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Alcohol-Specific Coping Styles of Adult Children of Individuals with Alcohol Use Disorders and Associations with Psychosocial Functioning

Michelle L. Drapkin^{1,2,*}, David Eddie³, Angela J. Buffington⁴,
and Barbara S. McCrady⁵

¹Philadelphia VA Medical Center, Philadelphia, PA, USA, ²Department of Psychiatry, University of Pennsylvania Perelman School of Medicine, Philadelphia, PA, USA, ³Center of Alcohol Studies, Rutgers, The State University of New Jersey, New Brunswick, NJ, USA, ⁴School of Psychology, Fielding Graduate University, Santa Barbara, CA, USA, and ⁵The Center on Alcoholism, Substance Abuse, and Addictions, University of New Mexico, Albuquerque, NM, USA

*Corresponding author: Department of Psychiatry, Philadelphia VA Medical Center, University of Pennsylvania Perelman School of Medicine, Philadelphia, PA, USA. E-mail: michelledrapkin@gmail.com

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Abstract

Parental alcohol use disorders (AUDs) have been conceptualized as a chronic stressor that can lead to deleterious long-term outcomes in children of individuals with AUDs. Yet, while many individuals are detrimentally affected by their parents' problematic alcohol use, and go on to manifest psychological problems, others do not. How individuals cope with the stress of having a parent with an AUD is believed to be an important moderator of this differential outcome. This study assessed whether individuals' alcohol-specific coping styles predicted alcohol use, positive or negative life events, and depression, using a sample of 465 college students, of whom 20% were adult children of individuals with alcohol use disorders, colloquially known as adult children of alcoholics (ACOAs), and a battery of well-validated, self-report measures. Participant ACOAs reported less 'engaged' and 'total' alcohol-specific coping strategies and more 'withdrawal' alcohol-specific coping strategies than their non adult children of alcoholics (NACOAs) counterparts. Across participants, women reported more 'engaged', 'tolerant/inactive', and 'total' coping than men. Although ACOAs reported significantly more negative life events, which predicted more passive coping styles, they did not differ significantly from NACOAs on measures of problematic alcohol use or depression, supporting theories of resilience in ACOAs regardless of their alcohol-specific coping styles. For NACOAs, 'tolerant' coping predicted greater depression and alcohol-related problems; 'engaged' coping predicted fewer alcohol problems. Results suggest that ACOAs cope differently with problematic alcohol use among relatives and friends compared with NACOAs and are more likely to experience negative life events. Additionally, alcohol-related coping strategies have more predictive utility in NACOAs than ACOAs.

INTRODUCTION

Approximately, one in five North Americans reports growing up with one or more parent who has an alcohol use disorder (AUD; [Belliveau and Stoppard, 1995](#); [Dube et al., 2001](#)). As adults, children of individuals with AUDs report higher rates of problem drinking ([Warner et al., 2007](#)) and are at increased risk for developing substance use

problems ([Chassin et al., 2004](#); [Eddie et al., 2015](#)), emotional and behavioral problems ([Elkins et al., 2004](#); [Disney et al., 2008](#)), and personality disorders ([Trull, 2001](#); [Harman, 2004](#)).

Although historically clinicians have approached adult children of individuals with AUDs—commonly referred to as adult children of alcoholics (ACOAs)—from a vulnerabilities perspective, more recently

there has been a shift to focus on resiliency factors. It has been observed that ACOAs commonly develop skills to overcome the major challenges associated with being raised by parents with AUDs (Palmer, 1997; Carle and Chassin, 2004). Resiliency in ACOAs is especially important given that parental AUDs can be thought of as a chronic stressor (Clair and Genest, 1987; Hussong *et al.*, 2008). The ways in which ACOAs cope with the stressors associated with parental AUDs may be a mediating factor in their resiliency.

In an important early study, Moos *et al.* (1982) investigated coping styles and functioning in individuals with AUDs and their families, and matched controls. They assessed both general and alcohol-specific stressors in the environment that may or may not have resulted from the problem drinker's behavior. As predicted, family members of relapsed individuals with AUDs were not functioning as well as family members of controls, while families of recovered problem drinkers appeared to be able to function normally in comparison with the families of relapsed problem drinkers. Notably, spousal coping styles were differentially associated with functioning, such that spousal mood and health were positively associated with active coping styles and negatively associated with avoidant coping styles.

