007). A variety of studies also examine other factors that could potentially influence an individual's attitude toward seeking help or even inhibit help-seeking behaviors. Some avoidance factors to seeking psychological help include: social stigma (Komiya, Good, & Sherrod, 2000), treatment fears (Deane & Todd, 1996; Kushner & Sher, 1989), fear of emotion (Komiya, Good, & Sherrod, 2000), anticipated utility and risks (Vogel & Wester, 2003), and fear of self-disclosure (Hinson & Swanson, 1993; Vogel & Wester, 2003). Conversely, elements indicated in positively influencing attitudes include: when an individual is encouraged to seek help, knowing someone who had sought psychological help (Vogel et al.,
and the perception that an individual’s problems are more severe than others’ problems (Goodman, Sewell, & Jampol, 1984).

A critical component of the therapeutic process is the act of self-disclosure by the client. This is related to help-seeking because the thought of anticipated self-disclosure can be quite daunting and create more negative attitudes toward seeking help. Research studies have examined the risk of self-disclosure and the kinds of feelings or thoughts that are uncovered when contemplating self-disclosure. Research on self-disclosure is especially pertinent to counseling because the process of therapy essentially revolves around the decision of whether or not to self-disclose a problem to someone else (Keith-Lucas, 1994). Additionally, research on self-disclosure has become more popular as researchers hypothesize the potential benefits that self-disclosure produces, such as increased positive affect and decreased distressing symptoms (Vogel & Wester, 2003). As cited in Vogel and Wester’s article (2003), two research studies focusing on the relationship of self-disclosure and an individual’s desire to seek counseling services concluded that a desire to keep personal information secret predicted an individual’s help-seeking intentions (Kelly & Achter, 1995; Cepeda-Benito & Short, 1998). Results indicated individuals with a higher tendency to conceal personal information were more likely to maintain negative attitudes toward help-seeking.

In another study by Komiya, Good, and Sherrod (2000) researchers discovered the fear of disclosing highly emotional material led to negative attitudes toward counseling. Komiya et al. (2000) resolved that an individual’s apprehension around having to experience and disclose difficult emotions is the greatest barrier to seeking counseling services. A multitude of research supports the idea that family attitudes toward emotional expression have an impact on children’s attitudes toward their emotions and resulting emotional expression (Balswick & Avertt, 1977;
Bronstein, Fitzgerald, Briones, Pieciadz & D’Ari, 1993; Cassidy, Parke, Butkovsky, & Braungart, 1992; Denham & Grout, 1993). Emotional expression has been found to be associated with more positive attitudes toward seeking psychological help (Komiya, Good, & Sherrod, 2000). This leads into an important discussion about the characteristics of ACOAs. As aforementioned, there is often a distinct rule present in the childhood home of an ACOA—do not talk/trust/feel. There is also abundant confusion regarding safe emotions. This further complicates the approach to counseling, therefore, current researchers postulate this hinders help-seeking even further.

Research also looks at how clients with religious or spiritual beliefs experience psychological help-seeking and what that means for them. There appears to be preferences in both directions; however, research from Crosby and Bossley (2012) has shown that individuals with a higher degree of religiosity prefer to use a religious leader for mental health needs for two primary reasons: convenience and fear of their beliefs not aligning with those of a mental health provider. The stress of not knowing how to approach his or her religious belief and if it is safe or not, can be more intimidating than dealing with the mental health concern itself. Additionally, individuals with a higher preference for seeking help from a religious representative were inclined to perceive less benefit in seeking help from a psychological professional (Crosby & Bossley, 2012).

Another study examined preferences for clergy versus mental health professionals among Filipino-Americans, seeking to understand how religious variables may impact the help-seeking patterns of this group. Researchers investigated the potential for a relationship between religious variables and level of psychiatric distress, whether or not the participants seeking help from religious representatives presented as less emotionally distressed than those seeking help from
mental health professionals, and which type of counsel is sought out more among emotionally distressed individuals in the Filipino American sample. Results indicated participants who reported higher levels of spirituality were less likely to experience psychiatric distress ($r = -0.12$, $p < 0.01$). There was not a statistically significant difference in regard to level of emotional distress between those seeking clergy and those seeking mental health professionals. The study presented that familiarity and accessibility for Filipino Americans involved in a church may have accounted for greater use of clergy rather than mental health professionals for issues related to emotional distress that arose. Overall, with this particular sample, individuals sought help from clergy and mental health professionals at the same rate (average of 2.7%). Filipino Americans underutilize both mental health services and the services of clergy in respect to emotional distress. Their findings also suggested increased spirituality was significantly correlated with a reduced probability of help-seeking from a mental health professional; however, it was also not correlated with greater help-seeking from members of clergy. Researchers in the study concluded that individuals high in spirituality might be experiencing feelings of a divergent worldview (ideas conflicting with one's core beliefs) in both sectors of care; mental health and clergy. While this study can give some insight into the behaviors and beliefs of a specific culture, it unfortunately does not do much for the general population, which admittedly was not the intention. However, it does exemplify the necessity for further research into the role that spiritual and religious factors play in help-seeking, hopefully in a sample more representative to the general population (Abe-Kim, Gong, & Takeuchi, 2004).

Attitudes toward help-seeking in this study utilizes the same operational definition as Edward Fischer and John Turner (1970). In the development of the Attitudes toward Seeking Professional Psychological Help Scale (used in the current study), authors Fischer and Turner
described attitudes toward seeking help using four distinct factors: a recognition of a need for psychotherapeutic help, stigma tolerance, interpersonal openness, and confidence in one’s mental health practitioner. The study will examine scores from the Attitudes toward Seeking Professional Psychological Help Scale on a continuum; the higher the score, the more positive the attitude towards seeking help (Fischer & Turner, 1970).

Significance of current study

The significance of the current study is multifaceted. First, this study attempts to identify a potential resiliency factor that may help protect against the development of psychological distress. After examining the literature, researchers concluded that constructs within the field of religion and spirituality seemed plausible. An individual’s perception of God provides some insight into how depression, anxiety, and stress is experienced. Second, the relationship between religious coping styles and psychological distress provides some additional understanding as to the interplay between the two factors, again potentially highlighting an element that might aid in resiliency for an at-risk group, such as ACOAs. Lastly, the help-seeking attitudes portion of the current study seeks to pull this closer to the clinical environment, with hopes of understanding how individuals perceive receiving help from psychological professionals.

