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A Comparison of Personality Correlates of Self-Identified and Nonidentified Adult Children of Alcoholics

Patti K. Hampsten
Eastern Illinois University
This research is a product of the graduate program in Psychology at Eastern Illinois University. Find out more about the program.

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A Comparison Of Personality Correlates of

Self-Identified and Nonidentified Adult Children of Alcoholics

(TITLE)

BY

Patti K. Hampsten

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

Master of Arts

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

1996

YEAR

I HEREBY RECOMMEND THIS THESIS BE ACCEPTED AS FULFILLING
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Abstract

This study compared personality traits of adult children of alcoholics with adults who did not come from alcoholic home environments, for the purpose of developing treatment protocols. It was hypothesized that 1) there would be differences between clinical ACOA's and non-clinical ACOA's, 2) clinical ACOA's would differ from non-ACOA's, 3) non-clinical ACOA's would differ from non-ACOA's. Four groups were used in the comparison, adult children of alcoholics in treatment, adult children of alcoholics with no treatment history, non-adult children of alcoholics in treatment, and non-adult children of alcoholics with no treatment history. The fifty-two female participants were administered the Children of Alcoholics Screening Test to determine ACOA status and the Personality Screening Inventory to measure specified personality traits (Alienation, Social Nonconformity, Discomfort, Expression, Defensiveness). Partial support was found for two of the three hypotheses. The first hypothesis which anticipated trait differences between clinical and non-clinical ACOA's was not supported. Contrary to expectations, there were no significant differences between ACOA's on the basis on treatment experience. Analysis revealed significant differences between clinical ACOA's and non-ACOA's. Clinical ACOA's scored higher on three of the five scales of the PSI (Alienation, Social Nonconformity, and Discomfort). Differences were also expected between non-clinical ACOA's and non-ACOA's. There was partial support for this hypothesis as non-clinical ACOA's had higher scores on Social Nonconformity
and Discomfort Scales. Implications for clinical practices are discussed as well as recommendations for further research.
Dedication

This study is dedicated to all the ACOA's I have had the good fortune to know and from whom I have learned so much about the true meaning of courage. Each one has been an inspiration, but there are three ACOA's who have made the most indelible impact on my life; Karen, Jan, and my mother, Patsy.
Acknowledgments

I am indebted to many people, without whom this research would not have been possible. I would like to begin by expressing my appreciation to my committee, Dr. William Kirk, Dr. William Bailey, and Dr. Michael Havey.

Dr. Havey was generous in sharing his experience and knowledge of COA's, the CAST, and the PSI. In addition to his valuable feedback, Dr. Bailey was graciously patient while assisting me with the statistics for which I thank him.

Dr. Kirk has been my advisor, has served as Chair of my thesis committee, and most importantly, has been my friend. His compassion and patience are an inspiration. Without his encouragement and support this project would not have come to fruition.

I would also like to extend my thanks to my friends and co-workers at Heartland Human Services. To Cheryl Compton, Executive Director, I owe a debt of gratitude for allowing me to have access to Heartland Human Services' clients in order to conduct this research and for allowing me flexibility in my schedule in order to pursue this graduate degree. There are many people whose concern and support have meant more to me than they will ever know, Chris Winters, Lucille Musser, Ellen Couch, Julie Tull, Curt Starkey, Jim O'Neil, Linda Heiden, and Robin Kralman to name but a few. A special thanks to Jenna Standerfer who came to my rescue in times of computer crises, she is a friend indeed. And to Janna Scott, my dear friend, for her steady advice and unwavering confidence in me which gave me strength when I had none.
I am forever in the debt of my family who have encouraged me and supported me in my pursuit of my education. To my parents, Kaye and Patsy Smith, who have always encouraged and supported me in any endeavor, thank you hardly seems enough. The knowledge that they were always behind me and the strength of their love has allowed me to reach for my goals. To my other parents, Carrell and Brenda Hampsten, thank you for being my cheering section and for always being there for me. Thank you to my aunt Karen Evon, who has always been a role model and who sparked my interest in psychology.