In a similar vein, using the Coping Questionnaire (CQ; Orford, 1996), a measure that assesses alcohol-specific coping with three subscales (Tolerant/Inactive, Engaged, and Withdrawal coping), Orford and colleagues (2001) found that compared with other coping styles, Tolerant/Inactive coping was most highly associated with a greater rate of reported physical and psychological problems among individuals close to someone with alcohol or drug dependence.

The aforementioned research has focused mostly on partners of individuals with AUDs and has, therefore, offered little insight into ACOAs' coping styles or psychosocial functioning. It has, however, been postulated that ACOAs' personality characteristics are shaped by the stressful environment in which they were raised (Harter, 2000). Clair and Genest (1987) administered the Ways of Coping Checklist (WOC; Folkman and Lazarus, 1980) to 30 ACOAs and 40 non adult children of alcoholics (NACOAs). A higher proportion of ACOAs (93.2%) than NACOAs (6.8%) perceived their family stressful situations as unchangeable or as requiring acceptance (i.e. beyond their control). ACOAs also reported using more emotion-focused coping (as opposed to avoidant coping), wishful thinking and help seeking, and avoidance-escape coping than the NACOAs.

Kelly and Myers (1996) also examined coping in ACOAs. They compared the responses of female ACOAs and NACOAs on the Revised Ways of Coping Checklist (RWOC; Vitaliano *et al.*, 1985). The groups did not differ significantly in their responses to the family situations portrayed in vignettes in which they were asked to imagine themselves being harshly reprimanded by their parents. Kelly and Myers also measured depression and found that ACOAs reported more depression than NACOAs, although all participants scored within the healthy range.

More recently, Hussong and Chassin (2004) used a latent trajectory model to assess stress and general coping strategies among ACOAs transitioning into adulthood. They found that ACOAs were marginally less likely to report active coping in young adulthood when compared with their peers, but found no differences in cognitive or avoidant coping. In addition, using Carver *et al.*'s (1989) *Multidimensional Coping Inventory* and the *Profile of Mood States* (McNair *et al.*, 1992), Klostermann and colleagues (2011) found that ACOAs reported more behavior disengagement, denial, and focus on and venting of emotions. ACOAs also reported significantly greater drinking to cope and depressive symptomatology.

The extant literature on coping styles of ACOAs is relatively small and has shown mixed results. The present study, therefore, tested the following hypotheses: (a) that ACOAs would report more inactive and less engaged coping styles than the NACOAs, independent of gender-related differences, (b) that ACOAs would report more alcohol-related problems than NACOAs, (c) that ACOAs would report more depression than NACOAs, (d) that ACOAs would report more negative life events and fewer positive life events than NACOAs, and (e) that within the ACOA group, engaged coping would be inversely associated with depression and alcohol-related problems, while withdrawal and tolerant/inactive coping styles would be positively associated with depression and alcohol-related problems.

METHOD

Participants

Participants were 465 undergraduate students (57% female) enrolled in an introductory psychology course or a research methods course at a large Eastern public university. In exchange for study participation, volunteers either received extra course credit or fulfilled a course research experience requirement. Enrollment in one of these courses and consent to participate were the only inclusion criteria. Participants were excluded from the analyses only if their ACOAs/NACOAs status was indeterminate due to missing data.

Measures

Designating ACOAs/NACOAs status

Participants completed two adapted versions of the Short Michigan Alcoholism Screening Test (SMAST; Selzer *et al.*, 1976), one to assess paternal AUDs (F-SMAST; Crews and Sher, 1992) and the other to assess maternal AUDs (M-SMAST; Crews and Sher, 1992). One item was added to both versions of the parent SMASTs to ask participants if they thought their mother/father was an 'alcoholic'. This single item for assessing family history has demonstrated acceptable sensitivity and specificity (Crews and Sher, 1992). Participants were identified as ACOAs if they answered yes to the single item and/or received a score of three or greater on either of the parent SMASTs. Crews and Sher (1992) have defined individuals who score three or more on either of the parent SMASTs the 'potential high risk group' (p. 580). Because we were most interested in exposure to heavy parental alcohol use as a stressor (and not strictly parental alcohol dependence), we decided to err on the side of over-inclusion and utilize a cut score of three. For our purposes, any participant scoring three or above on the F-SMAST and/or the M-SMAST was designated as an ACOA. The Cronbach internal consistency estimates for this sample were 0.88 and 0.87 for the F-SMAST and M-SMAST, respectively.