This study aims to add to the literature on ACOAs a perspective relative to identifying positive factors that aid in lower levels of psychological distress and greater overall psychological well-being. A large portion of the current literature examines factors that might predict future substance use or mental illness. While this is valuable, researchers of the current study find the inclusion of spiritual beliefs as a resiliency factor to be equally relevant.
CHAPTER 3
METHODS

Participants

Participants for this study were sought out through social media and electronic mailings from virtually anywhere, geographically. Social media sites utilized included Facebook and LinkedIn. Additionally, some individuals were sought out via electronic mail, which could then be forwarded along to interested parties. Researchers did reach out to ACOA specific groups as well as the general population. The groups that agreed to post the link on their social media page included Warsaw Adult Children of Alcoholics and AlcoholicShare.org. The goals of the study were to determine the relationship between an individual’s image of God and psychological distress, psychological well-being, and help-seeking attitudes. The University of Wisconsin-Platteville Institutional Review Board approved the study protocol.

Eligibility and recruitment

Participants were required to be age 18 or older and have a parent that drank alcohol. Thousands of individuals would have seen the survey post with the invitation to participate. Two hundred and fifty nine individuals agreed and attempted to participate in the research. After removing any participants that did not complete at least 75% of the questions, left five or more questions consecutively unanswered, as well as anyone that did not meet ACOA status, data was analyzed for 90 participants (35%).

Hypotheses

Based on the literature and goals for this study, researchers formulated several hypotheses. Researchers first propose ACOAs with a higher degree of belief in the image of an
angry (or judgmental) God will correlate with higher levels of anxiety, depression, and stress, and lower levels of psychological well-being. Conversely, ACOAs with a higher degree of belief in the image of an engaged God will correlate with lower levels of anxiety, depression, and stress, and higher levels of psychological well-being. These hypotheses are based on research that reflects a negative correlation between spirituality and mental illness (Schreiber, 2011; Thune-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2013; Moreira-Almeida et al., 2006).

Additionally, researchers contend ACOAs with lower spiritual struggle will correlate with lower levels of anxiety, depression, and stress, and higher levels of psychological well-being. On the contrary, ACOAs with high spiritual struggle will correlate with higher levels of anxiety, depression, and stress, and lower levels of psychological well-being. Related research shows that using religious/spiritual resources in the process of coping with medical diagnoses can be beneficial in overall adjustment as well as overall attainment of positive psychological well-being (Schreiber, 2011; Thune-Boyle, Stygall, Keshtgar, Davidson, & Newman, 2013). Thus, researchers postulated the lower the spiritual struggle, the lower the levels of psychological distress and the higher the levels of psychological well-being.

Finally, in regard to help-seeking attitudes, ACOAs showing a positive attitude towards seeking professional psychological help will correlate with lower levels of anxiety, depression, and stress, and higher levels of psychological well-being. Lastly, in opposition, ACOAs showing a negative attitude towards seeking professional psychological help will correlate with higher levels of anxiety, depression, and stress, and lower levels of psychological well-being. These hypotheses grew out of the literature contending that positive attitudes toward help-seeking predict true intention to seek professional psychological help (Komiya, Good, & Sherrod 2000).
Researchers postulated that individuals who seek help would be less likely to report symptoms of psychological distress.

Data collection and measures

Six assessment and a demographic survey are examined in this study. A demographic survey was used to collect basic information including gender, age, education level, race, years spent living with one’s parents or primary caregivers, current relationship status, and a single question asking if the participant believes that either or both parent had/has a drinking problem.

*The Children of Alcoholics Screening Test (CAST; Pilat & Jones, 1984/1985).*

The Children of Alcoholics Screening Test (CAST) developed by Jones and Pilat is an instrument designed to identify individuals that grew up in a home with at least one alcoholic parent. The measure also intends to measure the impact as well as the severity of the drinking on the adult child. The screening test contains 30 questions that operate on a yes/no response system. A score of at least six on the screening test indicates the likelihood that an individual was or is a part of an alcoholic environment. Psychometric data reported for the CAST indicates that it is a reliable and valid measure of ACOA status. Research by Jones in 1991 (as cited in Beesley & Stoltenberg, 2002) reported Spearman-Brown split-half reliability coefficients of .98 with a variety of samples of latency-age, adolescent, and adult children of alcoholics. Clair and Genest (1992) discovered that the CAST proved reliable over a 2-month period yielding a test-retest reliability coefficient of .88. As cited in Beesley & Stoltenberg (2002) several studies have supplied validity data in respect to self-identified children of alcoholics consistently scoring six or greater on the CAST (Carroll, 1991; Jones, 1991; Pilat & Jones, 1984/1985). Pilat and Jones reported a validity coefficient of .78 with a p value of <.0001, when comparing ACOA versus
ACONA with total CAST scores (Beesley & Stoltenberg, 2002). Additional research by Charland and Cote (1998) reported a reliability coefficient of $k=0.83$ and validity coefficient of $k=0.78$. This study used the CAST cut off score of six to determine which participants would be included in the research. Cronbach’s alpha for the current study for the CAST is 0.89.

*The Depression Anxiety Stress Scales (DASS; Lovibond & Lovibond, 1993).*

The Depression Anxiety Stress Scales (DASS) is a self-report instrument developed by Lovibond and Lovibond in 1993, using an Australian sample. The instrument has since been adapted to American English and validated both in community and clinical samples (Antony, Beiling, Cox, Enns, & Swinson, 1998; Brown, Chorpita, Korotitsch, & Barlow, 1997; as cited in Hernandez, 2013). The measure contains 42 items that assess symptomology of depression, anxiety, and stress on three scales, using a 4-point severity scale indicating experience in the last week. Each scale contains 14 items, the higher the score on each scale reflects a greater level of symptomology. The DASS has proven to be both valid and reliable across different samples. The normative data reflected alpha coefficients of 0.91 for depression, 0.84 for anxiety, and 0.90 for stress (Lovibond & Lovibond, 1995). Several other studies have reported consistently high alpha coefficients as well (Antony, Beiling, Cox, Enns, & Swinson, 1998; Hernandez, 2013). Validity was also reported in respect to concurrent and convergent validity. The DASS anxiety scale and the Beck Anxiety Inventory were highly correlated with a coefficient of 0.81, as were the DASS depression scale and the Beck Depression Inventory with a coefficient of 0.74. Concurrent validity coefficients of 0.54 and 0.58 were discovered when the aforementioned scales were cross correlated (Lovibond & Lovibond, 1995). The current research study reported alpha levels of 0.97 for depression, 0.94 for anxiety, and 0.95 for stress.
The Scales of Psychological Well-Being (SPWB; Ryff, 1989).

