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Tamara K. Young
Eastern Illinois University

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Personality Variables of Adult Children of Alcoholics

In a Treatment Sample As Measured By The

Personality Research Form-E

(TITLE)

BY

Tamara K. Young

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

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IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
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Personality Variables of Adult Children of Alcoholics

In a Treatment Sample As Measured By The

Personality Research Form-E

Tamara K. Young

Eastern Illinois University

Abstract

There has been much personality research in the area of Adult Children of Alcoholics with varying results. This study examines personality variables in archival data of alcoholic clients in a residential treatment center with the use of the Personality Research Form-E (Jackson, 1984). A comparison was made between groups of non-ACOA clients and those with alcoholic parents in the areas of aggression, defendence, dominance and desirability. No significant differences were found between groups. Two other hypotheses were generated concerning male participants only. No significant differences were found for the trait of autonomy; however, male ACOA alcoholic participants were found to be more impulsive than non-ACOA alcoholic participants. Clinical implications and areas for future research are discussed.

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Statement of the Problem

The effects of alcoholism on the family are numerous and deserve attention. Recently, there has emerged a focus on the effects of alcoholism on the children of alcoholics, who have now been clinically designated adult children of alcoholics, ACOAs. Certain trends have been identified from research on such individuals. Fifty to sixty percent of all alcoholics have at least one alcoholic parent (Black, 1981). A disproportionate number of people involved with the legal system, employee assistance programs, mental health facilities, and school counselors have been raised in an alcoholic family (Johnston, 1991). Research has also shown that children of alcoholics tend to develop emotional and/or psychological patterns that cause problems in adulthood (Black, 1981). Alcoholism is considered a multigenerational disease; that is, alcoholics are thought to influence their offspring by modeling dysfunctional traits which have been found to cause significant problems for their children, both in childhood and adulthood. Although adult children of alcoholics often try to create the family they wish they had externally, their internal suffering continues (Smith, 1988).

A child's being raised in an environment where alcohol and/or drug use is encouraged may be a major factor in teenage addiction. There is evidence that children brought up by alcoholic parents undergo significant physical, mental and emotional abuse. Alcohol is a factor in 90% of child

abuse cases (Johnston, 1991). Children brought up with this kind of physical and emotional pain, in combination with an open alcohol use policy, often learn early in life that alcohol will kill the pain they feel. They may have many unmet needs and are often sent mixed messages about their worth. Children in alcoholic homes often have no positive role models and grow into adulthood thinking that alcohol is the way to "fix" the pain they are feeling (Kinney & Leaton, 1983).

Children of alcoholics develop rigid role acquisition, that is, children have little room to grow up healthfully and are taught not to talk or trust and that their feelings are unimportant (Black, 1981). These roles allow the child to adapt to the difficulties of living with an alcoholic and are, in effect, a buffer against unacceptable reality. The most commonly identified roles reported in treatment and in the literature are: the hero, the scapegoat, the clown and the lost one (Black, 1981). These roles are often overlapping in that more than one role is seen at a time or different roles appear at different times in a child's life (Kritsberg, 1985). Adult children of alcoholics who are receiving treatment for substance abuse most commonly identify with the role of the scapegoat (Potter & Williams, 1991).

Children who adopt the role of scapegoat often act out in a negative way to cope with the alcoholism in the family and have often learned that this is the only way they can

gain attention. These children often begin using substances at a very young age which leads to early onset alcoholism. They feel much anger and have difficulty identifying other emotions (Black, 1981).

Children who are raised in alcoholic families miss proportionately more school than non-ACOAs. They also experience more difficulties in school both academically and behaviorally (Potter & Williams, 1991). ACOAs have a high incidence of learning disabilities, including dyslexia, that often go undetected for a considerable period of time. Children who experience attention deficit disorder or who are hyperactive often come from alcoholic families (Pihl & Peterson, 1990). This is so prevalent that the DSM-III list alcohol dependence or abuse as a suggested familial pattern for hyperactive disorder or attention deficit disorder (Knoblauch, 1990). This possible causal pattern continues to be described in the DSM-IV (American Psychiatric Association, 1994).

Growing up in an alcoholic family leads to an emotional baseline of fear and anger. Many characteristics of adult children arise out of these emotions, but the core feelings remain the same. When children learn early in life not to trust, based on dysfunctional family patterns, they develop a strong need to control their environment. A need to control is found to be higher in ACOAs than in non-ACOAs and is seen as a key characteristic of adult children of alcoholics with no gender differences (Knoblauch, 1990). The higher the need

to control, the more dysfunctional the person becomes in relationships with other people and in self-concept. This need is linked to anxiety, depression, low self-worth and intimacy problems (Potter & Williams, 1991).