Parental contact

All participants completed a rubric indicating the amount of contact with their mother and father during varying times of their life (ages from birth to 6 years, 7 to 12 years, 13 to 18 years, and current). The amount of contact was indicated on a scale ranging from daily contact (7) to no contact (0), with a midpoint of every other week (4).

Alcohol use disorders identification test (AUDIT)

The AUDIT (Saunders *et al.*, 1993) is a 10-item self-report measure that assesses the amount and frequency of alcohol use, alcohol dependence, and problems caused by alcohol. A score of eight or greater is indicative of hazardous drinking. Cronbach's alpha for this sample was 0.82.

Beck Depression Inventory II (BDI-II)

The BDI-II (Beck *et al.*, 1996) is a 21-item self-report measure of depressive symptoms. Each item contains a four-point (0–3) scale arranged in increasing severity of a symptom. The sum of the ratings on the 21 items is utilized to interpret the measure; total scores range from 0 to 63. Cronbach's alpha for college students has been reported as 0.93 (Beck *et al.*, 1996); the alpha for the present sample was 0.87.

Life events

The student version of the Life Experiences Survey (LES; Sarason *et al.*, 1978) was administered to all participants. The student version contains items relevant to university students (e.g. exams, change in residence). Participants were asked to indicate which of 54 events they had experienced either in the past 6 months or in their lifetime prior to the past 6 months. Participants then indicated whether each event they experienced had had a positive or negative impact on them. From the LES, we calculated two variables: the number of positive events and the number of negative events (i.e. the total number of events endorsed as having had a positive or negative impact, regardless of the extent of impact or time period indicated).

The Coping Questionnaire—short version (CQ)

The CQ (Orford, 1996) was used to assess alcohol-specific coping in both ACOAs and NACOAs. A 30-item self-assessment, the CQ, measures the types of behaviors individuals use to respond to a family member's problem drinking (i.e. alcohol-specific coping). The header of the questionnaire asks 'Have you recently (in the last three months). . .?' Family members respond to each statement by indicating if they have never (a), once or twice (b), sometimes (c), or often (d) used each coping response. Scores are totaled from the selected frequency a family member indicates for each item. Total scores can range from 0 to 120. Higher scores indicate greater employment of coping strategies. The CQ has three identified factors: Tolerant/Inactive (the sum of 9 items), Engaged (the sum of 14 items), and Withdrawal coping (the sum of 7 items with 2 items subtracted; Orford, 1996). ACOAs were instructed to respond to the questionnaire with their problem-drinking parent(s) in mind, while NACOAs were instructed to respond with a close friend/relative who drinks too much in mind.

Procedure

Participants were recruited via the university's Psychology Department web page or an announcement in their class. Volunteers were provided with an overview of the study and were given the opportunity to ask questions prior to giving informed consent. They were then informed that they would complete two sets of questionnaires—one set that is the same for everyone and a second set that would differ across respondents. Participants then completed the first set of questionnaires, including a demographic questionnaire, the F-SMAST and the M-SMAST, the AUDIT, and the BDI-II. Participants were instructed to hand the experimenter the envelope and return to their seats after they complete the first set of questionnaires. At this point, the investigator scored the F-SMAST and M-SMAST. The investigator then called participants back up and handed them a second set of questionnaires. Because of the sensitive nature of some of the data collected, anonymous questionnaires were used.