The Scales of Psychological Well-Being (SPWB) was developed by researcher Carol Ryff in 1989 as she sought out an operational definition for psychological well-being (Ryff, 1989). Ryff developed a scale that measures six dimensions of psychological well-being: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. Higher or lower scores on these scales indicates the level of psychological well-being. The SPWB has been adapted and modified to three different versions. The original is 120 items, then there is a 54-item and an 18-item version. This study uses the 54-item version, which operates on a Likert scale of 1 (strongly disagree) to 6 (strongly agree). Cronbach's alpha coefficients for this version are autonomy: .82, environmental mastery: .91, personal growth: .91, positive relations with others: .87, purpose in life: .91, and self-acceptance: .92 (Urry, Nirschke, Dolski, Jackson, Dalton, Mueller, Rosenkranz, Ryff, Singer, & Davidson, 2004). As reported by Ryff during the development of the instrument, validity was reported when SPWB was compared to prior measurements of positive functioning (such as affect balance, self-esteem, internal control) and yielded positive and significant results of .25-.73. Correlations with measures of negative functioning were negative and significant, with coefficients ranging from -.30 to -.60 (Ryff, 1989). It is also important to note that this version was also translated into the Spanish language; researchers contend that the positive results indicate the flexibility to use this measure across different cultural contexts (van Dierendonck, Diaz, Rodriguez-Carvajal, Blanco, & Moreno-Jimenez, 2007). Cronbach’s alpha reliability coefficients for the current study are as follows: positive relations with others .84, autonomy .84, environmental mastery .84, personal growth .78, purpose in life .84, and self-acceptance .89.
The Image of God Scale (IGS; Bader & Froese, 2005).

The Image of God Scale (IGS) is a 14-item instrument developed by Bader and Froese in an effort to identify how individuals conceptualize God and how involved He is in the world (Schreiber, 2011). There are two scales on the instrument; belief that God is engaged (eight items, alpha=.91) and belief that God is angry, also referred to as the judgment subscale (six items, alpha=.85). Together, these two scales construct four different types of believers: belief that God is either benevolent, authoritarian, distant, or critical. Scoring is done on a five-point Likert system, with 1 being strongly disagree or not at all and 5 being strongly agree or very well. The type of God in which an individual believes is determined by the combined scores of the two subscales. The current study focuses mainly on either belief in an angry God or belief in an engaged God, rather than each specific type.

In a sample of breast cancer survivors, Schreiber used the IGS to assess how individuals might use God as a key component when dealing with a cancer diagnosis. Reliability and validity were found to hold stable with alpha coefficients of .80 for the judgment subscale and .89 for the engagement subscale. Validity is reported to be acceptable (Bader & Froese, 2005; Schreiber, 2011). Researchers for the current study report alpha coefficients of .84 for judgment and .93 for engagement.

The Brief Religious Coping scale (BRCOPE; Pargament, Koenig, & Perez, 1998).

Another measure related to religiosity or spirituality used in the current study is the Brief Religious COPE scale (BRCOPE). This measure was derived from the full-scale Religious Coping Scale, RCOPE, developed by Pargament, Koenig, and Perez in 1998. This scale is based on the theory of religious coping developed by Pargament. This theory contends that religious
coping is a way in which individuals use 'the sacred', referring to their individual belief of God or other aspects of life that are associated with God, to understand and deal with life stressors. Pargament's theory emphasizes several factors associated with religious coping. To begin with it can serve several functions such as identity, control, anxiety-reduction, a search for spirituality, or a search for meaning in life. It also involves multiple methods of expression such as through emotions, behaviors, relationships, and cognitions. It is an intricate process that changes respective to time, context, and circumstances. The theory also postulates that religious-coping can produce both helpful and harmful outcomes and has the potential to add a new dimension to the entire coping process by involving concerns about the spiritual aspect. Finally, due to the fact that expression of religion can vary depending on the circumstance, religious coping may contribute significantly to the understanding of religion and the links to health and well-being (Pargament, et al., 2011). This theoretical perspective shaped how the scale was developed. The original, full-scale instrument was designed to be multi-functional, reflecting five religious functions of meaning, control, comfort, intimacy, life transformation, and then of course, the search for spirituality or the sacred. The scale was also designed to measure the different modes through which religious coping is employed such as cognitively, behaviorally, emotionally, and relationally. The final aspect of the measure is the characteristic of it to measure both the positive and negative aspects of religious coping. It is built on the assumption that there are both adaptive and maladaptive religious coping strategies; however, it is not assumed that positive is adaptive and negative is maladaptive. Items were selected from previous empirical studies, existing religious coping scales, and drawn from clinical experience and interviews with individuals currently using religious coping skills reflecting both the positive and negative coping methods.
Positive coping methods consist of methods that are founded on a generally secure connection with whatever the individual believes is sacred. Negative coping methods are consistent with the idea that there is tension, conflict, and struggle with whatever the individual finds sacred. The full RCOPE is valuable and theoretically-based; however, it is difficult to use as it consists of 105 items. The Brief RCOPE grew out of a need for a condensed, yet still reliable version of the scale. Factor analysis indicated most of the questions on the full RCOPE could be categorized as either positive or negative in nature. This provided a strong foundation for narrowing the items. Confirmatory factor analysis of the Brief RCOPE, 14-item, 2-scale measure resulted in confirmation that the two-factor solution provided adequate fit for the data sampled. The scale operates on a four-point Likert scale of 1 (indicating agreement or application of not at all) to 4 (indicating a great deal). Each scale, positive and negative, is scored separately (Pargament, et al., 2011). Higher scores for the positive religious coping scale indicate a higher degree of positive religious coping skills, while a higher score on the negative religious coping scale indicates greater spiritual struggle.

Psychometric data for the Brief RCOPE has been consistently supportive. Initial examination yielded a median Cronbach’s alpha for the positive religious coping scale of .92 and .81 for the negative religious coping scale. Additional studies have shown stable measures of internal consistency, with positive coping at .87 and negative coping at .88 (Nurasikin, Khatijah, Aini, Ramli, Aida, Zainal, & Ng, 2012). The Brief RCOPE has also demonstrated high concurrent validity. The positive religious coping scale is strongly and consistently correlated to measures of positive psychological concepts and spiritual well-being. The negative religious coping scale is consistently associated with indicators of poor functioning, including depression, anxiety, PTSD symptoms, pain, and negative affect. The alpha values for the current study are
consistent with prior research with the positive religious coping scale .94 and the negative coping scale .87.

