To the Graduate Council:

I am submitting herewith a dissertation written by Connie Sanders Cole entitled "The Personality Characteristics of Adult Children of Alcoholics: An Empirical Investigation". I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

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PERSONALITY CHARACTERISTICS OF ADULT CHILDREN OF ALCOHOLICS: AN EMPIRICAL INVESTIGATION

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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Connie Sanders Cole

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DEDICATION

This dissertation is dedicated to my father, whose love and support have made it possible for me to return to graduate school and whose constant encouragement enabled me to persevere and to reach this goal.

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Abstract

There has been increasing attention directed towards the effects of being raised in a home where parental alcoholism is present. This study attempted to empirically validate some of the personality characteristics of adult children of alcoholics. Two groups of 30 subjects were administered the Children of Alcoholics Screening Test, the MMPI, the Interpersonal Checklist and a personal data sheet. Subjects in the experimental group were women whose fathers were alcoholic; control group subjects had neither parent alcoholic. Tests were scored according to the Leary Interpersonal System.

Results indicated that adult children of alcoholics scored on Leary Octants that depict them as bitter, cynical and distrustful of others on a public level. The underlying character structure is one that eschews responsibility to and for others, and is uncomfortable in leadership roles. Adult children of alcoholics (ACOAs) had less maternal identification than control subjects. In addition, results of the MMPI indicate that ACOAs have significantly more psychological symptoms than control subjects. They showed more depression, low self-esteem and a great deal of underlying anger towards authority. The mediating factors had little impact on the psychological adjustment indicated on the Leary and the MMPI results.

The results of the study call into question the validity of the description given by clinicians of adult children of alcoholics and suggest the need for future research to clarify both the personality characteristics described and the assumed homogeneity of this group.

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CHAPTER I

INTRODUCTION

It has been estimated that alcoholism affects one in four families and that every alcoholic directly affects the lives of four to six other people (Hecht, 1975). Alcohol's destructive effects on marital-family interactions and on social relationships are of major proportions. In a survey conducted for the National Institute on Alcohol Abuse and Alcoholism, it was estimated that there are over 28 million children of alcoholics in the United States (Russell, Henderson & Blume, 1985). Children of alcoholics are often characterized as a population at risk for the development of psychological and interpersonal difficulties.

In recent years, investigators have become increasingly interested in determining the degree and nature of the impact of parental alcoholism. Initial research on children of alcoholics focused on their propensity to become alcoholics themselves (Hindman, 1976; Chafetz, 1979; Corrigan, 1980; Kenward & Rissover, 1980) and primarily focused on children with noticeable social or behavioral problems. Information for these studies came predominately from agency treatment populations and treatment records. Goodwin (1971) found that sons of alcoholics were more than four times as likely to become alcoholic than sons of nonalcoholics, even if they had been

separated from their alcoholic parents and reared by nonrelatives who did not drink excessively. Much early research focused on characteristics of young children of alcoholic parents. For example, Cantwell's (1975) review of prior research indicated that families of hyperactive children have increased prevalence of alcoholic parents. Other studies focused on the link between children of alcoholic parents and childhood conduct disorders, delinquency and truancy. Stewart, deBlois, & Cummings (1980) reported a higher incidence of alcoholism in fathers of children with unsocialized-aggressive conduct disorders, compared with fathers of children having other psychological disorders. Although not consistent across studies, there is also a documentable relationship between parental alcoholism and adolescent alcohol abuse (summarized in West & Prinz, 1987). There is a great deal of literature examining the relationship between parental alcoholism and childhood/adolescent delinquency.

Hughes (1977) reported that 25 adolescent children of alcoholics had significantly more contacts with police than did children of nonalcoholics matched for age, gender, grade level and father's occupational level. Other investigations explored the relationship between parental alcoholism and children's I.Q. and academic performance in addition to a subfocus on neuropsychological deficits among children of alcoholics in comparison with other groups (Tarter, Hegedus,

Goldstein, Shelley, & Alterman, 1984; Steinhausen, Gobel, & Nestler, 1984). Schuckit & Chiles (1978) compared children of alcoholic and antisocial parents with three other groups: children of affective disorder parents, children of divorced and nondivorced parents without a psychological diagnosis. Of all the groups, children of alcoholic and antisocial parents had the lowest grade average in school and the highest percentage repeating a grade in school.

Researchers have only recently begun to examine or address the emotional, psychological and interpersonal consequences of being a child of an alcoholic. Despite numerous assertions in the literature that children of alcoholics experience intense social and interpersonal difficulties, few investigators have examined this issue empirically. The literature on children of alcoholics has been described as relatively small and methodologically weak, with few well-controlled studies available (Jacob 1980; West & Prinz 1987). Those empirical studies that do exist focus primarily on young children, despite the fact that clinicians report a growing trend towards treating and identifying numerous issues found in children of alcoholic parents as they reach adulthood and have difficulties coping with their lives. Even fewer empirical studies exist on adult children of alcoholics, although there are numerous books written by clinicians stating that adult children of

alcoholics indeed have common, identifiable psychological characteristics.

CHAPTER II

REVIEW OF THE LITERATURE

Alcoholism and the Family

Many researchers view alcoholism from a family systems perspective, stating that all members of an alcoholic's family are affected by alcoholism--emotionally, economically, socially, and often physically (Fox, 1962). From a family systems perspective, all family members are as involved with the disease as the alcoholic, and certain behaviors, defenses and symptoms develop as the individuals focus their lives upon the alcoholic, often ignoring their own and other family members' needs. The responses and defenses they use to survive in the home often become constraining and dysfunctional in the outside world.

The effects of alcoholism on family functioning is documented by a sizeable clinical literature and a small body of empirical literature. Although family systems theorists and family therapists differ on their formulations of alcohol's effects on the family, they agree that in many families alcoholism becomes such a central part of the family system that it is an organizing factor in the system and is maintained by the family system's homeostatic mechanisms (Ackerman, 1983; Kaufman, 1984). " A family with alcoholism ceases to provide

the stable social and economic environment that the well functioning family provides for its members: an environment in which family members' roles and responsibilities are clear, appropriate, and provide for mutual love, esteem, and needs for dependency and independence (Tharinger & Koranek, 1988).

According to Wegscheider (1981), it is the alcoholic who sets the unspoken rules for the alcoholic family system because it is to the alcoholic that the other family members must adjust. Many of the unspoken rules serve the purpose of denial, which is the pervasive defense in the alcoholic family system. Thus, children growing up in such a family are exposed to an environment that fails to confirm their experience. Black (1981) sums it up with one rule: " Don't think; don't talk (about it, within or to anyone outside the family); don't feel" (p. 14). In general, the family atmosphere is characterized by chaos and unpredictability. There is an inconsistency of behavioral expectations and limits, responsiveness to communication and interactions, and physical and emotional care (Beletsis & Brown, 1981).

Benson (1980) identified characteristics of the alcoholic family that create a negative influence on child development. These include a higher degree of parental conflict; less emotional support for the developing child; and inconsistent, unstable expectancies about love and affection in relationships with parents. It is documented that many children who

grow up in an alcoholic family have a chaotic and anxious experience of family life.

Jacob, Favorini, Meisel, & Anderson (1978) reviewed the literature on alcoholic families and found that there is more marital conflict in alcoholic marriages (Kammeier, 1971; Wilson & Orford, 1978). In alcoholic families, parents' ability to provide fair and consistent discipline is significantly impaired (Beletsis & Brown, 1981). In his study of U.S. Navy families, Ellwood (1980) compared alcoholic parents with non-alcoholic parents and found more abusive upbringing and marital discord for the alcoholic parents.

Some investigators have attempted to assess the impact of the alcoholic family's home environment and interaction style on the children (Moos & Billings, 1982; Moos & Moos (1984). In Moos & Billing's (1982) comparison of non-alcoholic and alcoholic families using the Family Environment Scale (FES), alcoholic families had lower cohesion, expressiveness, and husband-wife congruence. Filstead, McElfresh, & Anderson (1981) administered the FES to 42 families with an alcoholic member and compared them with reference families from Moos & Billings' (1982) and Moos & Moos' (1984) study. The alcoholic families exhibited less cohesion, expressiveness, independence, intellectual-cultural orientation, recreational orientation, and had greater conflict. Clair & Genest's (1987) study replicated these findings that alcoholic families were

more dysfunctional and provided less guidance than nonalcoholic families.

West & Prinz (1987) concluded in a recent review of the literature that parental alcoholism is undoubtedly disruptive to family life and contend that the effects of parental alcoholism need to be viewed within a theoretical framework that considers multiple sources of stress on children.

Lund & Landesman-Dwyer (1979) and Tarter et al. (1984) report a higher incidence of child abuse in alcoholic families as compared with families with no parental alcoholism. Lund & Landesman-Dwyer (1979) analyzed data obtained on the Devereux Adolescent Behavior Rating Scale for 1013 adolescents (two-thirds male) in residential treatment facilities. There were differences in the group with an alcoholic parent from those raised in nonalcoholic homes. The researchers summarized these findings: "These males appeared to have a greater need for adult support, approval, or some type of dependent relationship, while at the same time showing an increased tendency to assert themselves physically and socially" (p. 347). In the same sample, the children of alcoholics were also significantly more likely to have experienced physical abuse, neglect, inadequate supervision, as well as parental conflict, divorce, imprisonment, or financial problems. It is thus important to attend to secondary factors caused by the alcoholism or as a result of being reared in any dysfunctional

family system.

In a survey of records from a child guidance clinic, Chafetz, Blane & Hill (1971) compared demographic and clinical data on 100 children of alcoholics and 100 children of psychiatrically disturbed nonalcoholics. The alcoholic's families had significantly higher rates of instability (marital problems, separation and lower family income). Although children of alcoholics were similar to the children in the nonalcoholic group, they were significantly more likely to have school problems, accidents or problems with police or courts. The authors cited "distinct and deleterious social consequences" to being the child of an alcoholic, though Jacob, Favorini, Meisel, & Anderson (1987) state that it is "not clear whether these consequences result from the alcoholism or from the higher incidence of family instability".

Children of Alcoholics

Fine, Yudin, Holmes, & Heinemann (1976) used the Devereux Behavior Rating Scales to compare 39 children who had a parent in treatment for alcoholism with 39 children who had a parent in outpatient treatment for some other psychiatric disorder. Both of these groups were compared with 523 children in a normative group. The groups were matched for age, sex, race, family size and socioeconomic status. Pre-adolescent children of alcoholics (ages 8 to 12) showed significantly more

emotional detachment, dependency, and social aggression than children from nonalcoholic families in both other groups. Compared with adolescent children of counseled parents and normal adolescents, children of alcoholics showed significantly more pathology than either group of adolescents.

Jacob & Leonard (1986) completed a more recent study comparing the psychosocial functioning in children (ages 10 to 18) of alcoholic fathers, depressed fathers, and control fathers using the Child Behavior Checklist and Conner Teacher Rating Scales. In this study, children of alcoholics and depressed parents were rated higher on behavior problems by parents than the children of controls; however, only a minority of these children received scores indicative of severe impairment.

Miller & Tuchfeld (1986) contend that children of alcoholics lack a consistent model of adulthood and of healthy relationships, have an unpredictable and often chaotic early home life, learn early to actively deny issues and feelings, and are often forced to assume adult responsibilities which often results in their bypassing the status and experience of being a child. Woititz (1984), in a summary of the literature of alcoholism and the family states that there are certain predominant patterns of characteristics of alcoholic parents. These include excessive dependency, emotional immaturity, low frustration tolerance, inability to express emotions, high

level of anxiety in interpersonal relationships, low self-esteem, feelings of isolation, perfectionism, guilt, ambivalence toward authority, compulsiveness, grandiosity, and sex role confusion. The children experience distorted role models and thus have difficulty with identification and assumption of roles later in life.

Roles and Psychosocial Development

Several authors have postulated stage theories pertinent to children of alcoholics in an attempt to provide a theoretical framework to view the problems that children of alcoholics exhibit. Beletsis & Brown (1981) modified both Erikson and Mahler's theories of psychosocial development to explain what happens to children of alcoholics. Either from the mother's own alcoholism or her preoccupation/concern for her partner's alcoholism, the child's loss of input or responsiveness from the mother at early developmental stages results in serious consequences. "It is the failure to develop basic trust in the early months of life which is the precursor of more severe problems with interpersonal relationships, inability to tolerate intimacy, and confusion over the locus of control. Further, in the alcoholic family, the parents' ability to provide fair and consistent discipline and flexible and loving control which is supportive of the child's growing need for autonomy

is severely impaired" (Beletsis & Brown, p.189).

