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AUTHOR	Fredricks, Randi; And Others
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ABSTRACT

Noting that children of alcoholic parents come from home settings similar to those identif s potential sources of communication apprehension, a study compared communication apprehension scores of adult children of alcoholics (ACoA) with those of non-ACoAs. Subjects, 85 men and 109 women, were drawn from a local church, undergraduate and graduate classes at a northern California university, and northern California Al-Anon ACoA meetings. They ranged from 18 to 60 years of age, with a wide range of educational backgrounds. Each subject completed a questionnaire that consisted of two instruments: the Children of Alcoholics Screening Test (CAST) and McCroskey's Personal Report of Communication Apprehension Test (PRCA-24). Results indicated a strong relationship between ACoAs and CA except where subjects were involved in a group communication situation. Findings suggest that future research investigating communication and ACoAs is called for. (Two tables of data are included. Contains 21 references.) (NH)

Communication Apprehension Among Adult Children of Alcoholics

Randi Fredricks, Cynthia Stinson, & Paul A. Soukup, S.J.
Communication Department
Santa Clara University
Santa Clara, CA 95053
(408) 554-2798
fax: (408) 554-4913

[Please address all correspondence to Paul A. Soukup.]

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Abstract

Children of alcoholic parents come from home settings similar to those McCroskey identifies as potential sources of communication apprehension. This study compared communication apprehension scores of adult children of alcoholics (ACoA) with those of non-ACoAs. The ACoAs showed significantly more communication apprehension on all measures in the PRCA-24 except for the small group setting.

Communication Apprehension Among Adult Children of Alcoholics

A growing concern about the effects of alcoholism has brought increasing clinical attention to the 28 to 34 million people who have grown up in alcoholic families (*The Twelve Steps*, 1987). Although doctors and clinicians studied the effects of alcoholism since the 1950s, only from around 1970 did they begin to focus on those who have grown up in alcoholic families.

Despite recent studies that have raised some doubt as to the distinctiveness of adult children of alcoholics (ACoAs) in the general population (Berkowitz & Perkins, 1988), clinicians in the field of alcoholism treatment have, over the last 10 years, developed a model that suggests ACoAs have certain characteristics distinguishing them from non-ACoAs (Black, 1982; Brown, 1988; Cermak, 1985; Wegsheider-Cruse, 1985; Woititz, 1985). Some compare the effects of growing up in an alcoholic home to Post-Traumatic Stress Disorder because ACoAs exhibit the same chronic symptoms of acute anxiety, nightmares, and sleep disturbance as war veterans and children of the holocaust (Brown, 21).

Another characteristic frequently attributed to ACoAs is the inability to form intimate relationships (Black, 1982; Brown, 1988; Cermak, 1985; Wegsheider-Cruse, 1985; Woititz, 1985). Clinicians theorize this disability stems from psychological abuse experienced during childhood in an alcoholic home, during which the ACoA develops dysfunctional patterns of communicating. Because of this abuse, ACoAs have a difficult time trusting people.

This study examines whether ACoAs show more communication apprehension (CA) than non-ACoAs when measured by the Personal Report of Communication Apprehension (PRCA-24) test designed by James McCroskey (1982).

The construct of communication apprehension (CA) has been central to the study of communication avoidance since 1970 (Daly & McCroskey, 1984) when McCroskey developed the theory of communication apprehension while studying how college students communicated in a classroom setting. The theory asserts that children who are not taught how to communicate or who are in some way punished for communicating develop a fear of communicating and exhibit that fear as adults. McCroskey and Wheeless hold that CA derives not from hereditary factors but from the environment in which an individual grows up (1978, p. 88). For the individual suffering from CA the apprehension about participating in communication outweighs any gain projected from the interaction.

McCroskey designed the Personal Report of Communication Apprehension (PRCA-24) in order to measure the amount of fear or anxiety an individual has regarding communicating. In general, the PRCA-24 progressively determines four levels, with high PRCA-24 scores correlated with CA high levels (McCroskey & Richmond, 1986). A low score on the PRCA-24 indicates a person without significant apprehension who may actively seek out opportunities to interact with others. Very few communication situations cause this person to feel fearful or anxious (p. 47). Second, a normal score reflects a balanced individual who may feel anxious in some

communication situations and quite comfortable in others. Next, a high score on the PRCA-24 points to a low talker who actively avoids many communication situations because s/he feels a high level of anxiety and tension in those situations. Finally, an extremely high score indicates someone who may experience debilitating enough CA to interfere with normal life. For example, a person with extreme CA would feel nervous even talking with a friend on the telephone.