*The Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970).*

Finally, the Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS) was utilized in an effort to understand the potential relationship between help-seeking attitudes and levels of psychological distress. Developed in 1970 by Edward Fischer and John Turner, the ATSSPHS seeks to measure an individual's attitude toward seeking professional help for a psychological disturbance. The authors set out to understand the underlying attitude to seeking or avoiding help for a personal crisis and through research came to realize a variety of reasons as to why individuals either engage or not in psychiatric care. Some of these include the level of therapeutic rapport, fear of being stigmatized, degree of support from family or friends, preconceived beliefs about mental health care, and the degree to which an individual is willing or able to self-disclose intimate thoughts and feelings about their life. The primary goal of the research study used to develop this scale was to formulate a scale that sampled an attitude domain parallel to several of the pertinent factors aforementioned (Fischer & Turner, 1970). The scale was developed by asking several diverse and experienced clinical psychologists to write attitude statements. There were originally 47 statements written and after examination by a panel of experts, and elimination of two statements that poorly correlated with the summed attitude score, a total of 29 statements were used in the final scale. The scale contains four different factors of attitudes including the recognition of need for psychotherapeutic help, stigma tolerance, interpersonal openness, and confidence in mental health practitioners. These subscales contain a relatively low number of items, thus researchers suggest using the full scale for best
results (Fischer & Turner, 1970). The scale uses a four-point Likert scale of 1 (strongly disagree) to 4 (strongly agree) and contains 18 reverse-scored items. The higher the score, the more positive the individual’s attitude is towards seeking professional psychological help.

In respect to psychometric data, the internal reliability of the ATSPPHS for the norming group was .86 and .83 on a later study with the same researchers. Test-retest reliability ranged from .73 to .89. With the exception of one score, the attitude scores remained relatively stable over time (Fischer & Turner, 1970). This study reported Cronbach’s alpha of .91.

Analyses

Descriptive statistics were used to characterize the sample and Pearson correlations were computed for all variables. Statistical analysis was performed using SPSS version 22 (IBM Corp., 2013). Two-way ANOVAs were used to determine the relationship of each of the following variables: attitudes toward help-seeking, positive religious coping, negative religious coping, self-acceptance, purpose, personal growth, environmental mastery, autonomy, positive relations with others, total psychological well-being, stress, anxiety, and depression to the judgment and engagement scales on the IGS.
CHAPTER 4
RESULTS

Description of Sample

The sample consisted of the following education status: 33% attended some college, 15.6% held an associate’s degree, 20% a bachelor’s degree, 6.7% a master’s degree, 17.8% either finished high school or obtained a GED, and only 6.7% did not complete a high school education. Most participants were Caucasian (90% Caucasian, 3.3% Spanish/Hispanic/Latino, 2.2% African American, and 4.4% identified as other) women (77 females; 85.6%, 12 males; 13.3%, 1 identified as other; 1.1%), with the mean age being 42 years (SD =12.5). 71.9% of respondents reported living with their parents or primary caregivers for 16-20 years and 93.3% responded ‘yes’ to the single question on the demographics questionnaire inquiring as to if the individual believed that either one or both of their parents/caregivers have/had a drinking problem. The relationship status reported with the majority married: 54.4% married, 17.8% single, 10% dating, 7.8% divorced, 6.7% separated, and 3.3% widowed.
Table 1

**Demographics**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percentage</th>
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<tr>
<td>Male</td>
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<tr>
<td>Female</td>
<td>77</td>
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<td>Did not complete high school</td>
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<tr>
<td>High School diploma or GED</td>
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<td>17.8%</td>
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<tr>
<td>Attended some college</td>
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<tr>
<td>Associates degree</td>
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<tr>
<td>Bachelor’s degree</td>
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<tr>
<td>Master’s degree</td>
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<th>Race/Ethnicity</th>
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<tr>
<td>Caucasian</td>
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<tr>
<td>Spanish/Hispanic/Latino</td>
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<tr>
<td>Other</td>
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<th>Relationship Status</th>
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<td>Married</td>
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<tr>
<td>Single</td>
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<td>17.8%</td>
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<tr>
<td>Dating</td>
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<tr>
<td>Divorced</td>
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<td>7.8%</td>
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<tr>
<td>Separated</td>
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<td>6.7%</td>
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<tr>
<td>Widowed</td>
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<td>3.3%</td>
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<tr>
<th>Number of years with Caregivers</th>
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<td>1 to 5</td>
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<td>6 to 10</td>
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<td>11 to 15</td>
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<td>16 to 20</td>
<td>64</td>
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<td>30 or more</td>
<td>1</td>
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Correlations between Study Variables

Correlations of all the study variables were compared and are presented in Table 2.

Table 2

Variable Correlations

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<th>Variable</th>
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<td>1. Engagement Category</td>
<td>-</td>
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<td>2. Judgment Category</td>
<td>- .24</td>
<td>-</td>
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<tr>
<td>3. Positive Coping</td>
<td>** .54</td>
<td>- .12</td>
<td>-</td>
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<td>4. Negative Coping</td>
<td>- .21</td>
<td>** .29</td>
<td>.05</td>
<td>-</td>
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<td>5. Attitude</td>
<td>- .23</td>
<td>.20</td>
<td>.04</td>
<td>.21</td>
<td>-</td>
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<td>7. Anxiety</td>
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<td>9. Well-Being</td>
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<td>10. Positive Relations</td>
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<td>13. Personal Growth</td>
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<td>15. Self-acceptance</td>
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Mean: 1.56 1.55 18.40 12.25 58.15 28.64 24.53 31.40 220.87 36.37 37.00 35.31 40.45 37.03 34.27 22.27

SD: .50  .48  6.84  5.40  11.95  13.20  10.00  11.24  44.24  8.89  8.52  9.15  7.94  5.50  5.98

Alpha: .33  .84  .94  .87  .91  .97  .94  .95  .96  .84  .96  .78  .84  .89

Note: *p<.05, **p<.01. Engagement Category = Engagement subscale on the IGS; Judgment Category = Judgment subscale on the IGS; Positive Coping = Positive Coping subscale on the Brief ROPE; Negative Coping = Negative Coping subscale on the Brief ROPE; Attitude = Reported attitude toward seeking professional psychological help on the ATSPH scale; Depression = DASS Depression subscale; Anxiety = DASS Anxiety subscale; Stress = DASS Stress subscale; Well-Being = Total score on RyF's Scales of Psychological Well-Being (SPWB); Positive Relations = SPWB Positive Relations to Others subscale; Autonomy = SPWB Autonomy subscale; Enviromastery = SPWB Environmental Mastery subscale; Personal Growth = SPWB Personal Growth subscale; Purpose = SPWB Purpose in Life subscale; Self-acceptance = SPWB Self-Acceptance subscale.