By the time a child in an alcoholic family reaches school age, the child's needs and behaviors are increasingly dictated by the state of the alcoholic as well as the nonalcoholic's level of involvement. Defensively, control becomes increasingly important as the child attempts to manage the actions and responses of others. Competence is driven by necessity and anxiety, as many children adopt a parental role in tending to the house, younger children, and often to caretaking the alcoholic parent him/herself. "It is not surprising that the outward appearance of this child, school performance, responsibility and apparent maturity, is very often the result of the development of a "false self", different from the subjective experience of doubt, inadequacy, and an overwhelming feeling of responsibility" (Beletsis & Brown, 1981, p. 193). Brown (1988) contends that whether one or both parents is alcoholic, the impact of the problem and the obsession with alcohol makes it likely that neither parent has been available as an appropriate role model throughout childhood.

Nardi (1981) states that a central finding that emerges in studies on children of alcoholics is the child's perception of confused and inconsistent expectations. " This operates in two ways: confusion and uncertainty concerning both the role the parent is playing (drunk or sober, angry or happy, passive or violent) and the role the child is enacting (surrogate

parent or child, independent or dependent). The child finds it difficult to anticipate or discern conditions and to play the role the situation demands. Woititz (1978) describes both role confusion and role reversal in these families. Confusion results when the childrens' roles are constantly changing: behavior acceptable one day may be punished the next. Role reversal occurs when the parent becomes the helpless one and the children take on parental responsibilities.

Problems in identifying with an alcoholic parent were noted by Nardi (1981) and Richards (1977) and concerns for gender identity and sex role development are discussed by numerous authors (Hecht, 1973). Evidence from studies on adult children of alcoholics suggests that there is usually a primary identification (often unconscious) with the alcoholic, someone who is out of control (Beletsis & Brown, 1981). The child may act on the identification with the alcoholic by becoming delinquent or abusing drugs and alcohol. If the anger and contempt for the alcoholic is acknowledged, the child may identify with the nonalcoholic parent as a victim. Often, the nonalcoholic parent is seen by the child as critical, depressed and the cause of the drinking; thus the child may identify with the alcoholic. Many children are said to leave home early, often marrying a dependent spouse or an alcoholic (Beletsis & Brown, 1981; Nici, 1979). Morehouse (1984) contends that adult children of alcoholics will have problems in

identification and thus in identity formation; they reject familiar adult roles such as the alcoholic parent or the non-alcoholic spouse. Within the family, the child may be treated, at various times, like a parent, spouse or child, often resulting in serious identity and role confusion. These children then become overly dependent on peers for a sense of identity. Cermak & Brown (1982) stress that the child is not only denied the intimacy and structure of a normal parent-child relationship, but that childhood itself is often "aborted".

Personality Characteristics

A growing body of literature supports the fact that children of alcoholics have major personality difficulties. Margaret Cork (1969) interviewed 115 children with alcoholic parents. She found that these children were self-blaming, overly concerned and worried a great deal about their alcoholic parents and family life. They also exhibited a multitude of personality and behavioral problems. Other research that followed reported that children of alcoholics have lowered self-esteem and are prone to negative moods (Hughes, 1977; Anderson & Quast, 1983); serious role confusion (Nardi, 1988); manifest hostility, impulsiveness, and depression (Sloboda, 1974).

Kern, Hassett, Collipp, Bridges, Solomon, & Condren (1981)

compared children of alcoholics in treatment with children of nonalcoholics from the same population, using the Nowicki-Strickland Locus of Control Scale for Children. They found that children of alcoholics scored significantly higher in external locus of control. Becker & Miller (1978) state that children of alcoholics are more likely to be expelled from school, to leave high school prior to graduation, and to receive school counseling for psychological problems. They are also more likely to experience serious illnesses, accidents and problems with the police or courts than children from nonalcoholic families (Chafetz, Blane & Hill, 1971). Impaired peer relationships are frequently reported and there are consistent reports of lack of close friendships (Wilson & Orford, 1978). Jacob, et al. (1978) and Haberman (1966) report elevated rates of depression, dependency and emotional detachment in the children of alcoholics. Fewer social competencies, more aggressiveness and behavior problems are reported by Jacob & Leonard (1986); McKenna & Pickens (1983) found that children of alcoholics had increased scale four elevations on the MMPI, indicating more hostility and aggressiveness.

Werner & Smith (1982)'s information obtained from a subsample from their longitudinal study of children at risk in Hawaii shows that by the time children from alcoholic families reached 18, 30% had records of repeated or serious delinquencies, and 25% had serious mental health problems requiring in

or outpatient care. This proportion was almost three times as high as that of offspring of parents who were nonalcoholic.

Adult Children of Alcoholics

Clinical reports have suggested that by the time children of alcoholics reach adulthood, they exhibit problems in personality development, identity formation, role performance and the ability to form relationships. At a general level of functioning, the greater inconsistency and unpredictability of parental expectations and support in alcoholic families is thought to affect the children's sense of trust, security, self-esteem and confidence in others (Fox, 1962). Clinicians repeatedly describe the following issues and personality characteristics that they see in adult children of alcoholics:

1. Inability to trust others. Their behavior is overly self-reliant (Cermak & Brown, 1982; Black, 1982).

2. Excessive sense of personal responsibility. (Black, 1982; Woititz, 1984).

3. Denial of their own needs. They hesitate to ask others for help and often appear emotionally distant from others. They have difficulty maintaining intimate relationships and engaging in relationships where their own needs are met (Wegscheider, 1981; Usher, Jay &

Glass, 1982).

4. They are out of touch with their own feelings and have difficulty identifying and expressing feelings and emotions. According to Cermak & Brown (1982)'s clinical observations, children of alcoholics distrust not only their feelings, but the validity of their perceptions. Children who confront parents about their alcoholism are often told that it isn't true, that they see incorrectly or are bad for noticing at all." The result is that adult children of alcoholics continue to ignore direct experience in favor of the facade for the sake of maintaining an extremely tenuous status quo" (Cermak & Brown, 1982, p. 380).

5. Conflicts surrounding issues of control are pervasive. Clinicians report that adult children of alcoholics have a profound need to control situations and relationships Beletsis & Brown, 1981; Cermak & Brown, 1982; Wegscheider, 1981).

6. Compulsive need for approval. They display an exaggerated need to please others to gain approval. Difficulty maintaining satisfactory relationships often causes a shift to focus on work and school as the primary areas in which to build self-esteem (Woititz, 1987; Ackerman,

1986).

7. Frequent depression. They are prone to frequent feelings of depression, often accompanied by a pervasive sense of guilt, fear and powerlessness (Black, Bucky, & Wilder-Padilla, 1986).

From their work with adult children of alcoholics, Cermak & Brown (1980) identified five central issues that many children of alcoholics face. It is their contention that control of environment, self, and others is so pervasive that it influences the other major issues which include mistrusting, ignoring personal needs, denying feelings, and being unable to define or limit responsibility. Trusting others is equivalent to giving them control. "This reflects the early experience in the child's relationships with the family. It is safer to remain in control, not reveal pain or needs, as a defense against the unpredictable, insensitive, or destructive response" (Beletsis & Brown, 1981, p.198).

Gravitz & Bowden (1984) have added another central issue of "all or none" functioning, or to think, feel, and behave in mutually exclusive terms (i.e., all good/bad or all right/wrong). Other issues they observed from their clinical work with adult children of alcoholics are: difficulties in establishing relationships, problems with self-esteem regulation, pervasive denial and dissociation of feelings from awareness.

In her book, Adult Children of Alcoholics, Janet Woititz discusses 13 traits that most children of alcoholics experience to some degree. According to her extensive clinical experience, children of alcoholics:

1. guess at what normal behavior is
2. have difficulty following a project from beginning to end
3. lie when it would be just as easy to tell the truth
4. judge themselves without mercy
5. have difficulty having fun
6. take themselves very seriously
7. have difficulty with intimate relationships
8. overreact to changes over which they have no control
9. constantly seek approval and affirmation
10. feel that they are different from other people
11. are super-responsible or super-irresponsible
12. are extremely loyal, even in the face of evidence that the loyalty is undeserved
13. tend to lock themselves into a course of action without giving consideration to the consequences

Black (1979) has applied Adler's birth order and family systems theory to identify specific role patterns among the various reactions observed. Black (1979) states that the child with behavioral problems in the alcoholic home is in the minority. Yet, researchers tend to focus on this population. She goes on to state, as does Wegscheider (1981), that the

majority of children from alcoholic homes have asssumed the survival roles and therefore appear to be coping well. "It is only in adulthood that they may realize the useless aspect of these coping skills. Many feel depressed, lonely, unable to maintain intimate relationships, and that life has no meaning. Throughout their childhood, they learned not to feel or ventilate these feelings" (p.23). In attempting to explain how children's adaptive behaviors become habitual in the alcoholic family, Black (1985) described four roles that children of alcoholics assume: the Responsible Child, the Adjuster, the Placater, and the Acting Out Child. Children tend to adopt one or a combination of these roles. These roles are compensatory reactions to the parental alcoholism that permit the children to cope with their everyday life and to maintain a sense of emotional balance. They are often admired, praised and rewarded for these roles.

The "Responsible one" is often the oldest child, who frequently takes on parental responsibilities and a great deal of responsibility for him/herself and others in the family. The "Responsible one" seldom misbehaves and makes it easier for the parents by allowing the alcoholic to stay preoccupied with the drinking and the spouse to be more preoccupied with the alcoholic. This role brings a certain stability, comfort and sense of worth to the child. He/she relies completely on him/herself and believes that other adults, like his/her par-

ents, will be unavailable to him/her when help is needed. This role becomes so consistent that the "Responsible one" is often an expert at planning, organizing and manipulating situations. This child will often excel at school, often occupying a leadership role or position.

The "Adjuster" is usually not the oldest or the only child. As the middle or younger child, he/she feels that it is easier to exist in the chaotic household by accepting whatever happens, often attempting to avoid thinking about it or to respond emotionally to it. He/she follows directions and adjusts to circumstances, often appearing more flexible than others, but is also more emotionally, socially and physically detached from other family members.

The "Placater" is adept at diverting attention from him/herself and focusing it onto others. Black (1985) refers to the "Placater" as "the household social worker or caretaker"; the child who was busy taking care of everyone else's emotional needs. This individual is extremely sensitive and tuned into others' feelings and tries to reduce the pain and discomfort in the home by making others feel better. His/her behavior centers around pleasing others and gaining their approval; as an adult, others continue to see him/her as a nice person who is skilled at listening and communicating concern for others, but they pay a price for the imbalance of focus (Black,1985).

The "Acting Out Child" acted out his/her confusion and anxiety about situations at home in ways that bring him/her a great deal of negative attention. They could not survive in the other roles which cause less disruption. All these characteristics taken on by children to cope with events in the alcoholic family are valuable and constructive in the context of their childhood situations; however, over-development of these behaviors often results in psychological and emotional gaps in personality development and adult roles. In adulthood, these roles continue and often lead to unhealthy extremes. Unless the child of an alcoholic relearns what they have learned in the early environment that supports their sense of self and competency, the effects of growing up in the alcoholic home begin to become apparent when the child reaches young adulthood (Black, 1981).

Black et al.'s (1986) recent study of 409 adult children of alcoholics and 179 adults raised in nonalcoholic families who filled out questionnaires that focused on family history, past and present drug and alcohol use, problems growing up, communication with significant others, and items on physical and sexual abuse. The data were analyzed by means of a frequency count, percentages, chi-square tests, t-tests, and z tests for proportionality. The adults who were raised in alcoholic families reported significantly less utilization of interpersonal resources as a child; had significantly more

family disruptions characterized by a higher divorce rate and premature parental and sibling death; reported more emotional and psychological problems in adulthood; experienced more physical and sexual abuse as children; and more frequently became alcoholic and married alcoholics as compared to adults raised in nonalcoholic families.

Mediating Factors

There has been a recent focus towards identifying the variables that both contribute to and mediate different adaptations evidenced by children of alcoholics. As mentioned above, children raised in the same home often show different roles or coping strategies; many do not seek treatment and appear to have survived relatively well, while others are markedly impaired from the same set of circumstances. A national Adult Children of Alcoholics Research Study was conducted by Ackerman in 1987 which polled 500 adult children of alcoholics and 500 adults raised by nonalcoholic parents in an effort to examine the effects of exposure to parental alcoholism, and also to explore what may have contributed to differences among children of alcoholics. The following intervening variables were assessed:

1. The degree of alcoholism and its effects on parenting.
    a. What type of alcoholic parent did the child have?

b. What was the alcoholic's behavior while drinking? In the 1987 study, verbal belligerence was the most common form of behavior identified, with 84% of adult children of alcoholics stating that this behavior affected them greatly. However, 88.5% stated that offensive behavior by the alcoholic affected them most. Whether or not the parent drinks daily or is a binge drinker may also affect the adaptation and response by the child.