Participants who received a score indicating that they had at least one parent with an AUD received a second envelope containing the LES and CQ with instructions to respond with their problem-drinking

parent(s) in mind. Participants whose parent SMAST scores indicated that *neither* parent has an AUD received a second envelope containing the LES and CQ with instructions to respond by thinking of a relative/close friend who drinks too much. The differential contents of the envelopes were not obvious to the participants. This procedure enabled ACOAs to complete the CQ in response to their problem-drinking parent(s) without revealing their ACOA status to other participants: students met experimenters in a large classroom, allowing each student to have ample privacy when completing the questionnaires.

Analysis

Data were checked for normality of distribution. Exploratory factor analysis was used to confirm that the original factor structure of the CQ measure mapped onto the present sample. Using the combined sample of ACOAs and NACOAs, and promax rotation, the number of factors retained was decided by a combination of the screen test and an examination of eigenvalues. Items with absolute factor loadings >0.35 were retained unless they loaded comparably onto another factor. A model with three correlated factors was specified and demonstrated good fit. The Kaiser–Meyer–Olkin measure of sampling adequacy was 0.90, above the recommended value of 0.6, and Bartlett's test of sphericity was significant ($\chi^2(435) = 4771.80, P < 0.001$). The three factors accounted for 38.43% of the variance. Two items loaded comparably onto more than one factor, and four items had relatively small loadings on all three factors (i.e. <0.35). There was marked overlap between the scales derived from the factor analysis and those published. Correlations between published scales and the empirically derived scales were: $r = 0.96, P < 0.001$; $r = 0.94, P < 0.001$; and $r = 0.87, P < 0.001$ for Engaged, Withdrawal, and Tolerant/Inactive coping scales, respectively. Because of the high correlation with Orford *et al.*'s (1998) original factors, all scale scores were calculated using their specifications. The internal consistencies for the published scales in our sample were 0.89, 0.58, and 0.73 for Engaged, Withdrawal, and Tolerant/Inactive coping scales, respectively. The total score for the CQ was also calculated by summing the three subscales.

Hypothesis 1 (that ACOAs would report more inactive and less engaged coping styles than the NACOAs, independent of gender-related differences) was tested using MANOVA with appropriate post hoc analyses. Between-group differences in the amount of parent contact, depression, life events, and participants' own alcohol-related problems were tested using Student's *t*-test and chi-square test. Associations between alcohol-specific coping styles and psychosocial outcomes were investigated using Pearson's test of bivariate correlation. Because data were assumed to be missing at random, pairwise deletion was used in all analyses.

RESULTS

Descriptives

Participants ranged in age from 16 to 65 years with a mean age of 19.16 years ($SD = 3.45$). Approximately, half of the sample (54%) identified as Caucasian/White, 22% as Asian, 9% as African-American/Black, 8% as Hispanic, and 7% as other. Fifty-eight percent were freshman, 23% sophomores, and 19% upperclassman. Most (98%) of the sample reported that they were single (i.e. never married). Thirty-two percent reported family household income as $>\$90,000$; median household income was between \$60,000 and \$75,000.

ACOAs comprised 20% ($n = 91$) of the sample: 53 indicated that their father had an AUD, 23 indicated that their mother had an AUD,

Table 1. Mean scores for adult children of individuals with alcohol use disorders (ACOAs) and non adult children of individuals with alcohol use disorders (NACOAs) on the amount of contact with parents, problematic alcohol use (AUDIT), depression (BDI-II), and number of positive and negative life events

	ACOAs (<i>n</i> = 86)		NACOAs (<i>n</i> = 338)		<i>t</i>	df
	M	SD	M	SD		
	Contact with father					
Ages 0–6 years	5.90	1.96	6.59	1.43	–3.16**	461
Ages 7–12 years	5.26	2.30	6.26	1.78	–3.88**	461
Ages 13–18 years	4.81	2.54	5.96	1.93	–4.04**	460
Current	3.66	2.43	4.62	2.09	–3.47**	458
Contact with mother						
Ages 0–6 years	6.73	1.11	6.88	.81	–1.21	461
Ages 7–12 years	6.49	1.43	6.73	1.10	–1.50	461
Ages 13–18 years	6.54	1.13	6.55	1.28	–0.07	461
Current	4.86	1.86	5.12	1.78	–1.21	459
AUDIT (total)	6.47	6.25	5.13	4.98	–1.93	463
BDI-II (total)	10.75	6.79	9.60	7.11	–1.31	410
Positive life events	5.81	3.89	5.57	4.02	0.52	463
Negative life events	8.78	7.20	6.70	6.79	–2.62**	463

M, mean; SD, standard deviation; AUDIT, Alcohol Use Disorders Identification Test; BDI-II, Beck Depression Inventory II.