Controlling the environment helps the ACOA to feel safe, but this may lead to dysfunctional patterns of super-responsible or super-irresponsible behavior. ACOA offspring tend to experience what is described as all or nothing thinking and develop an inflexibility toward themselves and relationships with others. A person who is always trying to control everything has difficulty having fun, which in turn leads to substance abuse as a way to cope with these feelings (Kritsberg, 1985).

Kritsburg reports that intimacy problems are a natural result of the don't trust, don't feel rules that the adult child of the alcoholic was raised with. This could be further exacerbated by their own substance dependence. Difficulty trusting leads to a breakdown of communication. ACOAs are unable to identify and express feelings, needs and wants. They often develop manipulative techniques to get these needs met (Kritsberg, 1985).

Certain characteristics of ACOAs appear to be gender specific, for example, females raised in alcoholic families tend to experience chronic illness. Most women who are admitted to treatment for substance abuse or for ACOA treatment have experienced some type of physical or sexual abuse (Kritsberg, 1985). A study completed with a non-

clinical sample found a significantly higher incidence of sexual abuse by a relative in ACOAs than in non-ACOAs (Plansker, 1993). This can reinforce their feelings of fear and lack of trust. The combined effects of growing up in an alcoholic family, physical/sexual abuse, chemical use and somatic complaints lead to depression and lowered self-esteem (Webb, Post, Robinson and Moreland, 1992).

Another study conducted with young adult children of alcoholics and their peers, examined gender specific personality differences. Female COAs with an alcoholic father were more likely to report a greater self-depreciation. Male COAs reported a higher level of autonomy with no relevance to the gender of the alcoholic parent. COAs and their peers were similar on most of the other personality measures examined (Berkowitz & Perkins, 1988).

Males brought up in alcoholic families experience early onset alcoholism. They tend to show aggressive behavior which creates legal, family and social problems as well as increased rates of depression. Alcoholic ACOAs often exhibit symptoms similar to anti-social personality disorder and may have a family history of this disorder (Mulinski, 1989).

Adolescents who develop alcoholism later in life are often antisocial, impulsive or both. A large percentage of these individuals have alcoholic parents. This appears to be especially true of males with alcoholic fathers. Sons of alcoholic fathers show reduced performance on problem solving, visuospatial ability, perceptual motor capacity,

linguistic ability and deficits in IQ (Pihl, Peterson and Finn, 1990).

One study by Knowles and Schroeder focused on the personality traits of sons of alcohol abusers. Significant elevations were noted on the Minnesota Multiphasic Personality Inventory (MMPI) although these did remain within the normal ranges (T score < 70). The ACOA group, when compared to a matched control group of non-ACOAs, appear to have directional, but not significant problems with regard to family problems, sensory motor problems as well as general somatic complaints (Knowles & Schroeder, 1990). Another study found similar results with ACOAs having significant elevations on the neurotic triad (Scale 1, Hypochondriasis, Scale 2, Depression, and Scale 3, Hysteria) of the MMPI; these scores also remained below the clinically significant level of psychopathology (Tarter, Hegedus, Goldstein, Shelly, and Alterman, 1984).

Alcoholic children of alcoholics, were studied to determine if psychopathology and aggression were prevalent. MMPI clinical scales and the Huesmann et al show increased scores on aggression. The number of alcoholic parents was significantly related to scores on scale four, psychopathic deviate (McKenna & Pickens, 1983).

Purpose of the Study

There is a paucity of empirically based literature that describes specific personality traits of identified ACOAs. The present study was designed to examine the personality

traits of a group of ACOAs in a residential alcohol treatment setting. Personality was assessed using the Personality Research Form-E, PRF-E (Jackson, 1984). Scale scores of the ACOAs were compared with those of non-ACOA alcoholics in the same facility. An attempt was made to determine the validity of ACOA specific personality characteristics.

Hypothesis

Based on the research reviewed here, six hypotheses were generated. The literature indicates that ACOA participants tend to score higher on measures of aggression, low self esteem, environmental control, autonomy, and impulsivity. The following hypotheses were tested.