2. Different reactions to stress. According to Brenner (1984), the characteristics of children vulnerable to the negative aspects of stress develop characteristics such as: becoming overly sensitive and shy, moody, irritable, lonely; not able to make friends easily; constantly complaining; and easily angered. Children who are extremely vulnerable to stress are often withdrawn and preoccupied, frequently sick without organic cause, secretive, noncommunicative, belligerent, and prone to frequent nightmares. Some children show resiliency or invulnerabilty to stress (Anthony, 1984; Werner & Smith, 1984) by knowing how to attract and use the support of adults, and those who develop a high degree of autonomy early in life and get involved in numerous activities and projects.

Four common ways for children to handle stress are: denial, regression, withdrawal, and impulsive acting out (Ackerman, 1987). All of these behaviors have been cited

in research on children of alcoholics, from clinical reports to types of roles adopted (Black, 1985; Wegsheider, 1981) and behavioral and personality characteristics.

3. Age of exposure to parental alcoholism. It is generally thought that the younger the age of exposure, the more damaging the implications for personality growth and development. Fox (1962) identifies children's age at onset of parental alcoholism as a crucial factor in development. Chafetz (1979) notes that parental alcoholism may be more damaging for the young child who has no other role model and suggests that if parental alcoholism is delayed until the child reaches adolescence, when life values and attitudes have formed, the effects of parental drinking may not be as harmful.

4. Availablity of outside social support. In the majority of alcoholic families, there is often minimal outside social support available, as these families are often socially isolated from others in order to maintain the alcoholic's behavior and avoid disclosure or embarrassment of family members. Obuchowska (1974) found that a satisfying emotional contact with one's nonalcoholic mother may lessen the negative consequences of having an alcoholic father. In her study, children of alcoholic fathers who

also had a good emotional relationship with their mother compensated for home troubles by seeking affiliation and achieving results at school.

Other authors have recently added several other mediating factors that must be addressed:

5. Sex of child and alcoholic parent. The son of an alcoholic mother is affected differently from a daughter and vice-versa. Many researchers postulate that daughters of alcoholic mothers suffer the most deleterious effects (Seixas & Youcha, 1985). In addition, female children are often pushed into caretaking roles, while males are encouraged to adopt other means of coping.

6. Birth order. Most researchers feel that the younger a child is when alcoholism begins to affect family life, the more detrimental it will be to the child's health and development. Based on her research, Cork (1969) hypothesizes that younger children may be somewhat protected from the high amount of chaos in the home if they can develop closeness with older siblings.

7. Social and Economic status. The family that has financial resources and social stability is likely to weather the strain of an active alcoholic more successfully than one with few resources.

8. Aspects of the family functioning have been addressed by Tharinger and Koranek (1988). Variables include the quality and stability of the family as a caregiving environment, presence of other abuse in the family (spouse abuse and physical/sexual abuse) and degree of family isolation.

Lawson, Peterson & Lawson (1983) describe the child of alcoholics who is most at risk as: 1) children from a lower socioeconomic group who have 2) witnessed or experienced physical abuse, 3) were less than six years old at the onset of parental alcohol abuse, 4) were either an only or oldest child, and may be described as 5) lacking any supportive family situation.

Other authors (Wegscheider, 1981; Whitfield, 1984; Ackerman, 1986; Woititz, 1984) have discussed variations of these same issues, but most of this is based on clinical and anecdotal information. Often, hypotheses are drawn from individual testimonials, interviews and random questionnaires. Adult children of alcoholics are increasingly recognized as a relevant clinical population and may manifest symptoms that are subject to misdiagnosis (Miller & Tuchfield, 1986). Despite the consensus among clinicians that many adult children of alcoholics are severely impaired, relatively few empirical studies have examined this issue (as reviewed by El-

Guebaly & Offord, 1977; West & Prinz, 1987; Jacob et al., 1978).

Furthermore, most studies in this literature have been characterized by major methodological problems (Jacob & Leonard, 1986). In most investigations reviewed, conclusions about parent-child and family relationships were based on indirect, self-report procedures and surveys which have been described as methodologically weak and difficult to interpret (Frank, 1965; Jacob, 1975).

From the preceding review of relevant theories and research on adult children of alcoholics, it is readily apparent that there is a great need for future research to empirically validate the personality characteristics and roles that clinicians postulate. Secondly, are these characteristics and roles different from adults raised in nonalcoholic families? In addition, attention needs to focus on the mediating factors to assess their impact on the nature of these personality roles and characteristics.

Purpose of the Study

The purpose of this study was to clarify and attempt to empirically validate whether adult children of alcoholics exhibit identifiable, significant differences in personality characteristics from the normal population. The study attempted to examine these personality variables on three levels:

the surface presentation to others (primarily measured by the MMPI), the individual's perception of him/herself and others (measured by the Interpersonal Checklist) and to examine an underlying characterological or personality style (measured by the Leary summary points). In addition, comparisons were made of the individual's similarities to each of their parents on an interpersonal level in order to ascertain which parent (if any) they identify with the most.

These data will help to establish a beginning empirical basis for the characteristics described by numerous authors, speakers and clinicians as well as to present a comprehensive picture of the personality variables of adult children of alcoholics. The three levels are particularly suited to discerning personality variables of this subject group, as they are often described as presenting a "false self" or trying to appear competent and in control to others, when they really have low self esteem, feel vulnerable and unable to trust others (Beletsis & Brown, 1981).

Hypotheses

The following hypotheses were generated:

HYPOTHESIS 1: Children of alcoholics will place primarily in Octants 1, 2, 7, and 8 on Level 1s (public behavior). They will appear to others as self-reliant

and independent (2); as liking responsibility, managing others (1); as taking care of others, over-protective (8); over-eager to get along with others (7). Control subjects will have significantly fewer scores in these octants than ACOAs.

HYPOTHESIS 2: Children of alcoholics will place in Octants 4, 5, and 6 on Level IIImm. They will show underlying distrust of others (4); and lack self-confidence and self-esteem (5); show underlying dependent character structure (6). Control subjects will place in random octants, with fewer scores in 4, 5, and 6.

HYPOTHESIS 3: Children of alcoholics will have fewer matching octants with their parents than will control subjects on Leary level IIs. (ACOAs will have less parental identification than controls).

HYPOTHESIS 4: Adult children of alcoholics will have significantly higher MMPI scores than control subjects, except on the Ego Strength Scale, where their scores will be significantly lower than control scores.

CHAPTER III

METHOD

Subjects

Subjects for this study included 30 adult female volunteers who had alcoholic fathers and 30 adult female volunteers with neither parent alcoholic. Subjects were matched for age, education and socioeconomic status. The age range was from 25 to 50. Subjects who indicated that both parents were alcoholic or who had an alcoholic mother were excluded from the study. Subjects were recruited from ads in local newspapers, evening school classes at the University of Tennessee and announcements at a public seminar for adult children of alcoholics presented by Peninsula Hospital in Knoxville, Tennessee.

Procedure

All subjects signed consent forms prior to participating in the study. They were identified only by number and were separated into groups by their scores on the C.A.S.T. Each subject completed all measures in one session.

Evening school students received extra credit for their participation in the study. All subjects were told that they could receive copies of group results when the study was completed by giving their name and address to the person super-

vising the administration of the tests.

Measures

Each subject was administered four instruments. The first was the Children of Alcoholic Screening Test (CAST), a screening measure developed by J. W. Jones (Jones, 1981; Pilat & Jones, 1985) to identify children of alcoholics. The other measures were the MMPI and the Interpersonal Checklist, which are part of the Leary Battery of tests (Leary, 1956), and a personal data sheet.

Children of Alcoholics Screening Test (CAST)

The CAST is a 30-item inventory that measures adult children's feelings, attitudes, perceptions and experiences related to their parents' drinking behavior (see Appendix A). The test items were formulated from real-life experiences that were shared by clinically diagnosed children of alcoholics during group therapy from published case studies (Jones, 1981).

The CAST measures:

1. children's emotional distress associated with a parent's alcohol use
2. perception of drinking-related marital discord between their parents
3. attempts to control a parent's drinking
4. efforts to escape alcoholism
5. exposure to drinking-related family violence

6. tendencies to perceive their parents as being alcoholic
7. desire for help to deal with parents' drinking

The CAST can be used to identify latency-age, adolescent and adult children of alcoholics. Children nine years of age and older can usually complete the CAST with little or no assistance. All yes answers are tabulated to yield a total score. The total score can range from zero (no experience with parental alcohol misuse) to 30 (multiple experiences with parental alcohol abuse). Validity coefficients based on several studies yielded a validity coefficient of .78 ($p <= .0001$). It was also found that a cutoff score of six or more reliably identified 100 percent of the clinically diagnosed children of alcoholics and 100 percent of the self-reported children of alcoholics. A Spearman-Brown split half (odd vs. even) reliability coefficient of .98 was obtained.

MMPI

The Minnesota Multiphasic Personality Interview (MMPI) is the most widely used and researched objective personality measure (Greene, 1980). It consists of 550 true-false statements. The person's responses to these statements are scored on ten clinical scales that assess major categories of behavior. The test is self-administered and is scored by hand or by a computer scoring system. Most people with six to eight years of education can take the MMPI with little difficulty. For

this study, the ten basic clinical scales were utilized in addition to three newer scales (see below). All raw scores on scales were converted to T-scores, with T-scores of 44 and below considered to be low scores, 45 to 59 considered normal scores, 60 to 69 as moderate scores, and scores above 70 as marked elevations.

A brief description of the content of these scales is presented below. More comprehensive and detailed information can be found in Greene (1980) and Lachar (1974).

Scale 1 - Hypochondriasis

A wide variety of questions pertaining to body functioning are tapped by the items on Scale 1. Moderate scores (T scores of 60-69) indicate concern about body functioning, a lack of psychological sophistication, and a tendency to use somatization and repression to cope with tensions and conflicts (Lachar,1974, p. 43).

Scale 2 - Depression

The items on scale 2 measure symptomatic depression, and how comfortable or secure one feels about him/herself and the environment, with higher scores indicating dissatisfaction (Greene, 1980, p. 73). An elevated score on scale 2 reveals that the subject is upset and feeling depressed about something. As scores increase, the pessimism, depression, and hopelessness begin to affect the subject's entire life (Greene, 1980, p. 77).

Scale 3 - Hysteria

The items on scale 3 consist of two types that are closely related in persons thought to have a "hysterical personality" type (Greene, 1980, p. 77). Items measure specific somatic complaints and items that suggest a facade of superior psychological adjustment. Moderate score elevations suggest people who are naive, self-centered and deny problems, preferring to avoid unpleasant issues and extensive self-examination.

Scale 4 - Psychopathic Deviate

Items on this scale are associated with a lack of social conformity, general social maladjustment and score elevations often indicate rebelliousness, poor adjustment to authority figures, and impulsivity. High scorers often present a superficial social facade to others, which often recedes in longer interactions with others and in times of stress (Lachar, 1974, p. 79).

Scale 5 - Masculinity/Femininity

The items on this scale assess interests, preferences, personal sensitivity and passivity (Greene, 1980, p. 89). Women who score low on this scale strongly identify with the traditional feminine role, interests and activities and are often more passive than high scorers (Greene, 1980, p. 95).

Scale 6 - Paranoia

Items on scale 6 measure interpersonal sensitivity, suspiciousness, and guardedness (Greene, 1980, p. 96). Moderate elevations indicate subjects who are interpersonally sensitive, and those who may be overly sensitive to criticism, who often personalize the actions of others towards themselves.

Scale 7 - Psychasthenia

Items on this scale are designed to assess anxiety, self-doubt, guilt, worry, and rumination (Lachar, 1974, p. 11). High scoring females are desribed as being prone to worry, emotional, high strung, and generally dissatisfied with themselves (Greene, 1980, p. 101).

Scale 8 - Schizophrenia

The items on this scale measure a wide variety of areas, including bizarre thought processes, social alienation, difficulties in concentration and impulse control, problems with self-identity and self-worth, and sexual difficulties (Greene, 1980, p. 102). High scorers on Scale 8 are described as apathetic, alienated, misunderstood, and have difficulties in thinking and communication. They tend to avoid reality through fantasy and daydreams.