***P* < 0.01.

and 15 indicated that both parents had an AUD. All participants identifying either or both parents having an AUD were classified as ACOAs; we did not differentiate which parent(s) had an AUD. A total of 374 participants identified as NACOAs (total *N* = 465). ACOAs did not differ significantly from NACOAs on any demographic variable measured.

Parental contact

ACOAs reported significantly less contact than NACOAs with their fathers during all four time periods queried (see Table 1). ACOAs, however, did not differ from NACOAs on the amount of contact with their mothers during any of the four time periods queried (see Table 1).

Alcohol problems

A trend for significance was observed in terms of differences in AUDIT scores between ACOAs and NACOAs (*P* = 0.06) with ACOAs scoring marginally higher than NACOAs (see Table 1); this difference represented a small effect size (Cohen's *d* = 0.24). Both group means were below the cutoff for hazardous drinking.

Depression

Contrary to our hypothesis, ACOAs did not significantly differ from NACOAs on BDI-II scores (see Table 1).

Life events

When comparing life events, ACOAs reported similar amounts of positive events in their past, but, as predicted, reported significantly more negative events than NACOAs (see Table 1).

Coping behaviors

A MANOVA was conducted with two between-subject factors: ACOAs status and gender. The three coping subscales, as well as the total CQ score, were used as dependent measures. The omnibus test

Table 2. Mean CQ subscales and total scores for adult children of individuals with alcohol use disorders (ACOAs) and non adult children of individuals with alcohol use disorders (NACOAs), as well as Tukey's post hoc range test for between-group differences

Subscale	ACOAs (<i>n</i> = 86)		NACOAs (<i>n</i> = 338)		<i>F</i>	df
	M	SD	M	SD		
	CQ—Engaged	23.78	8.98	34.34		
CQ—Tolerant/ Inactive	16.14	5.17	16.74	4.37	1.57	422
CQ—Withdrawal	11.16	5.59	8.86	3.90	18.78**	422
CQ—Total	57.45	16.17	69.66	12.59	57.95**	422

M, mean; SD, standard deviation.

***P* < 0.01.

was significant, indicating a main effect for ACOAs status, *F* (4, 417) = 43.13, *P* < 0.001, and a main effect for gender, *F* (4, 417) = 6.71, *P* = 0.001, but as predicted, there was no interaction between gender and ACOAs status.

In light of the significant omnibus test, Tukey's post hoc analyses for ACOAs status and gender were conducted. ACOAs reported less Engaged and Total coping, and more Withdrawal coping on the CQ measure (see Table 2). Across participants, women reported more Engaged, *F* (1, 422) = 20.19, *P* < 0.01; Tolerant/Inactive, *F* (1, 422) = 4.12, *P* < 0.05; and Total coping than men, *F* (1, 422) = 12.05, *P* < 0.01; there were no gender differences in Withdrawal coping, *F* (1, 422) = 0.02, *P* = *n.s.*

Associations between alcohol-specific coping styles and psychosocial outcomes

The amount of contact with father and mother, level of depression, level of alcohol use problems, and number of positive and negative life events were examined as correlates of CQ-measured coping behaviors. For ACOAs, the amount of contact with their fathers at three time periods (from birth to 6 years, 13 to 18 years, and current) was negatively associated with the CQ—Withdrawal subscale (see Table 3). The more Withdrawal coping ACOAs reported, the less contact they had with their fathers during these time periods. For NACOAs, there were no significant relationships between any of the coping subscales and the parental contact variables.