And finally, to my best friend, my husband, Randy Hamptsen, who has been patient, tolerant, and who has shown me nothing but love and support during the struggle to obtain a graduate degree. He helped put things in the proper perspective when I became obsessed and gave me the strength and courage to go on when I wanted to quit. He stood by me as I struggled, without complaint, even though his life was often turned upside down by my chaotic schedule. I consider myself truly fortunate to have his love and dedication. Because of him, this leg of the journey is now complete.
Introduction

Concern over problem drinking has been documented since ancient times. The writings of Plato, Aristotle, Plutarch, and Cicero make reference to the problems caused by drunkenness. Interest in the effects of problem drinking on the offspring of alcohol abusers has also been chronicled from as early as Biblical times. The Bible makes references to mothers who drink during pregnancy giving birth to deformed babies (Stevens, 1990).

In more recent times, documentation reveals that alcohol abuse continues to be an issue of concern. In 18th century England there was widespread concern that the "Gin Epidemic" was responsible for the plummeting birth rate and the high infant mortality rate. In Switzerland in 1893, Auguste-Henri Forel, a professor of mental diseases at the University of Zurich, postulated that alcohol caused pathological changes in the body, particularly in the reproductive organs. During the late 19th century the moralistic tenor of the era ushered in the temperance movement, paving the way for Prohibition in the 1920's (Stevens, 1990).

But it was not until the 1940's that real progress was made in research investigating the biogenetic causes of alcohol abuse. That is when E.M. Jellineck, a modern pioneer in the field of alcohol studies, developed the Jellineck Chart. This instrument outlined the symptoms of alcohol abuse in chronological order of their appearance, thus outlining the course of the disease and providing the foundation for the theory that alcoholism was biogenetic in origin.
In 1955 The American Medical Association classified alcoholism as a disease. This move dispelled the myth that there was no hope for alcoholics; that they possessed weak moral character and lacked will power. This breakthrough helped shatter the stigma that had long shrouded the people afflicted with this disease and paved the way for more progressive, effective, and comprehensive treatment for this disease.

As the drug culture emerged in the 1960's and 1970's, once again the issue of substance abuse was brought to the forefront of public scrutiny. The need for more and better treatment became apparent. This resulted in the chemical dependency field refining its methods of treatment and it evolved into the highly specialized field it is today. A field of study that in comparison to other disciplines is still in its infancy.

In the 1970's a new dimension was added to the growing volume of information and speculation revolving around the disease of addiction. Attention was beginning to be paid to the spouses of alcoholics. The popular literature introduced the concept of codependency. There are as many definitions for codependency as there are people to supply those definitions. For the most part, the common thread that ties all these definitions together is a preoccupation with the behavior of the alcohol abuser and a tendency to neglect one's own behavior, wants, and needs in order to focus on the behavior, wants, and needs of the alcohol abuser.

Yet another new issue began to gain attention in the 1980's, the issue of
what happens to the children who are raised in a home with an alcoholic parent. For years the focus had been on the pain suffered by the alcoholic, but what about the damage inflicted upon the alcoholic's or drug addict's family? In the 1980's the codependency and adult children of alcoholics movements began to emerge. Clinicians who treated alcoholics and drug addicts, and who had the opportunity to interact with their families in a therapeutic setting began to notice that family members of alcoholics and addicts did not walk away from their experience with an addicted family member unscathed. Finally clinicians, researchers, and the general public began to ask questions about what happens to family members as a result of a loved one's drinking and/or drug use and the adult children of alcoholics movement was born.

It is estimated that there are 28 to 34 million children of alcoholics in America (Carroll 1989; Stevens 1990; Thomson 1990). It has been further estimated that there are currently ten million American adults afflicted with alcoholism who in turn directly affect another five to ten million lives (Stevens, 1990). Studies suggest that alcoholism affects one in four American families and that each alcoholic directly affects the lives of four to six other people (Cole, 1989) and it is believed that one out of every eight Americans has been raised in an alcoholic home (Thomson, 1990). Given that there are this many people who are affected by the addiction of another and suffer the consequences of being brought up in such an environment, it is not surprising that there are some who need help in dealing with the negative effects of being involved with an alcoholic
or addict.