Scale 9 - Hypomania

The items on Scale 9 measure psychomotor excitement, elated but unstable mood, grandiosity, egocentricity, and irritability. Moderate elevations indicate people who are active, outgoing, and energetic. External restrictions on their activity level may result in agitation and overtly expressed dissatisfaction (Greene, 1980, p. 109).

Scale 10 - Social Introversion

Items on this scale assess the social introversion-extroversion dimension with high scores reflecting social introversion. The social introvert is uncomfortable in social interactions and typically withdraws when possible (Greene, 1980, p. 113).

Repression Scale

Major content areas assessed by this scale include the denial of health and physical problems, willingness to acknowledge and discuss problems, and use of conscious supression or actual denial and repression. High scorers appear constricted, overcontrolled and lack insight into their own behavior. They are unwilling to discuss any form of psychopathology (Greene, 1980, p. 188)

Ego Strength Scale

Barron (1953) developed this scale to assess latent ego strength, which is described as possessing sufficient, flexible internal resources to cope with everyday demands. Subjects with high ego strength scores indicate that they have the appropriate internal resources and ability to deal with their problems.

MacAndrew Alcoholism Scale

This scale was developed to assess the likelihood or potential for alcohol or substance abuse in subjects. Research has consistently shown that the MAC scale will differentiate alcoholic from nonalcoholic patients (cited in Greene, 1980, p. 194). High scorers are described as being very likely to abuse alcohol or other drugs.

Interpersonal Checklist

The Interpersonal Checklist (ICL) devised by La Forge and Suczek (1955) Form IV was also administered to all subjects (see Appendix B). It is a self-administered test which consists of 128 adjectives thought to be descriptive of an individual's personality style and interpersonal behavior. The ICL's adjectives are grouped into eight categories, or octants, with 16 in each octant.

All responses were scored according to the system devised by Leary (1956, 1957). A set of interpersonal variables listed in a circular continuum was used to categorize behavior at all levels. The circle is conceived as a two-dimensional grid with the vertical axis measuring Dominance-Submission and the horizontal axis measuring Love-Hate. It is divided into eight segments with each octant representing characteristic ways of relating to others. Octant 1 is at the top of the circle with each succeeding octant moving in a counter-clockwise direction through Octant 8 (see Figure 1).

These eight octants have been labeled as:

OCTANT 1 Managerial/Autocratic

OCTANT 2 Competitive/Narcissistic

OCTANT 3 Aggressive/Sadistic

OCTANT 4 Rebellious/Distrustful

OCTANT 5 Self-Effacing/Masochistic

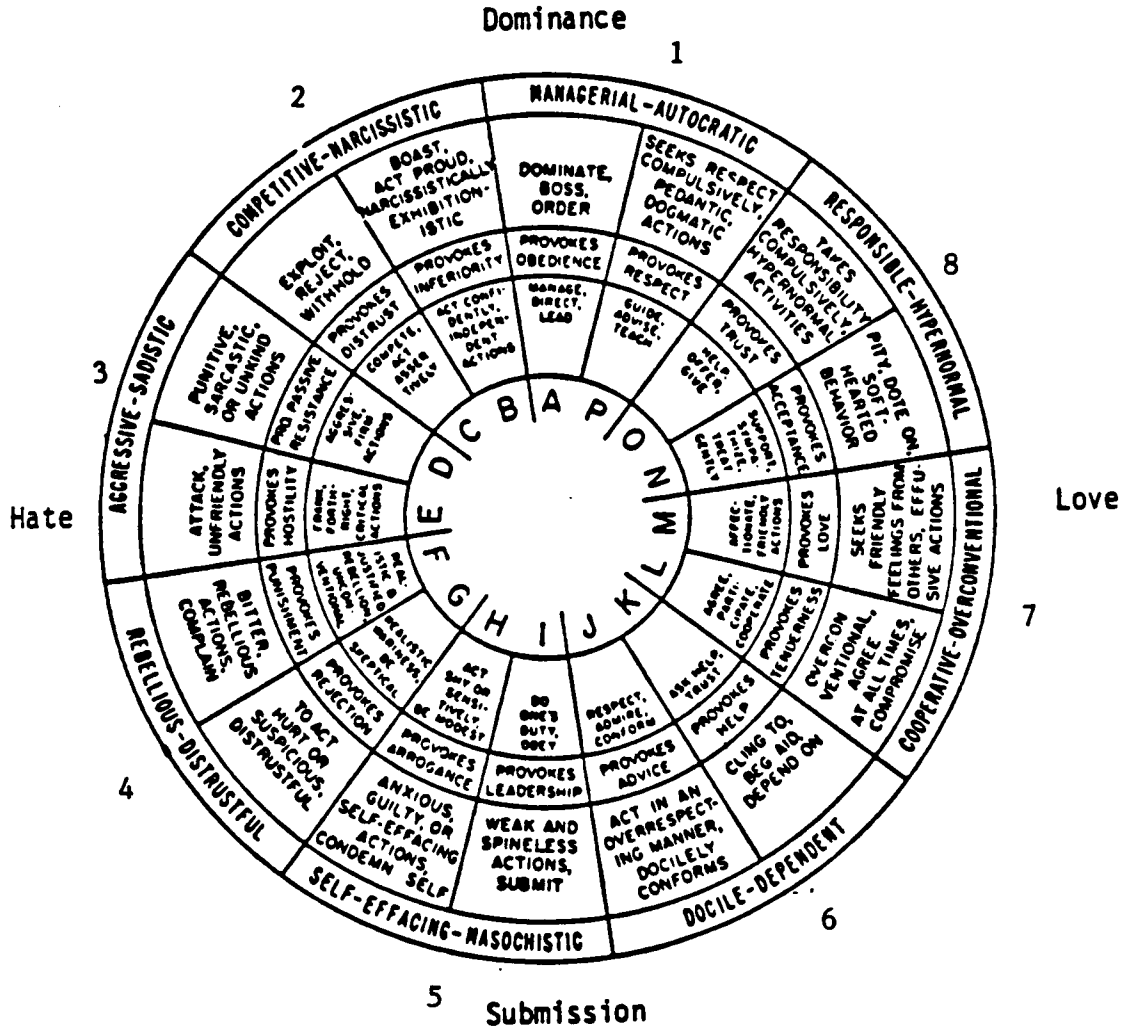


Figure 1. Leary Classification of Interpersonal Behavior

OCTANT 6 Docile/Dependent

OCTANT 7 Cooperative/Overconventional

OCTANT 8 Responsible/Hypernormal

The adjectives within these 8 octants range in intensity from a mild to an extreme characterization of a given personality trait. Ratings were gathered for self, mother and father. Reliability and validity coefficients for the ICL range from .62 to .95, indicating that it is a methodologically sound, reliable and valid instrument (La Forge & Suczek, 1955). Evidence for the ICL's split-half reliability was provided by Angleitner (1977) and for its internal consistency by Armstrong (1958). Meers & Neuringer (1967) found concurrent validation of ICL measures of adherence to social conventions by several independent measures of social desirability and social adherence; Hamilton (1971) found convergent validation of ICL dominance scores with three other measures of dominance.

The Leary System

The Leary system was chosen because it presents a multilevel view of a person's behavior. It was believed that this would offer more data about adult children of alcoholics because many researchers have discussed the "presentation of a false self, a competent self with few real feelings divulged

to others". The Leary system has been used to study a variety of populations in different settings. Cohen, White, and Schoolar (1971) differentiated between drug abusing vs. non-drug abusing patients; Bentler (1963) used the Leary to find differences between high hypnotic susceptibility and low hypnotic suceptibility; Waterhouse (1981) differentiated between high changers vs. low changers in psychotherapy; and Peabody (1981) found differences between successful therapy cases vs. premature terminators using this system.

Evidence of criterion-related validity for the Leary includes: a cross-validation between the Leary system (Level Is) and the Bales system of interaction process analysis (Scapinello & Sibbald, 1976); a study validating the use of the MMPI in the prediction of overt bahvior (Heintzelman, 1983); and a study validating the use of Level IIImm as a measure of the subject's approach (Basically cooperative or competitive) to their worlds (Warren, 1977).

Leary's system allows for the assessment of several levels of personality. The present study utilized the following three levels:

1. The level of public communication (Level I-s). This level "is concerned with the social impact that one human being has on another" (Leary, 1957, p. 91); it is how the individual appears to others. Expression at this level is spontaneous rather than deliberate.

2. The level of conscious communication (Level II-s). This level deals with the individual's conscious perception of himself or herself. At this level, we see how individuals choose to present themselves to the world; the focus is on how they perceive themselves and others. In this study, perceptions of self (II-S), mother (II-M) and father (II-F) were obtained.

3. The level of basic intentionality (Cohen, White, and Schoolar, 1971) in interpersonal behavior (Level IIImm). Briefly, basic intentionality is what one seeks (unconsciously) to accomplish with one's interpersonal behavior. This level has been described as the basic character structure that underlies any overt symptomatic adjustment (Leary, 1956).

Leary Scoring

The diagnosis of public communication (Level I-s) is obtained by substituting the appropriate MMPI- T scores in the following arithmetical formula: Dominance= (Ma-D) + (Hs-Pt) and Love= (K-F) + (Hy-Sc). These raw scores were converted into standard scores by reference to a table given in the manual (Leary, 1956). The standard scores were then used to plot the location of the summary point in one of the octants on the diagnostic grid.

To obtain Level II-s, scores are computed from the Interpersonal Checklist items. Of the 128 adjectives, there are 16

items for each octant. Total scores were substituted into a formula and converted to standard scores and plotted on the grid to obtain the octant placement.

Personal Data Sheet

This data sheet consisted of twenty-three questions on demographic information. It was designed to measure many of the mediating variables discussed above, in addition to pertinent data for matching subject variables in control and experimental groups (see Appendix C).

CHAPTER IV

RESULTS

Overview of Analysis

As stated in Chapter II, the purpose of this study was to empirically determine if adult children of alcoholics exhibit personality characteristics different from those exhibited in the normal population. In order to test the hypotheses proposed, the following statistical analyses were used: (1) chi-square analysis to test Hypotheses 1, 2 and 3; (2) t-tests to test Hypotheses 4 and to examine the mediating variables; and (3) analysis of variance (ANOVA) to separate out the interactions between mediating variables and other scores. Leary formulas were used to test Hypothesis 3.

Demographic Characteristics

Of the 60 subjects used in this study, exactly half (30) were adult children of alcoholics (ACOAS). For purposes of control, only ACOAs with alcoholic fathers were used. If both parents were alcoholic, if the mother was the alcoholic parent or if there was a long separation from the alcoholic parent during childhood, then the subject was not included in the study. The mean age for the ACOA sample was 35.83; the mean age for the non-ACOA group was 33.96. A t-test revealed no

significant differences in the two groups' mean ages (t=.9630, p= 0.3396).

Table 1 provides some descriptive statistics related to the ACOA sample. These frequency distributions provide the following overall picture of the ACOA sample: the majority are first born (43.3%) or second born (33.3%) children; the child's alcoholic parent received no treatment for his alcoholism (83.3%); and most of the alcoholic parents (83.3%) exhibited verbally belligerent behavior while drinking, were violent while drinking (63.3%), and were daily (vs. binge) drinkers (60%). In addition, while the quality of childcare in the home of the ACOA was generally described as medium, the level of family stability was usually described as low. Almost half (46.7%) of the ACOAs were born into alcoholic homes with almost all (86.7%) exposed to parental alcoholism before the age of 12. Slightly more than half (56.7%) of the subjects' parents are still drinking. The most common behavioral adaptation reported by ACOAs was either taking on a great deal of responsibilty in the home (40%) or detaching from family members (36.7%). Other studies of ACOAs (Ackerman, 1987; Black, Bucky, & Wilder-Padilla, 1986) have found similar profiles as the one described above.

The results of the statistical analyses used to test each of the five proposed hypotheses will be discussed in the following sections.