Correlations were calculated between CQ subscales and depression, alcohol-related problems, and positive and negative life events for ACOAs and NACOAs, respectively. For ACOAs, LES-measured negative life events were positively correlated with Tolerant/Inactive coping, *r* = 0.23, *P* < 0.05. Contrary to our hypotheses, however, all other correlations for ACOAs were non-significant. That is, ACOAs' coping style did not predict depression and alcohol-related problems. Examination of NACOAs data yielded a different pattern of results. For NACOAs, scores on the BDI-II were positively associated with CQ Tolerant/Inactive coping style scores, *r* = 0.16, *P* < 0.01, while their AUDIT scores were negatively associated with CQ Engaged scores, *r* = –0.18, *P* < 0.01, and positively associated with CQ Tolerant/Inactive scores, *r* = 0.11, *P* < 0.05.

DISCUSSION

The present investigation examined the relationship between alcohol-specific coping styles and alcohol-related problems, depression,

Table 3. Correlations between the CQ subscale, and total scores and parental contact for adult children of individuals with alcohol use disorders (ACOAs)

Subscale	Parental contact—father				Parental contact—mother			
	Birth to 6 years	7–12 years	13–18 years	Current	Birth to 6 years	7–12 years	13–18 years	Current
1. CQ—Engaged	0.00	0.05	−0.07	0.03	0.02	−0.16	−0.01	0.11
2. CQ—Tolerant/Inactive	−0.05	0.11	−0.03	0.02	0.04	0.06	0.04	0.05
3. CQ—Withdrawal	−0.32**	−0.17	−0.30**	−0.31**	0.03	0.05	−0.01	−0.01
4. CQ—Total	−0.05	0.07	−0.10	−0.01	0.07	−0.05	0.04	0.08

$n = 86$, ** $P < 0.01$.

positive and negative life events, and parental contact time in ACOAs and NACOAs.

Independent of the effects of gender, ACOAs reported less Engaged and Total alcohol-specific coping strategies and more Withdrawal strategies than their NACOAs counterparts, while across participants, women reported more Engaged, Tolerant/Inactive, and Total coping than men. ACOAs reported significantly more negative life events than NACOAs, which was associated with more passive coping styles. The groups, however, did not differ significantly on measures of problematic alcohol use or depression. Throughout their lifetime, ACOAs reported significantly less contact with their fathers compared with NACOAs but reported similar amounts of contact with their mothers.

It is noteworthy that the ACOAs in the present sample reported less Engaged and more Withdrawal alcohol-specific coping strategies than NACOAs. This result is concordant with [Hussong and Chassin's \(2004\)](#) finding that ACOAs employed less *general* 'active' coping than NACOAs, but discordant with their finding that ACOAs were similar to NACOAs in *general* 'avoidant' coping. Although alcohol-specific and general coping are distinct constructs, it is possible that alcohol-specific coping styles may generalize to general coping styles. Specifically, ACOAs may utilize less engaged coping styles for dealing with parents with an AUD, and this manner of coping may be used more broadly in other areas of their lives. More work is needed to elucidate the relationship between these constructs.

It is also possible that the between-group differences in coping strategies in the present sample may be attributable to the different circumstances in which the two groups would have ultimately been forced to exercise alcohol-specific coping strategies. ACOAs, who were likely to have close personal and physical proximity to the problem drinker in their lives (i.e. a parent), may be forced to cope differently with problem drinking than NACOAs, who answered the CQ with a family member or friend in mind. In many instances, for NACOAs, the target individuals may have been more personally and physically distal to the participant than a parent. If this is the case, it may speak to an intuitively plausible explanation that individuals employ differential coping strategies based on the nature of their relationship to the individual with an AUD.

There was a trend toward ACOAs in the present sample having more personal alcohol-related problems than NACOAs. This finding is in contrast to a large body of work that has shown ACOAs experience significantly higher rates of problem drinking than NACOAs (e.g. [Windle, 1996](#); [Warner et al., 2007](#)). This finding may be attributable to the fact that the present sample consisted entirely of college students, which may overrepresent more resilient ACOAs and under-represent less resilient ACOAs with alcohol-related problems. In addition, alcohol problem severity scores were not associated with alcohol-specific coping styles, suggesting that for ACOAs,

alcohol-specific coping styles do not influence personal drinking outcomes, or vice versa.