Participants who consistently reported a perception of an engaged God were more likely to endorse positive religious coping styles (r=.54, p<.01), maintain a less positive attitude toward seeking help from professional psychological services (r=-.23, p<.05), possess greater overall psychological well-being (r=.26, p<.05), retain greater personal autonomy (r=.22, p<.05), maintain higher levels of personal growth (r=.27, p<.05), and have a greater sense of purpose in life (r=.24, p<.05). Participants who subscribed to a view of an angry or judgmental God
revealed higher use of negative religious coping skills ($r=.29$, $p<.01$), and increased rates of depression ($r=.29$, $p<.05$), anxiety ($r=.41$, $p<.01$), and stress ($r=.34$, $p<.01$). Additionally, individuals with a view of an angry God reported lower total psychological well-being ($r=-.23$, $p<.05$), less autonomy ($r=-.27$, $p<.05$), lower overall sense of purpose in life ($r=-.21$, $p<.05$), and lower reported feelings of self-acceptance ($r=-.23$, $p<.05$). In respect to help-seeking attitudes, significant correlations existed with more positive attitudes toward seeking professional psychological help and increased anxiety ($r=.31$, $p<.01$), and lower overall psychological well-being ($r=-.29$, $p<.05$).

Significant correlations also existed for depression, anxiety, and stress, and all the subscales of psychological well-being, such that higher reported distress correlates with lower psychological well-being. This relationship is demonstrative of the potential negative influence that depression, anxiety, and stress can have on an individual’s experience and perception.

**Comparisons between Levels of God’s Engagement and Judgment and Dependent Variables**

The two-way ANOVAs revealed several significant main effects. God’s engagement was associated with more favorable help-seeking attitudes ($F(1, 612) = 4.70$, $p=.034$), more prevalent use of positive religious coping ($F(1, 755) = 23.05$, $p=.000$), higher levels of personal growth ($F(1, 192) = 4.13$, $p=.046$), and greater overall psychological well-being ($F(1, 8396) = 4.71$, $p=.033$). God’s judgment (belief in an angry God) was associated with more prevalent use of negative coping skills/higher spiritual struggle ($F(1, 159) = 6.61$, $p=.012$), higher levels of stress ($F(1, 863) = 8.22$, $p=.005$), higher levels of anxiety ($F(1, 958) = 11.9$, $p=.001$), and higher levels of depression ($F(1, 740) = 4.73$, $p=.033$). No interaction effects were found.
CHAPTER 5
DISCUSSION

Researchers used a variety of measures to attempt to discover a resiliency factor in the development of psychological distress in the group of ACOAs. Some significant factors emerged in relation to an individual’s reported image of God. The hypothesis contending that ACOAs with a higher degree of belief in the image of an angry God will correlate with higher levels of anxiety, depression, and stress, and lower levels of psychological well-being was partially confirmed in respect to anxiety, depression, and stress; however, not confirmed in regard to levels of psychological well-being. Ultimately, what this means is that participants holding a perspective that their God is judgmental or angry also consistently reported higher levels of psychological distress, specifically, anxiety, depression, and stress. However, just because these individuals are experiencing psychological distress, does not mean they are also experiencing lower levels of psychological well-being. Overall, they are distressed; however, still able to maintain overall well-being and functioning.

The second hypotheses that ACOAs with a higher degree of belief in the image of an engaged God will correlate with lower levels of anxiety, depression, and stress, and higher levels of psychological well-being was partially confirmed in that a greater belief in an engaged God correlated with higher overall psychological well-being. Research from Schreiber (2011) supports the incidence of the belief of an engaged God correlating with higher overall psychological well-being.

Results of this study suggested participants with low spiritual struggle did not report lower levels of anxiety, depression, and stress, and higher levels of psychological well-being, as expected. There were no significant relationships in regard to low spiritual struggle and
depression, anxiety, or well-being. Research by Pargament, Smith, Koenig, and Perez (1998) indicated similar findings in that positive religious coping styles, which equates to low spiritual struggle, were not related to depression or quality of life. Researcher explained this finding by referencing the idea that religious coping can produce both positive and negative consequences related to physical and mental health and well-being. Research by Herbert, Zdaniuk, Schulz, and Scheier (2009) produced similar findings in that low spiritual struggle/positive religious coping was not significantly related to any other variable. Researchers concluded the negative religious coping style/high spiritual struggle was more distressing than the positive was helpful. Research by Nuraskikin, Khatijah, Aini, Ramli, Aida, Zainal, and Ng (2012) produced similar findings and explanations. Level of reported stress was consistently positively correlated with both positive and negative coping styles. Stress appears to remain steady, regardless of the level of spiritual struggle. Religious coping is a style of coping with stressors in an individual’s life (Pargament et al., 1998), so it makes sense that regardless of the style of coping an individual employs, either characterized by high or low spiritual struggle, the level of stress would be similar. The difference is how that stress is then perceived and potentially affecting other factors of distress.

In respect to spiritual struggle, participants reporting high spiritual struggle did indeed also report higher levels of anxiety, depression, and stress, and lower levels of psychological well-being, as proposed. Higher incidences of the use of a negative coping style is described as spiritual struggle. The research revealed those with higher levels of spiritual struggle consistently reported higher levels of depression, anxiety, and stress and lower overall psychological well-being. This is supported with previous literature. In a study examining positive and negative patterns of religious coping, researchers Pargament, Smith, Koenig, and Perez (1998) revealed greater incidence of PTSD symptoms and callousness correlated with the use of negative
religious coping. Additionally, in a sample of women with a diagnosis of breast cancer, researchers concluded that women who consistently employed negative religious coping strategies also reported worse overall mental health, greater depressive symptoms, and lower life satisfaction (Hebert, Zdaniuk, Schulz, & Scheier, 2009).