Table 1

Demographic Characteristics of ACOA Group

Variable		Frequency	Percentage
Birth Order			
	1st	13	43.3
	2nd	10	33.3
	3rd	3	10.0
	5th	3	10.0
	8th	1	3.3
Parent Treatment			
	Yes	5	16.7
	No	25	83.3
You Treatment			
	Yes	16	53.3
	No	14	46.7
Parental Behavior			
	Verbally Belligerent	25	83.3
	Offensive Behavior	5	16.7
Parental Violence			
	Yes	19	63.3
	No	11	36.7
Type Drinker			
	Daily	18	60.0
	Binge	12	40.0
Parent Still Drinking			
	Yes	17	56.7
	No	13	43.3

TABLE 1 (continued)

Variable		Frequency	Percentage
Quality of Child Care			
	Low	8	26.7
	Med	14	46.7
	High	8	26.7
Family Stability			
	Low	17	56.7
	Med	10	33.3
	High	3	10.0
Age Exposed To Parental Drinking			
	Born Into	14	46.7
	Age 1-5	7	23.3
	Age 6-12	6	20.0
	Age 13-17	2	6.7
	Age 17 +	1	3.3
How Did You Adapt?			
	Took On Much Responsibility	12	40.0
	Problem-causing Child	2	6.7
	Detatched from Family Members	11	36.7
	Other	5	16.7

Level 1s

The first hypothesis predicted that adult children of alcoholics would place primarily in Octants 1 (managerial/autocratic), 2 (competitive/narcissistic), 7 (cooperative/overconventional, and 8 (responsible/hypernormal) on Level 1s (public behavior). According to Leary (1957), this level is concerned with how the individual appears to others. In this case, it was expected that ACOAs would appear on the surface to others as liking responsibility and wanting to manage others (1), as self-reliant and independent (2), as being overly eager to get along with others (7) and wanting to take care of others and being overly protective (8). These predictions were based upon descriptions of ACOAs found in the literature reviewed in Chapter II. The Leary categorizes the behavior of subjects into one or more of the previously described octants. Because of the categorical nature of this data, chi-square analyses were used to determine if the observed frequency distribution among the octants differed from the expected distribution.

The frequency distribution of Level 1s for both the ACOA group and the control group is found in Table 2. A 2 X 8 chi-square analysis was performed and found to have a value of 13.3 which was significant at the .05 level. More specifically, what these results tell us is that there are significantly more ACOAs in Octants 3 and 4 than would be expected by

Table 2

Octant Frequencies and Percentages
for ACOAs and Control Groups on Level Is

	ACOA		CONTROL	
	Frequency	Percent	Frequency	Percent
Octant 1	8	26.7	17	56.0
Octant 2	5	16.7	3	10.0
Octant 3	6	20.0	0	0
Octant 4	4	13.3	1	3.3
Octant 5	1	3.3	1	3.3
Octant 6	0	0	1	3.3
Octant 7	1	3.3	0	0
Octant 8	5	16.7	7	23.3

$X^2 = 13.873$, $p = 0.053$

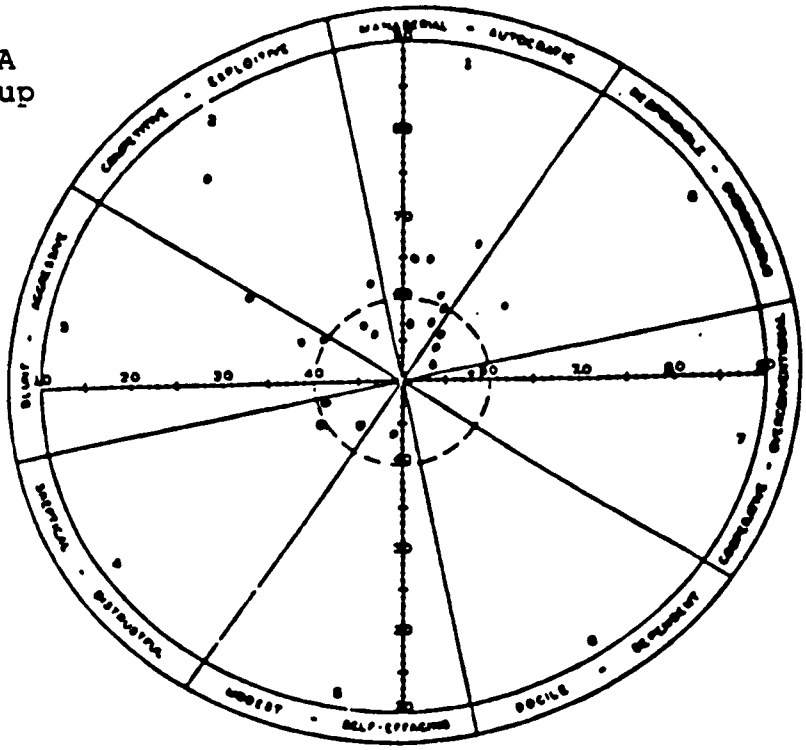
chance. In other words, ACOAS would appear on the surface to others as frank, forthright and at times, aggressive or hostile, in addition to being suspicious of others, touchy, and easily hurt. Also, there are significantly fewer ACOA subjects in Octant 1 than would be expected by chance, contrary to the hypothesis (see Figure 2).

While differences do exist, these differences are not the same as those proposed in Hypothesis 1; therefore, Hypothesis 1 is rejected. While the expected differences were not found, the differences that were found related to the ACOAs "public behavior" do offer further evidence that the ACOA does try to present a "false self" and tries to appear to be something he or she is not.

Level IIIMM

Hypothesis 2 was concerned with Level IIIMM of the Leary or the level of basic intentionality in interpersonal behavior. According to Leary (1956) this level describes the basic character structure which underlies any overt symptomatic adjustment. Hypothesis 2 predicted that adult children of alcoholics would place primarily in Octants 4 (rebellious/distrustful), 5 (self-effacing/masochistic), and 6 (docile/dependent) on Level IIImm. ACOAS would be expected to show underlying distrust of others (Octant 4); lack self-confidence and self-esteem (Octant 5); and show underlying dependent character structure (Octant 6).

ACOA group



Control group

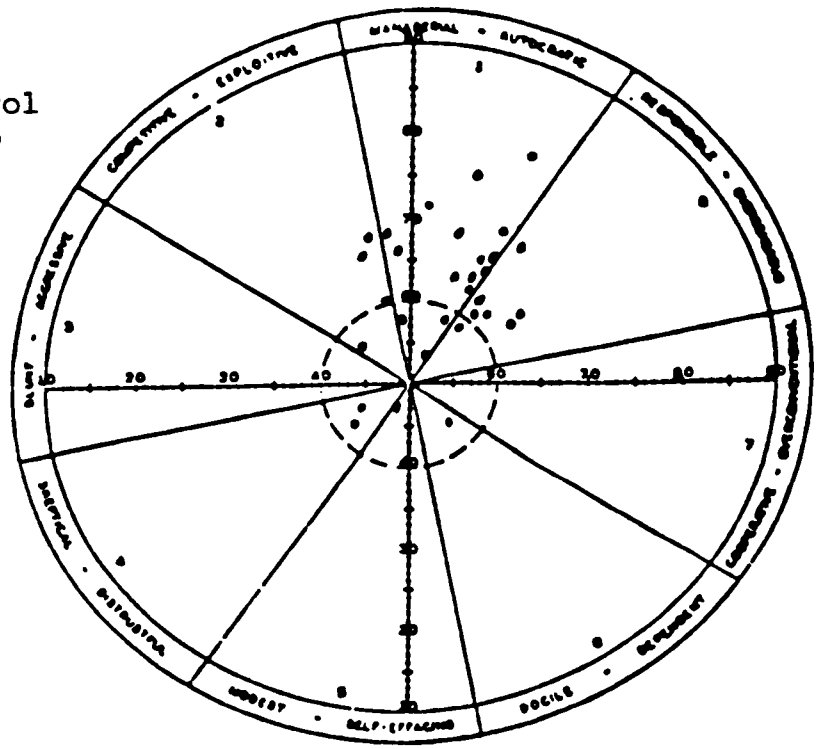


Figure 2. Level Is Summary Points for ACOA and Control Groups

Table 3 presents the frequency distribution of Level IIImm for both the ACOA group and the control group. Again a chi-square analysis was performed and found to have a value of 21.75 ($p < .001$). These results indicate that significantly fewer ACOAs were placed in Octants 1 and 8 than would be expected by chance (see Figure 3). In other words, ACOAs' basic intentionality could be described as not wanting responsibility or enjoying taking care of others, or wanting to be in a leadership position. The differences found here in Level IIIMM are not the same as those proposed in Hypothesis 2; therefore, Hypothesis 2 is rejected.

Parental Identification of ACOA

In Hypothesis 3 it was predicted that ACOAs would identify less often with either parent than control subjects. Identification was operationalized as subjects being placed in the same octant on Level IIs as their respective parent(s). Table 4 shows the results of comparisons on Level IIs frequencies and percentage of octant placement for both groups. Tables 5 and 6 list comparisons of ACOAs' and control groups' ratings for both their parents on Level II. Tables 7 and 8 list all ACOA and control subjects with their Level II Octant and each of their parents' Level II Octants. Asterisks indicate where the subject's octant matches that of their parent(s).

For the ACOA sample, five subjects (16.7%) identified with their nonalcoholic mothers while seven subjects (23.3%)

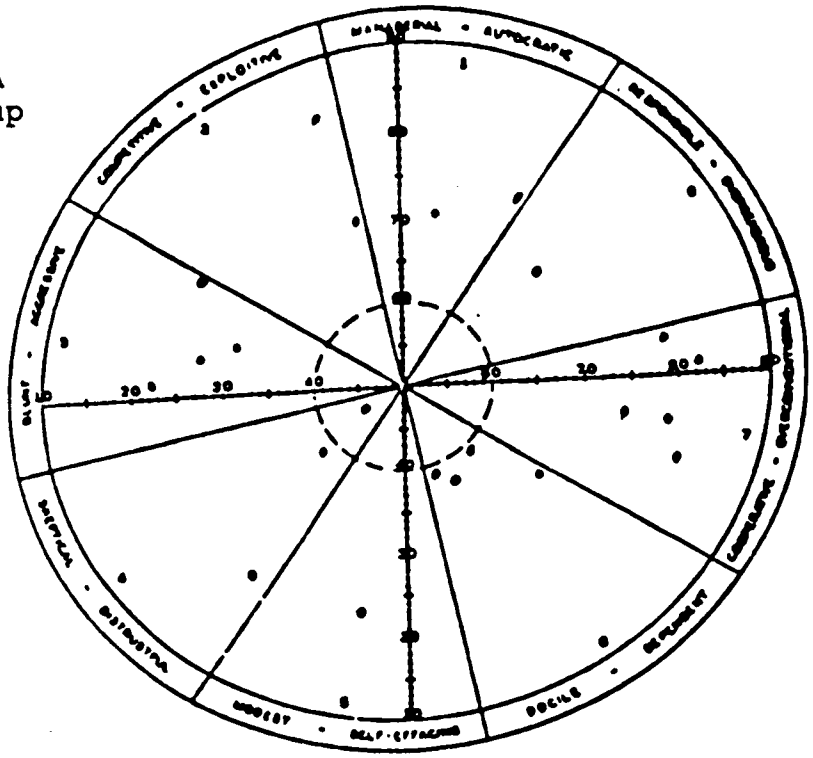
Table 3

Octant Frequencies and Percentages for ACOAs and Control Groups on Level IIImm

	ACOA		CONTROL	
	Frequency	Percent	Frequency	Percent
Octant 1	2	6.7	9	30.0
Octant 2	4	13.3	1	3.3
Octant 3	5	16.7	1	3.3
Octant 4	5	16.7	0	0
Octant 5	1	3.3	2	6.7
Octant 6	6	20.0	3	10.0
Octant 7	6	20.0	5	16.7
Octant 8	1	3.3	9	30.0

$X^2 = 21.745$, $p = 0.003$

ACOA group



Control group

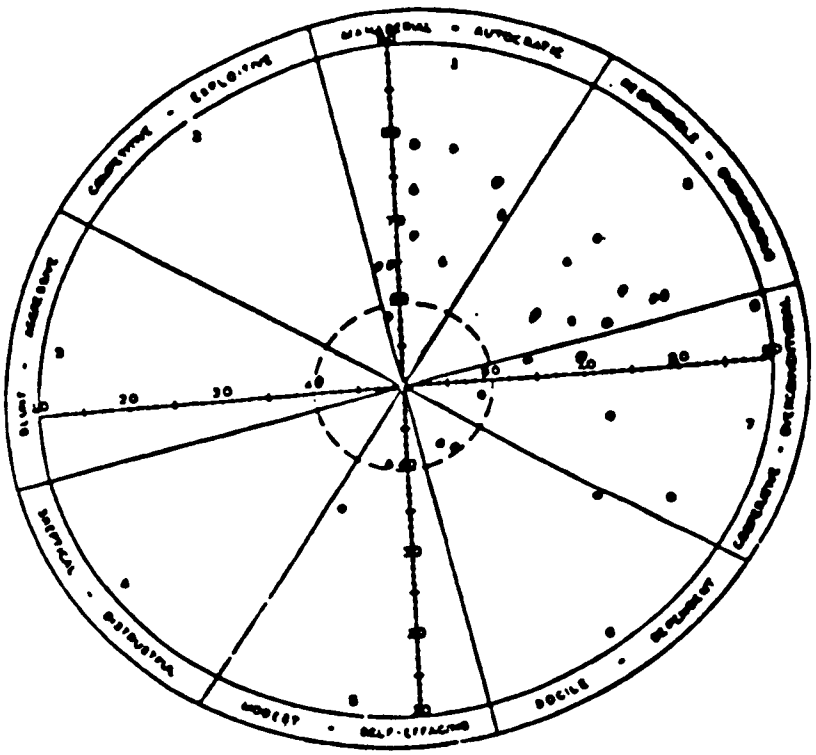


Figure 3. Level IIImm Summary Points for ACOA and Control Groups

Table 4

Octant Frequencies and Percentages for ACOAs and Control Groups on Level IIs

	ACOA		CONTROL	
	Frequency	Percent	Frequency	Percent
Octant 1	7	23.3	9	30
Octant 2	6	20.0	6	20
Octant 3	3	10.0	0	0
Octant 4	2	6.7	1	3.3
Octant 5	3	10.0	2	6.7
Octant 6	2	6.7	0	0
Octant 7	5	16.7	6	20
Octant 8	2	6.7	6	20