1. Individuals who are ACOAs will score higher on the aggression scale of the PRF-E than non-ACOA participants. Aggressive behavior was a common characteristic through all the studies cited.
2. Individuals who are ACOAs will score higher on the Defendence scale on the PRF-E than non-ACOA participants. ACOAs have a consistently lower level of trust and higher levels of fear and anxiety, in the literature, than do non-ACOAs.
3. Individuals who are ACOAs will score higher than non-ACOA participants on the PRF-E Dominance scale. Review of the literature show that ACOAs have a need to control their environment.
4. Individuals who are ACOAs will score lower on the

Desirability scale of the PRF-E than will non-ACOA participants. Another common thread throughout the literature is that of low self-esteem.

5. Males who are ACOA will score higher on the Autonomy scale of the PRF-E than will male non-ACOA participants. Research has shown that this appears as a gender specific trait. Male ACOAs appear to be more independent than their non-ACOA counterparts.

6. Males who are ACOA will score higher on the Impulsivity scale on the PRF-E than non-ACOA participants. Studies indicate that this also is a gender specific characteristic of male ACOAs and is linked to substance abuse problems.

Method

Participants were selected from an original sample of 164 clients who were first admitted to the intake unit of a residential treatment facility during 1992. Clients with invalid tests, a drug dependency only diagnosis and those with unknown family of origin were excluded. This resulted in an effective sample of 105 (56 males and 49 females). Thirty-four females identified themselves as having a parent with a drinking problem as did 25 males. Male participants ranged in age from 17 to 56 (m = 30.8), females from age 18 to 52 (m = 30.6). The male sample had a range of education to be 8-16 years with a mean of 11.6, the female sample had a range of 7-18 years with a mean of 11.9. Thirty-six of the females were White, 12 Black and one other; the male sample included 54 Whites and 2 Blacks. Seventy percent of the

sample were unemployed, with the other 30% having full or part-time employment. The sample included a range of marital status including married, single, divorced and married/separated. All participants, both female and male, reported prior treatment at another facility.

Prior to participation in this study, all participants signed a consent form giving their willingness to participate in research studies. Confidentiality of each person was maintained throughout the study. Participants were administered the Michigan Alcohol Screening Test (MAST) and the Personality Research Form-E, PRF-E (Jackson, 1984). All participants scored over 5 on the MAST, which is diagnostic of alcoholism (Selzer, 1971). Each participant was monitored for symptoms of withdrawal for at least two days prior to testing. Participants had varying lengths of abstinence prior to testing. All tests were hand scored and PRF-E raw scores were converted to scale scores. The data analyzed here were originally collected by Kevin Elliott (1993) for a more general study of inpatient alcoholics.

Results

The hypotheses were tested using one-way analyses of variance. None of the four hypotheses that included all ACOA participants were supported (all $p's > .05$). One of the two hypotheses involving male ACOA participants was supported. The relevant PRF-E scores for ACOAs and non-ACOAs overall and for males only are found in tables 1 and 2.

Insert Tables 1 and 2 about here

The prediction that male ACOA participants would score higher than non-ACOA male participants on the PRF-E Autonomy scale was not supported, ($p > .05$). However, the prediction that male ACOA participants would be more impulsive as measured by the PRF-E was supported, $F(1,55) = 3.286$, $p = .037$, 1-tailed.

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Discussion

The ACOAs and their non-ACOA counterparts scored similarly in the personality characteristics assessed by the PRF-E, with the exception of impulsivity. Male ACOA alcoholics appear to be more impulsive than non-ACOA alcoholics. This is similar to the findings of Pihl, Peterson and Finn (1990) who found a high rate of impulsivity in male ACOAs. Impulsive behavior is one of the main characteristics described by Woititz (1983) in his self-help book for ACOAs.

The literature suggests that ACOAs, particularly substance abusing ACOAs, have a higher proportion of social consequences, family problems and interpersonal relationship issues than non-ACOAs. Defining traits measured by the PRF-E Impulsivity scale include, but are not limited to, rash, reckless, foolhardy and volatile in emotional expression. A subject scoring high in these areas in combination with substance abuse issues are more likely to experience significant social consequences.

It is interesting to note that traits measured on the impulsivity scale of the PRF-E relate to characteristics of the role of "scapegoat" in the alcoholic family. In a study by Potter and Williams (1991), which examined the roles of ACOAs, those who identified with the role of scapegoat were the only subjects reporting alcohol and drug treatment. They also reported more problems overall than those who identified with other roles.

Some studies disagree with these findings on impulsivity. In a study designed to test Woititz's ACOA personality characteristics, Seefeldt and Lyon (1992), found no significant differences between ACOA and non-ACOA groups. This study also utilized the PRF-E, but assessed college participants as opposed to a clinical sample.