While there are some adult children of alcoholics (ACOA's) who do not seek treatment and who function relatively well, this is not the case for all ACOA's. It is believed by some that ACOA's are at a greater risk for psychological and physical distress (Kashubeck, 1994). Thomson (1990) reports that clinical studies have shown many people with psychological problems who present for treatment have at least one parent who is alcoholic. Adult children of alcoholics are disproportionately represented in our nation's correctional facilities, family court systems, spousal and child abuse cases, divorces, and within populations plagued with psychological and emotional problems (Carroll, 1988). This characterizes ACOA's as a population at risk, a population that in order to receive effective help, needs to be better understood.

While interest in this subject has grown in recent years, much of the information being reported is done so in the popular press or is based on clinical observation that has not been empirically validated. The clinical research has been described as small and methodologically weak (Cole, 1989), lacking in control groups, and using sample sizes that are too small to yield accurate results (Stevens, 1990). Cole (1989) makes the observation that the empirical studies that have been done focus primarily on young children and not adults. Due to the lack of empirical research, mental health clinics and substance abuse treatment centers have put together programs to treat ACOA's with the disadvantage of little or no research to validate that what is being done is appropriate or effective. Due
to the paucity of empirical literature on this population, further research is warranted. It has been suggested that the focus of additional research should include investigating personality characteristics (Fisher, Jenkins, Harrison, & Jesch, 1993). Also needed is research delineating the specific effects of parental drinking on family dynamics and individual functioning, both in clinical and non-clinical samples (Sheridan & Green 1993).

Since ACOA’s are a population at risk, it is reasonable to assume that many will find their way to helping professionals, be it through self referrals or referrals through other sources such as the court system, child welfare entities, or employee assistance programs. In the current atmosphere of managed care, where insurance companies and other entities dictate lengths of stay for clients who seek treatment, the clinician is no longer afforded the luxury of time she or he once was. Accurate assessments must be made with much speed and clients are moved through the treatment episode much more quickly than ever before. Models of therapy such as solution oriented approaches and brief episodic therapy are replacing more traditional interventions like client centered therapies and psychodynamic approaches to therapy. Faced with these kinds of changes, practicing clinicians need a framework to help them understand client issues so those issues can be appropriately addressed as soon as possible, often in the first clinical session.

The purpose of this study is to provide such a framework for clients and clinicians alike by identifying personality characteristics that differentiate ACOA’s
from non-ACOA's. If clusters of personality traits can be identified as occurring within the ACOA population, then perhaps interventions can be designed in such a way as to insure the likelihood that such interventions will be well received by this client population, thus enhancing the benefits of the treatment experience and expediting progress. This study explores the personality characteristics of identified adult children of alcoholics to discover similarities in a clinical group. ACOA's with no treatment experience are also studied for comparative purposes.
Literature Review

As reported previously, much of the literature that can be found on the ACOA population is found in the popular press. Book stores across the nation now have entire sections devoted to ACOA's, their issues, and their recovery. Journal articles that appear on this topic are often based on clinical observations, not empirical data. Of the clinical observation articles that have been published, some researchers have found common characteristics and dysfunctions among the ACOA population (Carroll 1989; Cole 1989; Thomson 1990; Sheridan & Green 1993; Fisher, et. al. 1993) while others have not found any significant differences in functioning (Stevens 1990; Seefeldt & Lyon 1992; Logue, Sher, & Frensch 1992; Kashubeck 1994).

Early research focused on the propensity of offspring of alcoholics to develop the disease of alcoholism themselves. The consensus is that sons from alcoholic homes are four times more likely to become alcoholic than sons from non-alcoholic homes (Cole, 1989). Sheridan and Green (1993) reported the most common adverse affect is an increased likelihood of developing alcoholism oneself or marrying an alcoholic. Their study also reports a higher incidence of (1) physical problems including fetal alcohol syndrome, hyperactivity, increased accident proneness, and stress related disorders; (2) psychological disorders such as anxiety, depression, neuroticism, and hysteria; (3) social and behavioral problems including difficulty with relationships, delinquency, and school related problems. Studies on family cohesion revealed overly close and overly distant
dynamics in alcoholic families. Studies on adaptability showed dysfunctional extremes ranging from rigid to chaotic. Communication incongruence was found with a narrow range of expression in both content and affect. These dynamics are thought to result in social isolation of the family members, deficits in self definition or the tendency to define oneself through other external relationships (Sheridan & Green 1993). The findings of Sheridan's and Green's study suggests that ACOA's may be handicapped in their adult lives as a result of deficits stemming from their experiences in the family of origin. They propose that the individual's condition is the result of ongoing exposure to a dysfunctional family system which impedes normal psycho-social development.