$X^2 = 7.874$, $p = 0.344$

Table 5

Octant Frequencies and Percentages for ACOAs and Control Groups on Level IIm

	ACOA		CONTROL	
	Frequency	Percent	Frequency	Percent
Octant 1	6	20.0	10	33.3
Octant 2	3	10.0	3	10.0
Octant 3	4	13.3	3	10.0
Octant 4	4	13.3	1	3.3
Octant 5	1	3.3	1	3.3
Octant 6	3	10.0	1	3.3
Octant 7	4	13.3	4	13.3
Octant 8	5	16.7	7	23.3

No significant differences between groups on level II-M;
$X^2 = 4.276$, $p = 0.747$

Table 6

Octant Frequencies and Percentages for ACOAs and Control Groups on Level IIf

	ACOA		CONTROL	
	Frequency	Percent	Frequency	Percent
Octant 1	5	16.7	13	43.3
Octant 2	9	30.0	9	30.0
Octant 3	6	20.0	5	16.7
Octant 4	1	3.3	1	3.3
Octant 5	1	3.3	0	0
Octant 6	1	3.3	1	3.3
Octant 7	2	6.7	0	0
Octant 8	5	16.7	1	3.3

$X^2 = 9.313$, $p = 0.231$.

Table 7

Identification With Parents:
ACOAS

Subject #	IIs Octant	IIm octant	IIf octant
1	1	8	8
2	2	8	5
3	1	1*	1*
4	7	7*	3
5	8	1	8*
6	4	1	2
7	6	7	4
8	7	5	1
9	2	1	1
10	7	7*	2
11	1	8	8
12	6	6*	1
13	3	6	2
14	2	7	3
15	3	4	3*
16	4	4*	7
17	2	1	3
18	5	6	2
19	3	2	3*
20	2	1	2*
21	1	8	8
22	1	3	2
23	2	8	6
24	8	4	2
25	7	3	7*
26	1	4	1*
27	1	3	8
28	5	2	2
29	7	3	2
30	5	2	3

Note: Identification indicated by asterisk (*)

Table 8

Identification With Parents:
Control Group

Subject #	IIs Octant	IIm octant	IIf octant
31	5	5*	1
32	5	8	3
33	7	1	1
34	1	1*	1*
35	7	7*	1
36	7	4	3
37	8	1	1
38	7	1	1
39	2	2*	1
40	8	8*	1
41	1	1*	2
42	4	3	3
43	2	7	2*
44	1	3	1*
45	8	8*	1
46	7	8	3
47	8	7	2
48	1	7	1*
49	1	6	4
50	1	8	2
51	2	3	1
52	1	1*	2
53	2	2*	2*
54	1	8	2
55	8	2	8*
56	2	1	2*
57	2	8	3
58	1	1*	2
59	7	1	1
60	8	1	6

Note: Identification indicated by asterisk (*)

identified with their alcoholic father. For the control (non-ACOA) subjects, ten (33.3%) identified with their mothers and seven (23.3%) identified with their fathers. Of particular interest is the fact that the same percentage of ACOAs identified with their fathers as did control subjects. Not as surprising is the fact that twice as many subjects in the control group identified with their mother as did ACOA subjects. A t-test for differences in proportionality revealed that there was no significant difference in the proportion of ACOAs and control subjects identifying with their mothers. Therefore, Hypothesis 3 was accepted for identification with the mother, but rejected for identification with the father.

MMPI Scale Results

The ten basic clinical scales of the MMPI were utilized in this study in addition to three newer scales (see discussion in Chapter III). Based upon the literature reviewed it was expected that ACOAs would exhibit significantly more symptomotology than the control subjects. Therefore, Hypothesis 4 predicted that ACOAs would have significantly higher MMPI scores than their non-ACOA counterparts on all of the scales except for Scale 5 (Masculinity/Femininity) and the Ego Strength scale.

Independent samples t-tests were run to compare group (ACOA and non-ACOA) means on each of the MMPI scales. Mean scores and t-test results are listed for each scale for each

of the two groups in Table 9. Results from t-test analyses showed significantly higher scores for the ACOA group in each of the following clinical scales: (1) Hypochondriasis, (2) Depression, (3) Hysteria, (4) Psychopathic deviate, (6) Paranoia, (7) Psychasthenia, (8) Schizophrenia, and (0) Social Introversion. The Ego Strength scale was significantly lower for the ACOA sample.

Results of the t-test analyses indicate, as expected, significantly greater symptomotology among ACOAs than non-ACOAs. Therefore, Hypothesis 4 is accepted.

Relationship Between Leary Scores and Demographic and Mediating Variables

Additional statistical analyses examined whether or not a relationship existed between Leary scores and MMPI scale scores and also with the demographic and mediating variables for both the ACOA and the control groups. It was predicted that no such relationship existed. If no relationship was found, then we would be able to state with greater certainty that the differences between ACOAs and the control group are not attributable to these other variables. Again due to the ordinal nature of this data, chi-square analyses were used first to determine if any systematic personality differences (using Leary scores as the dependent variable) existed when subjects were categorized according to the demographic and mediating variables. When comparing MMPI scores (interval

Table 9

T-Tests Comparing MMPI Mean Scores
of ACOA and Control Subjects

Scale	Mean Scores ACOA	Control	t	p
1. Hypochondriasis	56.0	48.8	2.85	0.0068
2. Depression	63.5	50.4	4.73	0.0001
3. Hysteria	60.5	54.8	2.58	0.0130
4. Psychopathic deviate	68.4	55.1	4.51	0.0001
5. Masculine-feminine	45.0	44.7	0.15	0.8842
6. Paranoia	63.2	53.9	4.43	0.0001
7. Psychasthenia	60.6	51.4	3.32	0.0016
8. Schizophrenia	65.9	51.3	4.99	0.0001
9. Mania	60.8	55.7	1.75	0.0860
0. Social Introversion	58.2	51.8	1.98	0.0524
R Repression	48.0	47.9	0.03	0.9764
ES Ego Strength	49.4	56.3	-2.57	0.0136
MAC MacAndrews Alcoholism	53.5	53.4	0.056	0.9561

data), both t-tests and analysis of variance were conducted to determine if personality differences existed when subjects were categorized by demographic and moderating variables. T-tests were used on all dichotomous variables (e.g., Yes-No); ANOVA with Duncan's multiple range test for multiple comparison was used to look at differences when there were three subgroups in the independent variable (e.g., high, medium, low).

Tables 10, 11 and 12 summarize the results of the differences in Leary scores at each of the three levels: Is, IIs and IIImm. No significant differences were found at the I-s level (public self). At the II-s level, the only difference found was that more ACOAs who experienced parental violence were placed in Octant 7 (cooperative/overconventional) than would be expected by chance. Finally, signficant differences were also found at the IIImm level: more ACOAs with high quality child care were placed in Octant 7 (cooperative/overconventional) than would be expected by chance; and more ACOAs with low and medium quality child care were placed in Octants 2 (competitive/narcissistic) and 3 (aggressive/sadistic) than would be expected by chance.

Results from the t-tests and ANOVA found no significant differences in distributions between groups except for one varaible in the control group. The control group had significantly more subjects who had received high quality

Table 10

Chi-Square Results
Leary Level I-S and Mediating Variables

Variable	Chi-Square	p
Parent Treatment	6.360	0.384
Subject Treatment	7.065	0.315
Type of Parental Behavior	2.580	0.859
Parent Violent	5.849	0.440
Type of Drinker	6.840	0.336
Quality of Child Care	10.652	0.559
Family Stability	10.971	0.531

Table 11

Chi-Square Results
Leary Level II-S and Mediating Variables

Variable	Chi-Square	p
Parent Treatment	7.440	0.385
Subject Treatment	1.550	0.981
Type of Parental Behavior	5.31	0.622
Parent Violent	14.005	0.05*
Type of Drinker	9.325	0.230
Quality of Child Care	14.094	0.443
Family Stability	13.000	0.527

Table 12

Chi-Square Results
Leary Level IIImm and Mediating Variables

Variable	Chi-Square	p
Parent Treatment	4.200	0.756
Subject Treatment	6.897	0.440
Type of Parental Behavior	6.360	0.498
Parent Violent	10.120	0.182
Type of Drinker	5.347	0.618
Quality of Child Care	27.170	0.018*
Family Stability	16.154	0.304

child care than the ACOA group.

In addition, levels of quality of child care and family stability were compared with MMPI scores by analysis of variance and subsequent Duncan's post-hoc anlysis. Results indicate that those subjects with a high level of child care in the home scored significantly lower on Scale 4 (Psychopathic Deviance) than did those with either medium or low quality of child care ($F = 5.5$, $p < 0.0096$). There was no significance between MMPI scores and level of family stability. These differences due to mediating variables will be clarified in the discussion.

CHAPTER V

DISCUSSION

The purpose of this study was to attempt to empirically validate some of the personality characteristics of adult children of alcoholics reported by clinicians and researchers. The data will be discussed initially as they relate to the hypotheses proposed. Then some of the implications of this study for the understanding of adult children of alcoholics will be explained. Finally, limitations of the study will be addressed as well as suggestions for future research based on the findings of this study.

In Hypothesis 1, it was predicted that adult children of alcoholics would show a public presentation of being competent, hypernormal, overcooperative individuals who assume great amounts of responsibility. The present study did not support this hypothesis. Instead of presenting a "false self", the ACOAs in this study presented personality characteristics and styles on an overt level that had been predicted to be on the underlying character level, shielded by a public or surface presentation that is more appealing to others.

On the level of public presentation, there were significantly more ACOAs in Octants 3 and 4 than would be expected by chance. Also, there were significantly fewer ACOAs in Octant 1 than control subjects. This implies that their surface or

public presentation to others is frank, forthright, and at times aggressive and hostile. It is important to consider Leary's premise that individuals select these personality characteristics or "operations" because they have found them to be effective in warding off anxiety.

Significantly more ACOAs placed in Octant 3 on Level I than did control subjects. Those placed in Octant 3 typically are very anxious in situations which call for tender, agreeable or docile feelings. "These individuals have developed their involuntary interpersonal reflexes because they have learned consciously or unwittingly that this is, for them, the safest mode of adjustment" (Leary, 1957, p.342). These outward behaviors serve several purposes. They help reduce anxiety and the feeling of defenselessness, something that is extremely discomforting for the child of an alcoholic, who feels out of control of her chaotic and unstable, unpredictable family life. Leary (1957) describes certain specific family situations that are typical of Octant 3 personality types. The primary one is the alcoholic family. The blunt, righteous, angry wife of the delinquent or alcoholic husband is one common example. The wife often supports the family and rules the spouse with a guilt-provoking disciplinary coldness" (p.347). This premise describing those who score in Octant 3 is supported by the literature stating that adult daughters of alcoholics frequently become the spouse of an alcoholic. Leary

continues to describe this: often the motive for people like this in seeking treatment is for help in dealing with their spouse, rather than changing her own behavior. This is typical of what others describe as a "codependent behavior" (Ackerman, 1987; Wegscheider, 1981) which is common among spouses and children of alcoholics. Leary (1957) further states that psychological testing often reveals masochistic trends underlying these stern, punitive overt operations of those who place in Octant 3. Octant 3 personalities often describe their parents as beaten, impotent, timid, unsuccessful and unloving people (Leary, 1957 p.350).