Finally, researchers contended participants showing a positive attitude towards seeking professional psychological help would correlate with lower levels of anxiety, depression, and stress. Additionally, higher levels of psychological well-being and negative attitudes would reveal higher rates of psychological distress and lower levels of psychological well-being. These hypotheses were actually disconfirmed. The research uncovered the opposite relationship; a more positive help-seeking attitude was related to higher reported levels of anxiety and lower overall psychological well-being. Reported experience of depression and stress did not produce significant results. One study examining the help-seeking attitudes specific to adolescents, determined that individuals were more willing to seeking help from both formal and informal sources when higher levels of psychological stress were experienced (Sheffield, Fiorenza, & Sofronoff, 2004). Additionally, research by Halgin, Weaver, Edell, and Spencer (1987) determined the experience of depression was positively correlated with help-seeking attitudes.

However, after further investigation, the literature appears to be inconclusive on this specific topic, as several studies also report as levels of psychological distress increase, attitudes toward seeking psychological help decrease (Chang, 2007; Obasi & Leong, 2009). Further research is necessary to clarify the relationship between psychological distress and help-seeking attitudes. It is important to mention also that this may be difficult to determine largely due to the compounding factors such as stigma and cultural values (Al-Darmaki, 2003; Shea & Yeh, 2008).
Limitations

It is essential to comment on limitations of this study. First, this sample consisted of primarily Caucasian women. The sample lacked racial/ethnic diversity and could therefore be said to lack generalizability as well. Replicating these results with other racial/ethnic groups would be essential. This can be especially true with individuals from different cultures, as it has been found that other cultural groups, such as African Americans, use religion to cope more often than Caucasians or other racial-ethnic groups in general (Lewis-Coles & Constantine, 2006). This could lead to differences in perspectives and subsequent psychological health. Additionally, the expression of faith and religion varies greatly across different groups and cultures, thus it would be critical to include individuals of other religious faiths as a part of future research on this topic.

A second limitation relates to the sample. The smaller sample size reduces the power of the study and makes it more difficult to see significant results. Several factors reported alpha levels just above .05, creating curiosity if a greater level of significance would be reached with a larger sample size, thus producing more meaningful results. Also, due to the fact that this is an observational study, the data does not allow for researchers to infer the direction of causality between the variables. It is possible that other, unmeasured variables mediate the relationships. Also, nearly all of the scales rely on subjective personal report of symptoms or experiences. This can create a greater level of error and inconsistency within the data set. Finally, the sample was obtained by convenience sampling through the internet. This may have impacted the characteristics of individuals responding. Researchers encountered great difficulty in recruiting ACOAs for inclusion in the study. It was communicated that the group as a whole was somewhat resistant to research, often feeling insignificant in the bigger picture. The ACOA World Service
Organization, which operates on the same standards as Alcoholics Anonymous, indicated they do not support or endorse any research requests through email distribution, meeting dissemination, or social media sites. There was a large number of ACOAs that unfortunately, simply could not be reached through that avenue.

Finally, the Image of God Scale as used in this study presents some limitations. To begin with, it simply has not been used in a large number of studies and therefore is yet to be psychometrically validated. Additionally, the scale, as well as the Brief RCOPE, does not account for an individual that does not have a belief in a God or does not use spiritual coping. This could potentially affect the results in an undesirable manner. While the scale identifies four distinct views of God, it is clear that the individual God types are not all that useful as compared to the two subscales of engagement and judgment. The results from this measure were difficult to interpret and relate to other variables. As the scale continues to be used and explored, hopefully the validity will grow.

Clinical Implications

In summary, religion and/or spirituality is an important coping mechanism for a variety of populations and situations, including adult children of alcoholics. The image of God an individual endorses can potentially shed light on the presence of other symptoms and struggles. This research aimed to identify a potential resiliency factor to reduce the prevalence of psychological distress and increase overall psychological well-being. While causality cannot be inferred from this type of study, the relationships detected can be used to inform intervention and as an opportunity for education.
For clinician’s working with ACOAs, there are a few items to keep in mind. First and foremost, the mere characterization of an individual as an ACOA does not automatically signify psychological distress. Presenting issues may or may not be related to growing up in an alcoholic home and it is important to be cognizant of that. In response to the results of this study, researchers encourage clinicians to be comfortable exploring the client’s view of spirituality or religion and be open to having conversations regarding it. The religious coping style the client endorses or the view of God he or she holds could be instrumental in examining the constellation of other symptoms. Also, in respect to religious coping style and spiritual struggle, the results of this study indicated individuals with higher spiritual struggle reported greater incidences of anxiety, depression, and stress and lower overall psychological well-being. Clinicians should remain thoughtful of the potential for the client to be experiencing a significant struggle beyond the clinical psychological presentation. The inclusion of the spiritual struggle may be quite distressing as well.

Future Research

Further research would be instrumental in understanding the interaction of intimate relationship development (referencing client, therapist relationship, relationship with others in life, or intimate relationship with one’s God) and psychological distress and well-being, within the population of adult children of alcoholics. The level of one’s relationship with his or her God as well as other individuals appears to be instrumental in understanding factors of distress and well-being.

Additionally, as aforementioned, the relationship between help-seeking attitudes and level of distress deserves more exploration. The current literature mostly presents quite specified topics, often examining specific cultures. This is helpful for those populations, but presents
difficulty in generalizing to other groups. However, it may be that levels of distress and help-seeking attitudes are truly that variable across a variety of factors.

There was some discussion about the level of spiritual struggle, characterized by negative and positive religious coping styles and the relation to psychological distress. The relationship shown here produced significant results for high spiritual struggle and higher rates of psychological distress; however, there were no significant relationships for low spiritual struggle apart from stress level. Further research would be helpful in determining the full scope of this relationship.

In relation to the research results indicating that participants who were more likely to endorse a perception of an engaged God also maintained a less positive attitude toward seeking help from professional psychological services, it would be valuable to determine the potential cause for that. It is unknown if this is due to the fact that these individuals are seeking help from spiritual leaders or members of clergy and that is why they maintain a less positive attitude towards psychological professionals or if they have some divergent worldview perceptions. Additionally, direction of causality cannot be inferred, so it would be interesting to study if it is less positive attitudes toward seeking help from psychological professionals that is leading to the perception of an engaged God.

As briefly aforementioned, the two scales used to evaluate an individual’s image of God and religious coping style leave more to be desired. While this study aimed to directly examine those variables, it is important to include the beliefs and perceptions of individuals that do not believe in a God or use religious coping. Future research could look to compare this group of individuals and highlight significant findings.
Finally, this research was conducted with a specific group of individuals; adult children of alcoholics. Further research of this same type, while comparing to individuals that are not adult children of alcoholics might produce some interesting findings. It might give some insight into the role that the alcoholic home plays in an individual’s development. Additionally, replicating this study, especially with a larger sample size would solidify the results.