Kashubeck's 1994 study reported results indicating that parental alcoholism was positively related to psychological distress. It is reported that ACOA's generally do not experience severe problems until adulthood and that the problems experienced typically emerge when they encounter adult stressors (Carroll, 1989). Clinical observations have produced the notion that adult daughters from alcoholic homes are affected the most (Carroll 1989; Kashubeck 1994). They are reported to display certain patterns of behavior that are problematic and have major personality difficulties. They are thought to experience more problems with greater problem severity. Cole (1989) reports that these problems result in more psychological symptoms: more depression, lower self esteem, and underlying anger and resentment for authority.

There are numerous reports that have found no significant differences in
personality of ACOA's. Stevens' study (1990) investigated adult daughters of alcoholics to see if they displayed problems in functioning in seven dimensions commonly associated with female ACOA's. No significant differences were found in any of the seven dimensions which included: (1) difficulty trusting others, (2) excessive desire for control, (3) hypervigilance, (4) guilt proneness, (5) excessive desire for approval, (6) denial of emotions, wants, and needs, (7) difficulty having fun. A 1989 study by Carroll could find no significant differences in these same dimensions. Logue, Sher, and Frensch (1992) suggest that the lack of significant differences in empirical studies could be due to the "Barnum Effect". They used Meehl's theory as inspiration for their 1992 study. The Barnum Effect is the "phenomena of accepting a personality description as valid, when in fact the description is merely so vague, double headed, and socially desirable, or of such a great base rate in the general population that it defies rejection" (Logue, Sher, & Frensch, 1992). Their study also supported that the Barnum Effect was found to exist in their sample. Seefeldt and Lyon (1992) also doubt the validity of the perception of ACOA's as a homogeneous group and argue the Barnum Effect in defense of their position.

Still, others have found mixed results. Carroll (1989) states that while there is no typical alcoholic family, all alcoholic families are dysfunctional. As a result of their shared experiences, Carroll believes that ACOA's develop core issues that set them apart from children from non-alcoholic homes. In a 1989 study, Cole suggested that alcoholic homes provide less emotional support for
developing children, inconsistent and unstable expectations about love and affection, and more parental conflict resulting in a lack of role modeling for appropriate adult behavior and healthy relationships. She goes on to say however, that many ACOA's appear to function well and do not present for treatment and therefore, the information that has been presented in clinical observations may not be true for all ACOA's.

Fischer, et. al, (1993) found in their study that ACOA's differed from adults with no identified dysfunctional family history but they did not differ significantly from other adults with dysfunctional family histories.

Millon defines personality as "ingrained and habitual ways of psychological functioning that emerge from the individual's entire developmental history. These traits are shaped by the individual's interactions with the world. Gradually, individuals acquire a pattern of relating to others and coping with their world" (Thomson 1990). If this is true, then the environment in which an individual is raised will certainly have an effect on the traits that individual develops. It is widely believed that an individual's personality is shaped by his or her early experiences and that those experiences will influence future behavior. If one grows up in a home environment where one or more parent is alcoholic, it would seem reasonable that this experience would also influence that individual's development. Since it is known that alcoholic families have sets of particular problems that differ from the problems of normal or non-alcoholic families, it is conceivable that there would be a difference in personality traits between children
exposed to an alcoholic home environment and children who were not. Does the experience of being an ACOA lead to the development and utilization of particular coping patterns and not others? Could data on ACOA's, both clinical and non-clinical, be integrated into a well documented and acceptable theory of personality? This study makes a contribution to the literature which helps to answer these questions and provides the basis of a framework for problem identification and treatment of the ACOA population by demonstrating that such differences do exist.