Berkowitz and Perkins (1988) assessed college students to examine the extent to which personality differences are gender specific. They found no difference between ACOA and non-ACOA participants in several variables, including impulsivity. This study also found a higher level of autonomy in male ACOAs. The clinical sample used in the study reported here found no significant difference on autonomy. This trait of autonomy would also be more closely linked to the "hero" role.

A vast majority of the studies cited here were done with college populations. As a whole, such an ACOA population would tend to be healthier than the population found in a treatment center seeking help for their problems. It would also include higher achievers who would, in all probability, relate more appropriately to the "hero" role identified by Black (1981).

Limitations

Failure to find significant differences on the other scales may indicate that the PRF-E measures personality traits that are common to all alcoholics and are not ACOA specific. Norms for both ACOA and the substance abuse

population are limited with this test. Denial is a trait that both ACOA and non-ACOA alcoholic subjects would share. There may be a tendency to fake good and show higher scores on the Desirability scale than would normally be expected for ACOAs.

Results of this study show that aggression and defendence are traits that are evenly matched in the ACOA and non-ACOA groups. These traits are also linked to denial and, in the case of court and/or DCFS referred clients, could be related to hostility at being in treatment as opposed to family of origin problems. The clinical sample utilized represents a large proportion of DCFS and other legal referrals.

A study by Wilson and Blocher (1990) on the personality characteristics of ACOAs found that problems exhibited by ACOAs were also found in adult children from other types of dysfunctional families. This would be a limitation to this current study as we did not examine this particular variable. It is possible the non-ACOA sample did have various other types of family of origin problems.

Other limitations to this study include a small sample size and lack of a non-alcoholic control group. ACOAs were categorized by self-report of a parent with a drinking problem as opposed to use of some multi-item assessment scale such as the Children of Alcoholics Screening Test (Jones, 1983). Use of such a testing device might have made subject selection more accurate.

Recommendations for Future Research

The results of this study, in combination with the literature review, suggest several areas of future research. Significant discrepancies are noted between researchers who study college populations as opposed to clinical samples. There appears to be a division in the findings on personality characteristics of ACOAs between clinical and college samples. No studies were available on a random sample of all backgrounds or a comparison of college and clinical samples combined. Future research in this area would benefit from examining a more random sample. It would seem that taking into consideration the different roles identified by Black (1981), together with the personality characteristics to be tested for, may yield better results.

Results of this study point to one significant difference between a clinical sample of ACOA alcoholic clients and non-ACOA alcoholic clients. This trait of impulsivity should be investigated further. It would be interesting to pursue how this trait of impulsivity impacts not only the alcoholism, but also the social complications that lead clients into treatment. Many studies identified aggression as a prevalent characteristic. This study failed to obtain that result. Future research may need to examine the role of impulsivity as it relates to aggression in the alcoholic/ACOA population.

Implications

Clinicians may need to be more aware of how impulsivity

could impact not only treatment, but ongoing recovery issues. This trait can seriously impact how ACOAs relate to family members and significant others. Impulsiveness as it relates to intimate or sexual relationships has been closely linked to relapse. It creates significant problems with attempts at working a recovery program and staying sober. Another interesting area of research would be how this trait impacts the spread of HIV/AIDS within the substance abuse population and whether or not ACOA males pose a greater risk of contracting this disease based on impulsive traits.

A greater awareness of this trait in the alcoholic-ACOA may help clinicians understand and work with this population more effectively. Helping the client become more aware of this trait and how it can impact relapse could be beneficial. Clinicians can assess impulsive behavior and help clients learn to make positive decisions and think through consequences of their behavior with a greater awareness of this trait. This could improve recovery, chances for ongoing sobriety and improved relationships with people in their life.

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Table 1

Means and Standard Deviations on PRF-E Scale Sores By Group

	Group			
	Non-ACOA		ACOA	
PRF-E Scales	M	SD	M	SD
Aggression	50.04	10.18	52.19	10.52
Defendence	54.09	9.51	52.52	9.43
Dominance	46.76	9.37	44.47	9.32
Desirability	43.83	11.32	40.77	13.00

* $p < .05$

Table 2

Means and Standard Deviations on PRF-E Scales for Males

	Group			
	Non-ACOA		ACOA	
PRF-E Scales	M	SD	M	SD
Autonomy	40.75	8.21	41.41	9.03
Impulsivity*	51.75	12.01	56.59	7.74

* $p < .05$, 1-tailed