Conclusion

This research offers important implications for the experiences of adult children of alcoholics in regard to psychological distress and well-being, help-seeking attitudes, and spiritual perspectives and coping styles. In summary, significant results of this research concluded that participants with a higher degree of belief in the image of an angry God consistently reported higher levels of anxiety, depression, and stress. However, those who held a belief in an engaged God consistently reported higher psychological well-being. In regard to spiritual coping, participants whom reported high spiritual struggle did indeed also report higher levels of anxiety, depression, and stress, and lower levels of psychological well-being. Finally, a positive help-seeking attitude was related to higher reported levels of anxiety and lower overall psychological well-being. Again, these results are representative of a small subset of the population and would greatly benefit from replication of this study for further support. This study also provides some important considerations for clinicians and ACOAs alike; the exploration of an individual’s perception of God, as well as religious coping style could prove to be instrumental in education and intervention services.
APPENDIX A

DEMOGRAPHIC FORM
Demographic Form

Please check only those responses that apply.

1. Gender:
   ___ Male
   ___ Female
   ___ Other

2. Age: _____ years old

3. Education Level: (Check the highest level that applies)
   ___ Did not finish High School
   ___ High School Diploma or GED
   ___ Some College
   ___ Associates Degree
   ___ Bachelor’s Degree
   ___ Master’s Degree
   ___ PhD

4. How would you describe your race? (Mark all that apply)
   ___ Spanish/Hispanic/Latino
   ___ White
   ___ Black/African American
   ___ American Indian or Alaska Native
   ___ Asian/Asian American/Pacific Islander
   ___ Other (please specify) ____________________________________________

5. Do you believe that either one or both of your parents/caregivers have/had a drinking problem?
   ___ Yes ___ No

6. How many years did you live with your parents/primary caregivers? __________

7. Please indicate your current relationship status:
   ___ Single
   ___ Dating
   ___ Married
   ___ Divorced
   ___ Widowed
APPENDIX B

ADULT CHILDREN OF ALCOHOLICS SCREENING TEST (CAST)
Children of Alcoholics Screening Test (CAST)

The following test was developed by two social workers – Jones and Pilat. Please check the answer below that best describes your feelings, behavior and experiences related to a parent’s alcohol use. Take your time and be as accurate as possible.

___ Have you ever thought that one of your parents had a drinking problem?

___ Have you ever lost sleep because of a parent’s drinking?

___ Did you ever encourage one of your parents to quit drinking?

___ Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?

___ Did you ever argue or fight with a parent when he or she was drinking?

___ Did you ever threaten to run away from home because of a parent’s drinking?

___ Has a parent ever yelled at or hit you or other family members when drinking?

___ Have you ever heard your parents fight when one of them was drunk?

___ Did you ever protect another family member from a parent who was drinking?

___ Did you ever feel like hiding or emptying a parent’s bottle of liquor?

___ Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?

___ Did you ever wish that a parent would stop drinking?

___ Did you ever feel responsible for or guilty about a parent’s drinking?
_ Did you ever fear that your parents would get divorced due to alcohol misuse?

_ Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent’s drinking problem?

_ Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?

_ Did you ever feel that you made a parent drink alcohol?

_ Have you ever felt that a problem drinking parent did not really love you?

_ Did you ever resent a parent’s drinking?

_ Have you ever worried about a parent’s health because of his or her alcohol use?

_ Have you ever been blamed for a parent’s drinking?

_ Did you ever think your father was an alcoholic?
APPENDIX C

DEPRESSION, ANXIETY, AND STRESS SCALES (DASS)
Depression, Anxiety, and Stress Scales (DASS)

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0- Did not apply to me at all

1- Applied to me to some degree, or some of the time

2- Applied to me to a considerable degree, or a good part of the time

3- Applied to me very much, or most of the time

1 I found myself getting upset by quite trivial things

2 I was aware of dryness of my mouth

3 I couldn't seem to experience any positive feeling at all

4 I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)

5 I just couldn't seem to get going

6 I tended to over-react to situations

7 I had a feeling of shakiness (e.g., legs going to give way)

8 I found it difficult to relax

9 I found myself in situations that made me so anxious I was most relieved when they ended

10 I felt that I had nothing to look forward to

11 I found myself getting upset rather easily

12 I felt that I was using a lot of nervous energy
13 I felt sad and depressed
14 I found myself getting impatient when I was delayed in any way (e.g., lifts, traffic lights, being kept waiting)
15 I had a feeling of faintness
16 I felt that I had lost interest in just about everything
17 I felt I wasn't worth much as a person
18 I felt that I was rather touchy
19 I perspired noticeably (e.g., hands sweaty) in the absence of high temperatures or physical exertion
20 I felt scared without any good reason
21 I felt that life wasn't worthwhile
22 I found it hard to wind down
23 I had difficulty in swallowing
24 I couldn't seem to get any enjoyment out of the things I did
25 I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)
26 I felt down-hearted and blue
27 I found that I was very irritable
28 I felt I was close to panic
29 I found it hard to calm down after something upset me
30 I feared that I would be "thrown" by some trivial but unfamiliar task
31 I was unable to become enthusiastic about anything
32 I found it difficult to tolerate interruptions to what I was doing
33 I was in a state of nervous tension
34 I felt I was pretty worthless
35 I was intolerant of anything that kept me from getting on with what I was doing
36 I felt terrified
37 I could see nothing in the future to be hopeful about
38 I felt that life was meaningless
39 I found myself getting agitated
40 I was worried about situations in which I might panic and make a fool of myself
41 I experienced trembling (e.g., in the hands)
42 I found it difficult to work up the initiative to do things
APPENDIX D

IMAGE OF GOD SCALE (IGS)
Image of God Scale (IGS)

A. God’s Judgment

How well do you feel that each of the following words describes God?

*Response range: Very Well, Somewhat Well, Undecided, Not very Well, Not at all.*

1. Loving
2. Critical
3. Punishing
4. Severe
5. Wrathful

Even if you might not believe in God, based on your personal understanding, what do you think God is like?

*Response range: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree*

1. Angered by human sin.
2. Angered by my sins.

B. God’s Engagement

How well do you feel that each of the following words describes God?

1. Distant
2. Ever-present

Even if you might not believe in God, based on your personal understanding, what do you think God is like?