For more specific evaluation, McCroskey divides the 24 questions of the PRCA-24 into four categories of communicative interaction: small groups, speaking in meetings, interpersonal encounters, and public speaking (p. 50). McCroskey defines "small groups" as groups in which participants get together either for social enjoyment or for the purpose of solving problems, setting plans or making policies. The second category, "speaking in meetings," resembles the first, except in size: the meeting is larger and therefore more formalized, such as in a classroom setting. "Interpersonal encounters," the third category, refers to interaction with others on a one-on-one basis. And the fourth category, "public speaking," refers to speaking in front of an audience.

Past CA studies indicate that 10 to 20% of the American population suffer from severe and debilitating communication apprehension and 20% of the population experience communication apprehension severe enough to interfere with normal functioning (p. 89). In comparison, alcohol abuse research has shown that between 10% and 20% of the American population are ACoAs (Ackerman, 1989; Berkowitz,

1988; Cermak, 1989; Gabrielli & Mednick, 1983; Harriman, 1987). While we do not suggest any statistically significant correlation in these figures, we suspect an overlap between the two groups because the alcoholic home is precisely the type of environment McCroskey refers to as conducive for the development of communication apprehension.

CA develops when children are punished in some way for communicating. Clinicians in the field of alcoholism treatment concur that one of the strictest rules in a alcoholic home is "Don't talk" (Black, 1982, p. 17). Both the alcoholic and the non-alcoholic parent restrict or punish their children for talking (Wegsheider, 1981, p. 83). This results primarily from the denial experienced by all family members in an alcoholic home. This denial takes the form of silence. Consciously or unconsciously members of an alcoholic family believe that the problem (alcoholism) doesn't exist if they don't talk about it. Sharon Wegsheider has described the alcoholic family as a closed system, "The parts of the system--the family members--are walled off from one another so that they cannot interact. Information and feelings stay bottled up inside" (1981, p. 52).

Currently little information exists on ACoAs and communication. In her 1982 literature review on the alcoholic family, Cook noted that little is known about the debilitating effects of the alcoholic home on ACoAs' communication patterns. Although clinicians hold a general consensus that ACoAs have a difficult time communicating, few studies have provided evidence or theoretical models to support

this belief. According to Cook, further research on the communication patterns of ACoAs is needed.

The only study subsequent to Cook's review that focused on both ACoAs and communication treats ACoAs as the independent variable and communication style as the dependent variable. Harriman (1987) used the Communicator Style Measure to test the hypothesis that individuals self-identified as ACoAs demonstrate a unique communicator style. Working with university students, Harriman found that ACoAs have underdeveloped perceptual skills, unhealthy self-concepts, and low self-esteem. ACoAs perceive themselves as having a less positive communicator image than non-ACoAs (p. 21). An individual with a less positive self-perception of communicator image is more likely to be uncomfortable interacting in "almost any setting ranging from greeting acquaintances to conversing with intimates" (p. 22).

Ackerman and Gondolf (1989) uncovered symptomatic commonalities among children of alcoholics that could account for their poor communication. These include perceived isolation, high approval needs, inconsistency, high control needs, rigidity, and fear of failure (p. 5). Portions of the Children of Alcoholics Screening Test (CAST) were used to identify ACoAs among participants at an ACoA conference. Results indicated that the more conflicted the parental relationship, the more severe the ACoA symptoms (p. 4). Nearly one half (47%) of the ACoAs considered themselves to be "highly affected" by parental problem drinking (p. 7).

In one other relevant study Dunlop (1986) examined the effects of parental alcoholism on communication within the family. Studying ACoAs in an Oregon treatment center, Dunlop found that ACoAs were generally passive communicators, but that assertive communication styles need to be developed to facilitate recovery.

This previous research raises the question as to the extent to which ACoAs experience a fear of communication. Because of the similarity between their early home life and what McCroskey theorizes about the origins of CA, we looked for correlations between CA scores and CAST scores. We posed the following hypothesis:

> H_1: Adults (18 and older) identified as ACoAs by their CAST scores will show significantly higher communication apprehension scores on the PRCA-24 than will non-ACoAs.

Method

Sample

The sample was drawn from a local church, undergraduate and graduate classes at a northern California university, and northern California Al-Anon ACoA meetings. Fairly evenly split between men and women, the sample consisted of 194 subjects, 85 men and 109 women. Subjects ranged from 18 to 60 years of age, with a wide range of educational background, from completion of the 8th grade only to completion of a Ph.D.