Those whose summary scores place them in Octant 4 are often described as expecting dishonesty and hostility in others, and are extremely sensitive to picking up rejection or punitive feelings in others. In their relations with others, this personality type consistently maintains attitudes of resentment and deprivation. They handle anxiety by establishing a distance between themselves and others. They are often passively resistent, bitter and cynical. Trust in others, cooperation, and affiliation seem to involve a certain loss of individuality and vulnerability that they avoid at all costs. For the ACOA who has experienced past humiliations, disappointments and rejections in early relationships, there are certain comforts or rewards in developing this protection. The purpose is to avoid the intense anxiety created by tender

feelings for others. These people have come to expect that loving feelings only set themselves up for anxiety and rejection. Distrust resolves this dilemma by pushing away the other person. Their skepticism protects them from surprises; cynicism prepares them for and softens future disappointments. This description is also typical of how clinicians describe the interpersonal relationships of many adult children of alcoholics, as well as their behavior observed while in group therapy (Cermak & Brown, 1982; Gravitz & Bowden, 1984).

People who score in both Octants 3 and 4 typically behave in ways that emphasize non-conformity and skeptical distrust which invariably isolate and alienate them from others. In addition, based upon the results of the Kaiser Foundation Project that helped to develop the Leary system (Leary, 1957), scores on Octant 4 on levels I or II are positively related to increased scores on the Depression (scale 2) and the Psychopathic Deviance (scale 4) scales of the MMPI. In addition, of all the Octant placements, those who are placed in Octant 4 are the most consciously disidentified with their parents. The findings of the present study corroborate this, with MMPI results for adult children of alcoholics significantly elevated above controls' scores on both of these (and other) MMPI scales in addition to less identification with their mothers.

Significantly fewer adult children of alcoholics placed in

Octant 1 on Level Is. According to the Leary system, an Octant 1 personality is characterized by energetic, organized behavior, and by an attitude of knowledge, strength, competence, and authority. It was predicted that adult children would place in Octant 1 more frequently than controls on this level of public presentation; in other words, they would present to others with knowledge, competence and strength. The finding is just the opposite for this octant. Apparently, these adult children of alcoholics do not present a public facade of strength and competence. It is possible that this is due to the fact that the majority of subjects in the ACOA group willingly volunteered to be in a study on adult children of alcoholics. The sample may be biased, in that those who were willing to come forward identified as ACOAs might be less prone to present a false front to others and thus would be more willing to openly acknowledge their true selves to others.

In summary, although these Octants are not those predicted on Level I, they are congruent with other descriptions of personality aspects of adult children of alcoholics. It was not predicted that these characteristics would be identifiable on a public level of behavior, however.

On Level II-s there were no significant differences found in the self-descriptions of adult children of alcoholics when compared to self-descriptions by control subjects. However,

when these self-descriptions were compared with those of their parents, some interesting differences occur. It was predicted that ACOAs would not identify with either parent; however, the ACOAs had the same number of parental identifications with their fathers as the control subjects did. This finding is surprising, and suggests that it makes no difference (for women) in frequency and extent of paternal identification whether their father was alcoholic or nonalcoholic. Perhaps this is due to what Beletsis & Brown (1981) describe as occurring when children identify with the alcoholic because they both share a sense of loss of control, helplessness and failure. Some children may blame the nonalcoholic spouse for the instability at home and their inability to make the alcoholic stop drinking; thus they identify more with the alcoholic than the nonalcoholic spouse.

The other finding of the present study involved comparing the ACOA group's extent of maternal identification with that of the control subjects. Results indicate that the ACOA group had half the number of conscious identifications with their mother when compared to the control group. This finding, although based on a small sample, suggests that daughters of alcoholics reject the co-dependent role played by the alcoholic's spouse. Since it is more typical for women to identify with their mothers in order to adopt a female role later in life, it suggests that ACOAs may have difficulty with identity

and role assumption, as reported by many researchers (Nardi, 1981; Beletsis & Brown, 1981). A young daughter may reject the maternal identification because this role appears as undesirable as that of the alcoholic. A young daughter may view her mother's antagonism toward the alcoholic father, or the mother may have assumed an overcontrolling dominant role in an attempt to keep the family functioning. Often in alcoholic homes, it is the nonalcoholic mother who must work outside the home in order to provide a consistent or stable income; thus her children are forced to assume the maternal duties in the home. Being burdened with these responsibilities at a time when they should be negotiating the stages of childhood may only serve to add to the ACOAs' disidentification with what they perceive as the mother's role. In other instances, the nonalcoholic parent, who is passive and too weak to change the family system, may turn to the children for inappropriate emotional support. Cork (1976)'s study found that children of alcoholics often perceive the nonalcoholic spouse as causing the family problems and alcoholism. This would have major implications for sex-role development and parental identification. It is thus not surprising that as an adult, the child from an alcoholic family would also reject her mother as a role model.

Hypothesis 2 predicted that ACOAs would have more frequent scores in Octants 4, 5, and 6, indicating an underlying char-

acter structure of distrust, lack self confidence and show unresolved dependency needs. The data did not support this hypothesis. Results indicate that significantly fewer adult children of alcoholics have underlying intentionality or character styles that place in Octants 1 and 8 than the normal population.

Those who score in these octants typically are comfortable with responsibility and having others depend on them. In addition, they are usually highly identified with their parents and exemplify a leadership role with others. Those who place in Octant 1 exhibit compulsive energy, authority, and dominance over others. Octant 8 placement indicates those who possess strong affiliative characteristics, and responsible protective behavior. Since fewer adult children of alcoholics scored in these octants, it suggests a tendency toward an underlying character structure that has less of these characteristics or a person who eschews this behavior. This could reflect what occurs when ACOAs are deprived of their childhood roles and forced to adapt in adult-like roles too early in life. At a time when they are able to free themselves of their family of origin, they reject these roles and dislike having others rely on them, perhaps because they have been burdened with this responsibility for much of their lives. Many ACOAs wrote comments on the questionnaire that are congruent with this character style.

Hypothesis 4 predicted that children of alcoholics MMPI scores would be higher than control group scores, except on the Ego Strength scale, where their scores would be lower. This hypothesis was generally supported by the data. MMPI results indicate that adult children of alcoholics had significantly higher scores on scales 1, 2, 3, 4, 6, 7, 8, and 0, and significantly lower scores on the Ego Strength scale. This is congruent with much of the literature reviewed which reports that ACOAs have higher levels of symptomatology in general. More specifically, examination of each scale reveals the following description of adult children of alcoholics.

Significantly higher scores (x= 56.0) on Scale 1 (Hypochondriasis) indicates that ACOAs in this study are typically less psychologically minded than the general population and tend to use somaticization and repression to cope with tensions and conflicts. This score is at the high end of the "normal" range and is not indicative of extreme tendencies even though it is significantluy higher than controls' scores.

A mean score of 63.5 falls within the "moderate" range of symptomatology on Scale 2 (Depression), with ACOAs exhibiting more dissatisfaction with themselves and their environment. Moderate feelings of depression and pessimism are likely (more than a normal amount). This score is supported by many citations about depression in the literature and clinical reports of ACOAs and suggests that their lives are not as satisfying

to them in general as compared to adults from nonalcoholic homes (Gravitz & Bowdwen, 1984; Woititz, 1978; Black, 1979; Ackerman, 1986).

ACOAs' significantly higher mean score of 60.5 on Scale 3 (Hysteria) falls into the "moderate" range of symptomatology, indicating that adult children of alcoholics tend to be somewhat naive, attempt to avoid unpleasant issues and deny problems in their lives. This supports much of the earlier literature on various adaptations and ways of coping in an alcoholic household and is likely a carryover from their childhood family environment, where the reality of the parent's alcoholism and erratic behavior was often denied.

Scale 4's mean of 68.4 is the most elevated of mean ACOA T-scores, and falls at the top of the "moderate" range of symptoms, just below the "marked symptoms" range. This indicates that ACOAs have problems in social adjustment, are impulsive, angry and harbor resentment towards authority figures. This is not surprising, considering their original authority figures often abused their trust, were unreliable, and at times verbally or physically abusive or neglectful. A marked score on scale 4 (70 and above) indicates the presence of antisocial behavior and attitudes (Greene, 1980) but it does not necessarily mean that these behaviors will be expressed overtly. The mean score for the ACOA group is close enough to the "marked" range that ACOAs can be expected to

have nonconforming, often antisocial tendencies in behavior and/or attitudes. McKenna and Pickens (1983) also found that daughters of alcoholics had elevations on Scale 4 as well, and they suggest that high rates of overt and directed aggression characterize children of alcoholics. In addition, their results suggest that the number of alcoholic parents is associated with increased levels of aggression and psychopathology in children of alcoholics.

A significantly higher mean score on Scale 6 (60.6) which falls in the "moderate" range of symptomatic behavior suggests that adult children of alcoholics are interpersonally sensitive, somewhat guarded and suspicious of others. This finding is congruent with the results on Leary level IIImm, which depict ACOAs as distrustful, suspicious and hostile to others.

Scale 7's significantly higher mean T-score of 60.6 also falls in the "moderate" range of behavior, indicating that ACOAs are somewhat prone to anxiety, worry, and a sense of dissatisfaction about themselves. This fits with the summary of the literature reviewed by Woodside (1983), and the conclusion that children of alcoholics experience a great deal of chronic anxiety and distress.

Scale 8's significantly higher mean (65.9) falls in the "moderate" range of symptomatology, suggesting that ACOAs think differently from others, often fantasizing to avoid reality, with some sense of social isolation and difficulty

with self-esteem and identity. This is supported in the literature which states that ACOAs feel different from others and have problems with role asssumption due to a diffuse sense of identity (Nardi, 1981; Beletsis and Brown, 1981). The use of fantasy to avoid facing reality is likely the result of having to deal with constant emotional upheaval and chaos at home, denial of the alcoholic's problem, and having little control to change the situation. This type of thinking could be viewed as an adaptive mechanism in childhood in response to the family environment; however, it causes some difficulty later in life (Black, 1985).

Scales 2, 7, and 8 are often labeled as the "distress scales", indicating high levels of subjective distress. The fact that all three of these scales were elevated significantly for ACOAs when compared with controls' scores suggests that adult children of alcoholics experience more subjective distress in their lives.

Scale 0 (Social Introversion)'s significantly higher mean reflects the same tendency to withdraw from others as well as indicating discomfort in social interactions with others. This result is also in line with the Leary results which suggest that ACOAs are uncomfortable in close relationships and have difficulties trusting and being close to others. This may be an outgrowth of Jacob and Leonard (1986)'s findings that children of alcoholics have decreased social competencies.

The significantly lower mean score for the ACOA group on the Ego Strength scale suggests that adult children of alcoholics have fewer internal resources to cope with stresss and to deal with problems in their lives. This reflects their low self-esteem and difficulties with flexibility in problem solving that has been cited in the literature (Woititz, 1984). This is likely a result of growing up in a family situation where children are taught not to trust their own perceptions, feel powerless to logically change things, and often receive less stable and inconsistent parenting. They have not had anyone teach them adaptive coping skills and problem solving, thus in adulthood, they lack these internal resources.

There were no significant differences in the mean T-scores for Scale 5 (Masculine/Feminine), Scale 9 (Mania), and the Repression Scale. This suggests that ACOAs are similar in interests, preferences and level of passivity to those raised in nonalcoholic homes. Also, their activity level and use of denial or repression is not significantly different from controls. It was predicted that adult children of alcoholics would score higher, especially on Scale 5, to reflect a more passive stance in life. It is possible that this lack of significance could be due to a biased sample; otherwise it reflects a need for further explanation of this variable.

An interesting finding was the fact that the mean T-score on the MacAndrews Alcoholism Scale was not significantly

higher for the adult children of alcoholics. This finding is contrary to previous hypotheses and research that indicated that adult children of alcoholics have a higher potential for alcohol or substance abuse than those reared in nonalcoholic homes. The results of the present study do not support that contention. This could be due to a sampling bias for either group, or may reflect that this hypothesis does not hold true for daughters of alcoholics (much of this research has been conducted on sons of alcoholics). Future research needs to clarify this finding.

Overall, the mediating variables made little impact on the nature of children of alcoholic's personality styles as measured by the instruments used in this study. This finding is not as predicted; however, there was a bias in terms of sample distribution of these charcteristics, with a trend towards what Lawson, Peterson & Lawson (1983) and Ackerman (1987) describe as the highest risk conditions. Perhaps if the range of distribution of these variables had been more even, one would find significant results for these variables.

Examination of mediating variables revealed a significant interaction between parental violence and Leary Level IIs. In other words, those ACOAS with parents who were violent while drinking had significant differences in self-perceptions than those whose parents were not violent. Since the majority of subjects (63.3%) in this study had parents who were

violent, it is difficult to assess the exact meaning of these findings and warrants further investigation and research.