This study investigated whether there are differences in personality traits by comparing measured personality traits of both clinical ACOA's and non-clinical ACOA's with adults not raised in an alcoholic home, some of whom had treatment experience and some of whom did not. Three hypotheses were tested. It was expected that (1) there would be differences in measured personality traits between clinical and non-clinical ACOA's; (2) that even more pronounced differences would occur between clinical ACOA's and non-ACOA's; (3) differences were also anticipated between non-clinical ACOA's and non-ACOA's.
Methods

Participants

This study utilized a total of fifty-two participants divided into four groups. Adults presenting for treatment in an outpatient mental health clinic who were raised in homes where at least one parent was alcoholic make up the first group (n=11). They are referred to as clinical adult children of alcoholics (clinical ACOA's) in this study. Adults who were raised in an alcoholic home where at least one parent was alcoholic and who identify themselves as adult children of an alcoholic, but who are not seeking treatment nor have had any prior treatment experience comprise the second group of participants (n=8). They are referred to as non-clinical adult children of alcoholics (non-clinical ACOA's). Adults presenting for treatment in the same outpatient mental health clinic but who have not been raised in an alcoholic home environment make up the third group (n=10) and are referred to as clinical non-adult children of alcoholics (clinical non-ACOA's). Lastly, the control group consisted of adults who were not raised in an alcoholic home environment, who were not seeking treatment, and who had no prior mental health counseling experience (n=23). This group is referred to as non-adult children of alcoholics (non-ACOA's). It has been suggested that there is a latent onset of problems in ACOA's; problems generally do not appear until the 20's and 30's with the most common age of onset of problems occurring in the mid 30's. To insure a more homogeneous group, all participants were females who ranged in age from 18 to 45.
Participants for these four groups were selected in two different ways. Participants in the clinical ACOA group had to meet three criteria: (1) they were selected from patients presenting for treatment at a community outpatient mental health clinic; (2) they were determined to have come from an alcoholic family of origin home environment; (3) they obtained a score of six (6) or more on the Children of Alcoholics Screening Test (CAST). Participants for the clinical non-ACOA group were also selected from patients presenting for treatment in the same community outpatient mental health facility, but they were determined not to have been raised in an alcoholic home environment and scored a zero (0) on the CAST. The non-clinical ACOA group as well as the non-ACOA group were selected from students attending school at a middle sized university in the same geographical area as the outpatient mental health clinic. These participants were asked to complete a demographic questionnaire to determine age, gender, and any prior counseling experience. They also completed the CAST to determine ACOA status. Participation in the study for all of these groups was voluntary. All participants signed consents allowing their test data to be used in the study.

Only female participants were used in this study as the literature suggests that daughters from alcoholic homes are more likely to experience problems and that the problems they experience are of greater severity. It has also been reported that females are more likely to seek help for their problems (Carroll, 1989; Kashubeck, 1994). Another factor that supports the use of female participants exclusively is concern that males and females respond to the CAST
differently (Dinning & Berk, 1989; Havey & Dodd, 1992; Havey & Dodd, 1995). If there is indeed a difference in CAST scores due to gender, then the use of only female participants eliminates a potential confounding variable.

**Materials**

Participants of all four groups completed a demographic questionnaire that also asked about family background and other possible sources of dysfunction such as the presence or absence of: (1) other types of parental substance abuse; (2) domestic violence; (3) incest; (4) chronic psychiatric problems; (5) chronic physical problems. Because family problems such as these have been reported to produce effects similar to parental alcoholism, the presence or absence of these problems needed to be determined (Sheridan & Green, 1993).

In order to determine whether or not participants were the child of an alcoholic, they completed the Children of Alcoholics Screening Test (Jones, 1981). The CAST is a 30 item inventory that measures feelings, attitudes, perceptions, and experiences related to parental drinking. Subjects respond "yes" or "no" to questions that ask about one's experience with parental drinking behavior, e.g. "Did you ever wish that a parent would stop drinking?" or "Have you ever lost sleep due to a parent's drinking?" The number of affirmative answers are summed to yield the respondent's score. Scores on the CAST can range from 0 to 30; a score of 0-1 indicates that the respondent is not an ACOA; scores of 2 to 5 indicate that the respondent has experienced problems due to parental drinking behavior; a score of 6 or above indicates ACOA status.
Although this is a recently developed instrument, testing of reliability and validity support its adequacy for screening ACOA status (Pilat & Jones, 1984/1985). It should be noted however, that in a recent study (Havey & Dodd, 1995) there were gender differences indicating that females are more likely to identify themselves as children of an alcoholic than are males.