By recruiting participants from Al-Anon meetings, we hoped to increase the likelihood of ACoA representation beyond the 13.5% estimated for the general population. As a goal we sought a sample of 100 ACoA subjects and 100 non-ACoA subjects. Our sample consisted of 77 subjects whose CAST scores identified them as ACoAs and 115 whose scores did not.

Apparatus

Each subject completed a questionnaire that consisted of two instruments: the Children of Alcoholics Screening Test (CAST) (Jones, 1985), and McCroskey's Personal Report of Communication Apprehension Test (PRCA-24) (McCroskey & Richmond, 1986). Some additional demographic questions asked gender, age, and educational background. Half the questionnaires began with the CAST test followed by the PRCA-24, and the other half switched the sequence in order to avoid any bias caused by test order.

Dr. John W. Jones first developed the CAST in 1981. This diagnostic instrument consists of 30 items that measure an individual's feelings, attitudes, perceptions, and experiences related to parental drinking behavior. Subjects answer the items with a "yes" or "no." Individuals who score six or more "yes" answers on the CAST are categorized as (adult) children of alcoholics (Jones, 1985; Pilat & Jones, 1984).

The PRCA-24 contains 24 Likert-type questions answered by indicating responses on a scale of "strongly agree" to "strongly disagree." Two separate formulae are used in evaluating the PRCA-24. The first formula provides an overall raw CA score for the individual which is then used to determine normative CA level (low, normal, or high). The second set of formulae provides scores for an individual's communication apprehension in a specific context or situation (group, meeting, interpersonal, public speaking). These formulas can also determine a normative CA level (low, normal, high, or extreme).[1]

Procedure

Depending on the location, we varied the amount of information given to the participants before they completed the questionnaire. Subjects from the church group were told that we were conducting a research project for which their input would be valuable. Subjects in classes and the Al-Anon groups were told that the questionnaire regarded adult children of alcoholics and communication.

Results

As indicated above, 77 subjects' CAST scores identified them as ACoAs. Their CAST scores ranged from 6 to 30, with a median of 18, indicating that this 40% of the sample fit the profile of an ACoA. The vast majority (96) of the non-ACoA part of the sample had a CAST score of 0.

The PRCA-24 mean was 76. For initial analysis we divided the PRCA-24 scores into high and normal or low, following the prescribed methods. This divided the sample into 62 high CA scorers and 130 normal or low scorers.

A cross-tabulation and Chi-square among the four groups indicated that 58% of the people who scored "high" on the PRCA-24 were ACoAs. In addition, non-ACoAs were twice as likely as ACoAs to score in the low to normal range. This result is significant at the .001 level ($\chi^2 = 12.29683$; df = 1; $p < .001$).

As confirmation of the initial Chi-square result, a t-test indicated that the ACoA mean CA score (80.3797) differed significantly from the non-ACoA CA mean (72.8000). Further t-tests, with the ACoA/non-ACoA groups as independent variables, examined the subtotals of the PRCA-2 for each of the four communication situations. In the first category of "small groups," ACoAs scored only slightly higher than non-ACoAs (see Table 1), yielding no significant difference between ACoAs and non-ACoAs.

However, in the other situations the ACoAs reported significantly higher levels of CA than did the non-ACoAs. In "formal meetings," ACoA mean scores were 17.3780 versus 14.8190 for non-ACoAs ($t = -3.21$; df = 142.94; $p < .002$). In "interpersonal encounters," ACoAs again scored significantly higher than non-ACoAs, 15.4634 to 13.9060 ($t = -2.21$; df = 161.24; $p < .05$). Finally, in public speaking situations, ACoAs once again scored significantly higher than non-ACoAs: 20.1875 to 17.6552 ($t = -3.20$; df = 149.70; $p < .01$). Of the ACoAs, 64% scored in the high to

extreme communication apprehension range here, while only 40% of the non-ACoAs scored in the high to extreme range.

We also looked for other factors that might have accounted for the differences. Correlation data with age and education showed a non-significant negative pattern: As a person ages and becomes more educated, the less CA he or she reports. ANOVA data on ACoA status and gender showed that gender also plays a role in CA (See Table 2), with women scoring significantly higher on the PRCA-24 than men. However, there were no significant interaction effects.