On level IIImm, there was a significant difference in Octant placement due to the quality of child care in the home. It could be argued that this variable is in fact responsible for the differences in scores and not the fact that ACOAs were exposed to parental alcoholism. Some researchers contend that social isolation or parental insularity, poverty and lack of social support and poor quality of child care would increase the incidence of childhood psychopathology apart from having an alcoholic parent in the home (Wahler, 1980; Werner, 1986).

In order to investigate this hypothesis, additional analyses were conducted to examine any effects of different levels of quality of child care or different levels of family stability and to determine if this affected the Leary or MMPI scores.

T-tests and analysis of variance revealed that no significant differences existed for controls; for ACOAs, significant differences existed only on MMPI scale 4 (Psychopathic Deviance). Duncan's post-hoc analysis revealed that the difference was due to significantly lower mean T-scores for those with a high level of child care in the home. Since Scale 4 reflects antisocial trends in behavior and hostility towards authority figures, it follows that those raised with better child care might view authority figures (parents are the intial exposure

to authority) in a more favorable light. However, since this is the only scale affected by differences in the quality of child care it still suggests that being raised in an alcoholic home has greater effects than would be caused by being raised in any home with a poor quality of child care. In addition, the level of family stability made no difference in scores whatsoever, which again supports the contention that there are dynamics present in the personalities of ACOAs that are likely due to the exposure to parental alcoholism and not solely to being raised in a chaotic, unstable, or insular home environment. Further research is needed to examine these factors in greater depth.

Summary

Although several of the hypotheses were not supported, it is believed that this study still adds to our understanding of the personality characteristics of adult children of alcoholics. The first hypothesis that ACOAs would exhibit a public presentation to others as being normal, well-adjusted and able to take care of others was not supported by the data results. Instead, we see a picture of women who are bitter, cynical, and distrustful of others. This behavior often results in pushing others away and a lack of true intimacy. The underlying character style is one that eschews responsibility to and for others, and is uncomfortable in leadership roles. In

addition, adult children of alcoholics appear to have more psychological symptomatology than the average woman. Depression is likely to be present, as are low self-esteem, denial of negative aspects of their lives, oddities in thinking and perceiving and a great deal of underlying anger and hostility towards authority.

Limitations of the Present Study

One of the major limitations of the study is its small sample size. It was initially thought that 60 subjects would provide a large enough data pool; however, because there were only 30 subjects in each group and the Leary data were distributed among eight different octants, the numbers were too small to perform a completely valid chi square analysis. Similar problems arose when attempting to sift out the effects of mediating variables.

As discussed above, the method for obtaining subjects may have created a bias in the type of responses obtained. While several of the ACOA subjects were obtained randomly from evening school student volunteers, most were those willing to acknowledge their ACOA status; many had attended a public seminar about problems that adult children of alcoholics experience. Thus, these people may be more open and willing to acknowledge their issues than a random selection would, or may have more specific issues that motivated them to attend the

seminar. However, if they are an atypical group, they illustrate the non-homogeneity of the ACOA population.

Finally, all measures were based on self-report measures, which may have potential bias, particularly for this group. Several researchers have reported that ACOAs use repression and denial frequently; thus the measures may show subjects' bias towards appearing socially desirable.

Implications for Future Research

While the results of the present study offer partial support for recent literature on adult children of alcoholics, there is still a great need for future research to clarify the premises and reports of clinicians and researchers. Additional attempts to empirically validate the reported personality characteristics need to address many issues. Much more of a research focus needs to explore the specific characteristics reported, in addition to examining the effects of differences across gender for both parents and children. Also, comparisons of having one or both parents who are alcoholic need to be made, and greater attention given towards sifting out mediating variables which effect the various types of adjustment and personality factors. Research also needs to explore and compare this group (ACOAs) with those raised in dysfunctional or insular homes. While a few initial studies have compared these groups, no one has compared these children in adulthood. Since many authors state that adult children of alcoholics are

prone to denial and lying (Woititz, 1983), research involving self-report data needs to be supplemented to include behavioral and observational measures designed to provide a more in-depth understanding of ACOAs and their unique personality patterns.

Conclusions

This study was undertaken in an attempt to provide some empirical validation for the personality characteristics of adult children of alcoholics as described by clinicians and researchers. While several of the hypotheses were not supported by the results obtained, the data nevertheless contributes to our understanding of ACOA's personality dynamics. It suggests that adult children of alcoholics are certainly not a homogeneous group, and that the personality dynamics described by various writers do not exist across the entire population of ACOAs. This study found emphatically opposite results on the level of public presentation to others, identification with the alcoholic parent, and underlying character structure. While there were significant differences between the adult children of alcoholics and the control group on these levels, they were not in the ways described by the popular literature. In other words, the ACOAs in this study did not exhibit a false public self to others to appear competent, self-asssured and hypernormal; they had the same number of paternal identi-

fications as controls even though their fathers were alcoholic; and ACOAs did not show an underlying dependent character structure that is skeptical and distrustful of others.

It may well be that the group that seeks psychological assistance exhibits the personality styles described in the popular literature. However, there are a significant number of adult children of alcoholics who do not seek treatment and who may differ in personality styles from the groups described by clinicians. It may imply that the segment who actively seek treatment may have problems secondary to being raised by an alcoholic parent and perhaps related to additional emotional or environmental factors. It is also possible that there are other types or subgroups of adult children of alcoholics that have not been addressed. It is important that future research aggressively and empirically question the homogeneity of this group as implied by the popular literature so that we can come to a better understanding of the long-term effects of being raised in an alcoholic home.

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APPENDICES

APPENDIX A

C.A.S.T.

PLease answer the questions below with a "yes" or "no" depending upon which best describes your feelings, behavior, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions.

Sex: Male____ Female____ Age____ Initials____

____ 1. Have you ever thought that one of your parents had a drinking problem?

____ 2. Have you ever lost sleep because of a parent's drinking?

____ 3. Did you ever encourage one of your parents to quit drinking?

____ 4. Did you ever feel alone, scared, nervous, angry, or frustrated because a parent was not able to stop drinking?

____ 5. Did you ever argue or fight with a parent when he or she was drinking?

____ 6. Did you ever threaten to run away from home because of a parent's drinking?

____ 7. Has a parent ever yelled at or hit you or other family members when drinking?

____ 8. Have you ever heard your parents fight when one of them was drunk?

____ 9. Did you ever protect another family member from a parent who was drinking?

____ 10. Did you ever feel like hiding or emptying a parent's bottle of liquor?

____ 11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?

____ 12. Did you ever wish that a parent would stop drinking?

____ 13. Did you ever feel responsible for and guilt about a parent's drinking?

____ 14. Did you ever fear that your parents would get divorced due to alcohol misuse?

____ 15. Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?

____ 16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?

____ 17. Did you ever feel that you made a parent drink alcohol?

____ 18. Did you ever feel that a problem drinking parent really did not love you?

____ 19. Did you ever resent a parent's drinking?

____ 20. Have you ever worried about a parent's health because of his or her alcohol abuse?

____ 21. Have you ever been blamed for a parent's drinking?

____ 22. Did you ever think your father was an alcoholic?

____ 23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?

____ 24. Did a parent ever make promises to you that he or she did not keep because of drinking?

____ 25. Did you ever think your mother was an alcoholic?

____ 26. Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?

____ 27. Did you ever fight with your brothers and sisters about a parent's drinking?

____ 28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?

____ 29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?

____ 30. Did you ever take over any chores and duties at home that were usually done be a parent before he or she developed a drinking problem?

APPENDIX B

LEARY INTERPERSONAL CHECK LIST

1. well thought of
2. makes a good impression
3. able to give orders
4. forceful
5. self-respecting
6. independent
7. able to take care of self
8. can be indifferent to others
9. can be strict if necessary
10. firm but just
11. can be frank and honest
12. critical of others
13. can complain if necessary
14. often gloomy
15. able to doubt others
16. frequently disappointed
17. able to criticize self
18. apologetic
19. can be obedient
20. usually gives in
21. grateful
22. admires and imitates others
23. appreciative
24. very anxious to be approved of
25. cooperative
26. eager to get along with others
27. friendly
28. affectionate and understanding
29. considerate
30. encourages others
31. helpful
32. big-hearted and unselfish
33. often admired
34. respected by others
35. good leader
36. likes responsibility
37. self-confident
38. self-reliant and assertive
39. businesslike
40. likes to compete with others
41. hard-boiled when necessary
42. stern but fair
43. irritable
44. straightforward and direct
45. resents being bossed
46. skeptical
47. hard to impress
48. touchy and easily hurt
49. easily embarrassed
50. lacks self-confidence
51. easily led
52. modest
53. often helped by others
54. very respectful to authority
55. accepts advice readily
56. trusting and eager to please
57. always pleasant and agreeable
58. wants everyone to like him
59. sociable and neighborly
60. warm
61. kind and reassuring
62. tender and soft-hearted

63. enjoys taking care of others
64. gives freely of self
65. always giving advice
66. acts important
67. bossy
68. dominating
69. boastful
70. proud and self-satisfied
71. thinks only of himself
72. shrewd and calculating
73. impatient with others' mistakes
74. self-seeking
75. outspoken
76. often unfriendly
77. bitter
78. complaining
79. jealous
80. slow to forgive a wrong
81. self-punishing
82. shy
83. passive and unaggressive
84. meek
85. dependent
86. wants to be led
87. lets others make decisions
88. easily fooled
89. too easily influenced by friends
90. will confide in anyone
91. fond of everyone
92. likes everybody
93. forgives anything
94. oversympathetic
95. generous to a fault
96. overprotective of others
97. tries to be too successful
98. expects everyone to admire him
99. manages others
100. dictatorial
101. somewhat snobbish
102. egotistical and conceited
103. selfish
104. cold and unfeeling
105. sarcastic
106. cruel and unkind
107. frequently angry
108. hard-hearted
109. resentful
110. rebels against everything
111. stubborn
112. distrusts everybody
113. timid
114. always ashamed of self
115. obeys too willingly
116. spineless
117. hardly ever talks back
118. clinging vine
119. likes to be taken care of
120. will believe anyone
121. wants everyone's love
122. agrees with everyone
123. friendly all the time
124. loves everyone
125. too lenient with others
126. tried to comfort everyone
127. too willing to give to others
128. spoils people with kindness

APPENDIX C

PERSONAL DATA ID#_____

1. What is your age? _____

2. Which parent had a problem with alcohol?
____father ___ mother ___ both ____other _____

3. What is the highest level of education you attained?

_____ some high school
_____ high school graduate
_____ some college
_____ college graduate
_____ Master's degree
_____ PhD

4. What was your father's occupation?

5. What was your mother's occupation?

6. How many children were in your family?_____

7. What was your birth order? (i.e. oldest, youngest) _____
_____

8. Did you live with both parents until you were at least 16?___
if no, explain_____
_____
_____

9. Did your alcoholic parent ever receive treatment for their alcoholism? If yes, explain_____
_____

10. Have you ever received counseling or drug/alcoholism treatment? If yes, explain which and how long you were in treatment_____
_____

11. Who were you closest to growing up?
___ mother _____ sibling
___ father _____ other (explain)_____
_____

12. Did you have anyone outside the family you could confide in?
_____

13. Did you have any extended separations from your parents?
_____ If yes, state how old you were and for how long.
_____
_____

13. Was your parent ever violent while drinking?_____

14. What kind of behaviors did your alcoholic parent exhibit while drinking?

_____ verbally belligerent
_____ offensive behavior
_____ other
_____ passive
_____ carefree

15. How often did your parent drink?

_____ daily drinker
_____ binge drinker
_____ other (explain)

16. What would you estimate the effects of parental alcoholism to be on your life? PLEASE EXPLAIN YOUR ANSWER.

_____ highly affected
_____ moderately affected
_____ not affected

_____
_____
_____
_____
_____

17. How would you rate your family's quality of child care?

_____ high
_____ middle
_____ low

18. How would you rate the stability of your family while you were growing up?

_____ high
_____ middle
_____ low

19. How old were you when you were first exposed to your parent's alcoholism?

_____ born into an alcoholic home
_____ age 1-5
_____ age 6-12
_____ age 12-17
_____ older

20. How old were you when you were willing to acknowledge that your parent had a drinking problem? _____

21. Is your parent still drinking? _____

22. If not, how old were you when they stopped? _____

23. How did you adapt emotionally?

_____ took on much responsibility
_____ problem-causing child
_____ detached from family members
_____ other (explain)
_____
_____

VITA

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