Personality is an abstract concept that is difficult to define. This study utilized participants' scores on the Psychological Screening Inventory (PSI) to measure personality traits. The PSI is a 130-item forced-choice instrument that consists of five scales. The five scales are Alienation, Social Nonconformity, Discomfort, Expression, and Defensiveness, and were selected to provide a maximum amount of useful information in a limited amount of time and with limited effort on the part of the respondent and the examiner (Lanyon, 1973). Respondents are asked to mark either "true" or "false" to the personalized statements that are presented on a single sheet of 8 1/2 x 11 paper printed on the front and back. The PSI is designed to meet the need for a brief mental health screening in situations where time is limited and clinical resources are under multiple demands. It is appropriate for use by clinical staff who are called upon to make fairly specific decisions about broad clinical populations. It is ideal for completion where space and privacy are limited, such as a clinic waiting room. It is also ideal for group administration. The items are worded to a grade school reading level and are found to be non-threatening to the vast majority of respondents (Lanyon, 1973). The PSI can normally be completed in fifteen
minutes. Ease of administration is accompanied by ease of scoring as the PSI can be scored in three to four minutes. It is suggested that a profile with two or more omissions be returned to the respondent and that the respondent be encouraged to choose the answer that best fits. Respondents are allowed to ask questions in order to clarify what an item is stating if need be; however, if more than two or three questions are asked, the profile should be interpreted with caution.

Development of the PSI began in 1964. Norms are based on 500 males and 500 females representative of the population in the United States with respect to age, education, and geographical location. Reliability compares favorably with reliability coefficients for the MMPI and validity of the PSI as a mental health screening device is supported by pilot studies (Lanyon, 1973).

Procedure

The clinical ACOA group and the clinical non-ACOA group were administered tests individually as part of their intake procedure. Debriefing occurred in the following individual therapy session. Test data became a part of the clients' clinical record and was incorporated into the development of their respective treatment plans.

The participants in the non-clinical ACOA group and the non-ACOA group were asked to complete the testing if they chose to do so and return completed testing to the designated university instructor. Each participant was provided with a written summary of the purpose of the study and was allowed to have any
questions about the study and their participation answered to their satisfaction. All participants signed a written consent form prior to participation. Debriefing sessions were offered to any of the participants who wished to discuss the results of their testing.
Results

The hypotheses were tested using 1-way ANOVAs for the five PSI scales. Partial support was found for two of the three hypotheses. The first hypothesis anticipated trait differences between clinical and non-clinical ACOA's. Contrary to expectations, there were no significant differences between the ACOA's on the basis of treatment experience (all p's < .05). Differences between clinical ACOA's and non-ACOA's were expected by the second hypothesis; this was partially supported. Analyses revealed significant differences on three of the five personality scales (p < .05). As shown in Table 1, ACOA's scored higher on Alienation, Social Nonconformity, and Discomfort. Partial support was also found for the final hypotheses, which anticipated differences between non-clinical ACOA's and non-ACOA's (p's < .05). As seen in Table 2, significant differences were revealed in the scores for Social Nonconformity and Discomfort, with ACOA's scoring higher.
Table 1

Means and (Standard Deviations) on the PSI Scales of
Clinical ACOA's and Non-ACOA's

<table>
<thead>
<tr>
<th></th>
<th>Alien.(a)</th>
<th>Soc.(b)</th>
<th>Discom.(c)</th>
<th>Express.</th>
<th>Def.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical ACOA's</td>
<td>57.82</td>
<td>60.82</td>
<td>58.64</td>
<td>52.91</td>
<td>48.18</td>
</tr>
<tr>
<td></td>
<td>(5.95)</td>
<td>(8.49)</td>
<td>(10.11)</td>
<td>(11.81)</td>
<td>(8.53)</td>
</tr>
<tr>
<td>Non-ACOA's</td>
<td>48.70</td>
<td>49.67</td>
<td>44.85</td>
<td>54.00</td>
<td>53.52</td>
</tr>
<tr>
<td></td>
<td>(8.64)</td>
<td>(7.26)</td>
<td>(8.39)</td>
<td>(10.52)</td>
<td>(9.71)</td>
</tr>
</tbody>
</table>