For ACOAs, Tolerant/Inactive coping style was positively correlated with the number of negative life events. Though the cross-sectional nature of the present data makes the direction of this association difficult to discern, it is possible that ACOAs experiencing greater adversity adopt this coping strategy as it is best suited to their circumstances or at least is more effective than Engaged or Withdrawal strategies for managing high levels of adversity. It is also possible that Tolerant/Inactive coping styles may be antecedent to negative life events, such that this coping style precludes the use of active coping strategies, leading to problems remaining unresolved and eventually worsening.

It is noteworthy that other coping styles were not associated with drinking problems and depression in ACOAs. It is possible that while individual coping styles may be an important predictor of psychosocial functioning in community samples of ACOAs, such as those observed by [Orford et al. \(1998, 2001\)](#), coping styles may not be a reliable predictor of psychosocial outcomes in college samples, such as the one used in the current investigation. This is in contrast to NACOAs in the present sample for whom alcohol-specific coping strategies were associated with drinking problem and depression outcomes.

For NACOAs participants, depression scores were positively associated with Tolerant/Inactive coping. It is plausible that Tolerant/Inactive coping may be an effect of depression symptomology, given that emotional containment and passive resignation are hallmarks of depression ([Ravindran et al., 2002](#); [Matheson and Anisman, 2003](#)). It should be noted, however, that on average NACOAs achieved BDI-II scores in the 'minimal depression' range, indicating that at the level of the mean NACOAs were not experiencing problematic levels of depression. In addition, in NACOAs, alcohol problem severity scores were positively associated with Tolerant/Inactive coping and negatively associated with Engaged coping. This is concordant with the prior work showing that general avoidant coping styles in adolescents and young adults predict problem drinking ([Fromme and Rivet, 1994](#); [Seiffge-Krenke, 2000](#)). This differing pattern of associations from ACOAs suggests that alcohol-specific coping styles may be a useful predictor of drinking outcomes in NACOAs, but not in individuals with parents with AUDs. It is, therefore, possible that growing up with parents with AUDs may precipitate greater levels of hazardous drinking by exerting psychosocial pressures on ACOAs that negate potential benefits of adopting certain coping styles. Future studies testing for moderation using longitudinal data will help parse out these effects.

There are several potential limitations to the present investigation. First, although the sample was diverse in gender and ethnicity, all study participants were college students. As noted earlier, this college sample may overrepresent more resilient or high-functioning ACOAs. An unanticipated benefit of this potential sampling bias, however, was

that it revealed important differences in the relationship between alcohol-specific coping strategies and psychosocial outcomes in community versus college samples. Other potential limitations include the fact that drinking to cope was not assessed, which may have elicited a set of behaviors that would have more clearly distinguished ACOAs from NACOAs (Park and Levenson, 2002). In addition, though coping styles are thought to develop at a relatively early age (Aldwin, 2007; Carson *et al.*, 1992; Kardum and Krapić, 2001), and it, therefore, may be presumed that they are antecedent to the psychosocial measures in the present investigation, the data used here were cross sectional in nature, meaning that causal associations between alcohol-specific coping styles and psychosocial measures could not be discerned.

Future research will benefit from a more in-depth analysis of both trait/dispositional and situational coping with alcohol-specific and general stressors. This could be accomplished using ecological momentary assessment in conjunction with retrospective reporting. In addition, current measures of coping do not address how and why individuals select specific coping strategies nor do they address their effectiveness. Development of a more specific methodology to clarify these issues might aid in our understanding of how ACOAs cope.

The present investigation suggests that ACOAs cope differently to NACOAs with problematic substance use among individuals close to them. Importantly, it also contributes valuable information about the potentially differing role of coping strategies in community versus college samples. While prior research has been inconclusive in determining whether parental AUDs are a risk factor for long-term, negative psychosocial outcomes, the present study found evidence that ACOAs are not necessarily adversely affected by having a parent with an AUD. In fact, this study provided support for resilience in a specific demographic of ACOAs. The present study also highlights the potential of alcohol-specific coping strategies to predict psychosocial outcomes in college NACOAs. An important direction for future longitudinal research will be to tease out the roots of resilience and the variables associated with its development, in both ACOAs and NACOAs. Identification of the core factors that contribute to resilience has the potential to inform future prevention and intervention research.

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