Discussion

The overall pattern of the data indicates a strong relationship between ACoAs and CA. The only PRCA-24 scores that did not show a significant difference between the ACoA and non-ACoA groups occurred in the group communication situation. One explanation for the small variance here is the high probability that most of the ACoA subjects in the sample came from Al-Anon ACoA group meetings where the ACoAs communicate in groups. Thus, repeated group work may have made these ACoA participants more comfortable in the group setting. Another, less satisfying explanation is that the individuals--for some antecedent reason, which we did not test for--feel free to participate in groups.

The higher incidence of women with CA may result from sampling errors or may indicate the greater likelihood of women to respond to an alcoholic home with silence.

These findings, while significant, are preliminary and exploratory. Moreover, several methodological choices compromise the findings. For one, the systematic sampling introduced a bias towards ACoAs attending Al-Anon ACoA meetings. Over 80% of the ACoAs in the sample came from ACoA Al-Anon meetings. Other studies might eliminate this by seeking a larger sample of ACoAs from the general population. A second limitation stems from the instruments of data collection which rely on self-reports. Many of the questions, especially in the CAST, required subjects to reflect on or recall experiences from childhood. This presents a problem because some of the subjects might have forgotten or repressed experiences that would have been relevant in response to this study. However, this problem applies to all ACoA studies, and would be nearly impossible to adjust for in future studies.

Implications

Although many factors can cause CA, this evidence suggests to us that ACoAs are predisposed to CA. Therefore, we would encourage future research investigating communication and ACoAs. It would be interesting, for example, to compare the level of CA in ACoAs who are in treatment or a recovery program with that of ACoAs who are not.

As with alcoholism, the most successful avenues of recovery for ACoAs involve individual therapy or a Twelve-step program (ACoA Al-Anon), which requires a regimen of group therapy. Both of these methods demand interpersonal and group communication skills. It seems logical that a person with CA would have difficulty communicating his or her feelings in these kinds of therapeutic settings. Sadly, CA may keep some ACoAs from seeking help or benefitting from it. Further, because ACoAs show more CA than non-ACoAs, improving their communication skills might actually hasten their recovery. Perhaps clinicians could focus more directly on communication skills, instead of viewing communication as merely a vehicle to facilitate recovery.

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TABLE 1: T-Test Results

	mean	t	d.f.	p
Communication Apprehension (Summary Measure)				
non-ACoA	72.8000	-2.78	137.24	.006
ACoA	80.3797			
Group Communication Apprehension				
non-ACoA	14.4188	-1.48	148.78	.142
ACoA	15.5432			
Meeting Communication Apprehension				
non-ACoA	14.8190	-3.21	142.94	.002
ACoA	17.3780			
Interpersonal Communication Apprehension				
non-ACoA	13.9060	-2.21	161.24	.029
ACoA	15.4634			
Public Speaking Communication Apprehension				
non-ACoA	17.6552	-3.20	149.70	.002
ACoA	20.1875			

Table 2: ANOVA Results

Source of Variation	Squares	DF	Squar	F	p
Main Effects	4486.659	2	2243.329	7.287	.001
ACoA	2159.717	1	2159.717	7.016	.009
Gender	1796.161	1	1796.161	5.835	.017
2-Way Interactions	21.867	1	21.867	.071	.790
ACoA gender	21.867	1	21.867	.071	.790
Explained	4508.525	3	1502.842	4.882	.003
Residual	58490.980	190	307.847		
Total	62999.505	193	326.422		

1. This is the PRCA-24 formula for determining overall communication apprehension: (1) Add the value of the choices marked for items 1, 3, 5, 7, 10, 11, 13, 15, 18, 20, 22, and 24; (2) add the value of the choices marked for items 2, 4, 6, 8, 9, 12, 14, 16, 17, 19, 21, and 23; (3) subtract the score of step 1 from 84. Then add that number to the score of step 2. This gives the raw PRCA score which should range between 24 and 120. The normative CA ranges are: 24-54 = LOW CA; 55-83 = NORMAL; and 84-120 = HIGH.

The PRCA-24 formulas for determining CA in specific contexts are Group CA = 18 + (Item 2 + Item 4 + Item 6 - Item 1 - Item 3 - Item 5); Meeting CA = 18 + (Item 8 + Item 9 + Item 12 - Item 7 - Item 10 - Item 11); Interpersonal CA = 18 + (Item 14 + Item 16 + Item 17 - Item 13 - Item 15 - Item 18); and Public Speaking CA = 18 + (Item 19 + Item 21 + Item 23 - Item 20 - Item 22 - Item 24). CA scores on these scales should range between 6 and 30. The normative ranges are 6-17 = NORMAL; 18-23 = HIGH; and 24-30 = EXTREME.