*Response range: Strongly Agree, Agree, Undecided, Disagree, Strongly Disagree*

1. Removed from worldly affairs.
2. Removed from my personal affairs.
3. Concerned with the well-being of the world.
5. Directly involved in worldly affairs.
6. Directly involved in my affairs.
APPENDIX E

BRIEF RCOPE SCALE
Brief RCOPE

The following items deal with ways you coped with a significant trauma or negative event in your life. There are many ways to try to deal with problems. These items ask what part religion played in what you did to cope with this negative event. Obviously different people deal with things in different ways, but we are interested in how you tried to deal with it. Each item says something about a particular way of coping. We want to know to what extent you did what the item says. How much or how frequently. Don’t answer on the basis of what worked or not – just whether or not you did it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

1 = Not at all 2 = Somewhat 3 = Quite a bit 4 = A great deal

1. Looked for a stronger connection with God.
2. Sought God’s love and care.
3. Sought help from God in letting go of my anger.
4. Tried to put my plans into action together with God.
5. Tried to see how God might be trying to strengthen me in this situation.
6. Asked forgiveness for my sins.
7. Focused on religion to stop worrying about my problems.
8. Wondered whether God had abandoned me.
9. Felt punished by God for my lack of devotion.
10. Wondered what I did for God to punish me.
11. Questioned God’s love for me.
12. Wondered whether my church had abandoned me.
13. Decided the devil made this happen.
14. Questioned the power of God.
APPENDIX F
ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP SCALE
(ATSPPHS)
Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS)

*Responses are Strongly Disagree, Disagree, Agree, and Strongly Agree*

1. Although there are clinics for people with mental troubles, I would not have much faith in them.

2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.

3. I would feel uneasy going to a psychiatrist because of what some people would think.

4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.

5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.

6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.

8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.

9. Emotional difficulties, like many things, tend to work out by themselves.

10. There are certain problems, which should not be discussed outside one's immediate family.
11. A person with a serious emotional disturbance would probably feel most secure in a good mental hospital.

12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

13. Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns.

14. Having been a psychiatric health patient is a blot on a person’s life.

15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.

16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.

17. I resent a person-professionally trained or not-who wants to know about my personal difficulties.

18. I would want to get psychiatric attention if I was worried or upset for a long period of time.

19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

20. Having been mentally ill carries with it a burden of shame.

21. There are experiences in my life I would not discuss with anyone.

22. It is probably best not to know everything about oneself.
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.

25. At some future time I might want to have psychological counseling.

26. A person should work out his problems; getting psychological counseling would be a last resort.

27. Had I received treatment in a mental hospital, I would not feel that it ought to be “covered up”.

28. If I thought I needed psychiatric help, I would get it no matter who knew about it.

29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.
APPENDIX G

SCALES OF PSYCHOLOGICAL WELL-BEING (SPWB)
Scales of Psychological Well-Being (SPWB)

The following set of statements deals with how you might feel about yourself and your life. Please remember that there are neither right nor wrong answers. Circle the number that best describes the degree to which you agree or disagree with each statement.

1 - Strongly Disagree
2 - Disagree
3 - Disagree Slightly
4 - Agree Slightly
5 - Agree
6 - Strongly Agree

1. Most people see me as loving and affectionate.

2. I am not afraid to voice my opinion, even when they are in opposition to the opinions of most people.

3. In general, I feel I am in charge of the situation in which I live.

4. I am not interested in activities that will expand my horizons.

5. I live life one day at a time and don’t really think about the future.

6. When I look at the story of my life, I am pleased with how things have turned out.

7. Maintaining close relationships has been difficulty and frustrating for me.

8. My decisions are not usually influenced by what everyone else is doing.

9. The demands of everyday life often get me down.
10. I don't want to try new ways of doing things—my life is fine the way it is.

11. I tend to focus on the present, because the future always brings me problems.

12. In general, I feel confident and positive about myself.

13. I often feel lonely because I have few close friends with whom to share my concerns.

14. I tend to worry about what other people think of me.

15. I do not fit very well with the people and the community around me.

16. I think it is important to have new experiences that challenge how you think about yourself and the world.

17. My daily activities often seem trivial and unimportant to me.

18. I feel like many of the people I know have gotten more out of life than I have.

19. I enjoy personal and mutual conversations with family members or friends.

20. Being happy with myself is more important to me than having others approve of me.

21. I am quite good at managing the many responsibilities of my daily life.

22. When I think about it, I haven't really improved much as a person over the years.

23. I don't have a good sense of what it is I'm trying to accomplish in my life.

24. I like most aspects of my personality.

25. I don't have many people who want to listen when I need to talk.

26. I tend to be influenced by people with strong opinions.

27. I often feel overwhelmed by my responsibilities.
28. I have a sense that I have developed a lot as a person over time.

29. I used to set goals for myself, but that now seems a waste of time.

30. I made some mistakes in the past, but I feel that all in all everything has worked out for the best.

31. It seems to me that most other people have more friends than I do.

32. I have confidence in my opinions, even if they are contrary to the general consensus.

33. I generally do a good job of taking care of my personal finances and affairs.

34. I do not enjoy being in new situations that require me to change my old familiar ways of doing things.

35. I enjoy making plans for the future and working to make them a reality.

36. In many ways, I feel disappointed about my achievements in my life.

37. People would describe me as a giving person, willing to share my time with others.

38. It’s difficult for me to voice my own opinions on controversial matters.

39. I am good at juggling my time so that I can fit everything in that needs to be done.

40. For me, life has been a continuous process of learning, changing, and growth.

41. I am an active person in carrying out the plans I set for myself.

42. My attitude about myself is probably not as positive as most people feel about themselves.

43. I have not experienced many warm and trusting relationships with others.

44. I often change my mind about decisions if my friends or family disagree.
45. I have difficulty arranging my life in a way that is satisfying to me.

46. I gave up trying to make big improvements or change in my life a long time ago.

47. Some people wander aimlessly through life, but I am not one of them.

48. The past has its ups and downs, but in general, I wouldn’t want to change it.

49. I know that I can trust my friends, and they know they can trust me.

50. I judge myself by what I think is important, not by the values of what others think is important.

51. I have been able to build a home and a lifestyle for myself that is much to my liking.

52. There is truth to the saying that you can’t teach an old dog new tricks.

53. I sometimes feel as if I’ve done all there is to do in life.

54. When I compare myself to friends and acquaintances, it makes me feel good about who I am.
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