Legend:

a. F(1,42) = 10.51, p = .0023

b. F(1,42) = 17.89, p = .0001

c. F(1,42) = 20.11, p = .001
Table 2

Means and (Standard Deviations) on the PSI Scales of Non-Clinical ACOA's and Non-ACOA's

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Non-Clinical</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACOA's</td>
<td>54.00</td>
<td>56.00</td>
<td>53.13</td>
<td>58.88</td>
<td>46.25</td>
</tr>
<tr>
<td></td>
<td>(12.09)</td>
<td>(8.35)</td>
<td>(10.79)</td>
<td>(10.93)</td>
<td>(10.47)</td>
</tr>
<tr>
<td><strong>Non-ACOA's</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>48.70</td>
<td>49.67</td>
<td>44.85</td>
<td>54.00</td>
<td>53.52</td>
</tr>
<tr>
<td></td>
<td>(8.64)</td>
<td>(7.26)</td>
<td>(8.39)</td>
<td>(10.52)</td>
<td>(9.71)</td>
</tr>
</tbody>
</table>

Legend:

a. $F(1,39) = 4.63$, $p = .0377$

b. $F(1,39) = 5.61$, $p = .0229$
Discussion

In this study, clinical ACOA's scored higher than non-ACOA's on the Alienation, Social Nonconformity, and Discomfort Scales of the PSI. This suggests that ACOA's who seek treatment are more likely to exhibit characteristics associated with pathology, such as unusual thoughts, deviant behavior, difficulty relating to people, and feelings of isolation than non-ACOA's. Complaints such as these are quite common in clinical settings and frequently are reasons for referral for many clients to treatment.

The higher scores on the Social Nonconformity Scale indicate ACOA's who are in treatment may tend to be more non-conforming socially and may have a tendency to act more impulsively than the general population. These individuals may be more likely to engage in acting-out behavior and have a disregard for social convention. This can often result in legal problems which often times culminate in a court ordered referral for psychiatric assessment and treatment. Behavior associated with high scores on the Social Nonconformity Scale may also interfere with job performance or the ability to get and keep a job, resulting in an employer referral for assessment and treatment. In both these instances, it may well be an intervening party who prompts the ACOA into treatment rather than the ACOA choosing to seek treatment entirely on their own. This group of ACOA's may be less motivated for treatment and could typically be described as non-compliant with treatment recommendations. They may view treatment as preferable to other sanctions and may not be invested in attempting any real
behavior change. This seeming lack of motivation coupled with their preference for socially non-conforming behavior can easily create an atmosphere conducive for power struggles, passive treatment resistance, and finally, treatment failure. This sort of dynamic can feed into the belief system that perpetuates socially non-conforming behavior which may in turn facilitate feelings of alienation and discomfort. Were it not for the insistence of the intervening party, this population of ACOA’s might never enter treatment.

Reported symptoms of depression and feelings of anxiety are common complaints among individuals who seek mental health treatment and are frequently the presenting problems prompting people to seek treatment. This is true whether or not the individual seeking treatment is an ACOA. Clinical ACOA's scored higher on the Discomfort Scale, suggesting that they may feel more awkward, have an increased sense of anxiety, and report more symptoms of depression than their non-ACOA comparison group. This is the group of ACOA's who would be more likely to willingly pursue treatment in an effort to gain some relief from the discomfort they are feeling. If this is indeed the case, they are likely to be more motivated for treatment and more compliant with treatment recommendations.

Clinical ACOA’s also scored higher on the Alienation Scale. Individuals who score high on this scale may feel disconnected or set apart from others; they may lack a social support structure, and in lieu of such, they may turn to professional counselors for support. For ACOA's for which this is true, treatment
might include the development of the social skills and communication skills necessary to establish and maintain interpersonal relationships. With the acquisition of these skills, the need for professional intervention for support purposes may decrease.

Non-clinical ACOA's, like their clinical counterparts, also scored higher on the Social Nonconformity and Discomfort Scales than did the non-ACOA group; there was, however, no significant difference in the Alienation Scale. This suggests that the non-clinical ACOA group also experiences more measured anxiety and symptoms of depression than the general population. This group may also engage in impulsive behavior, acting-out behavior, or other forms of socially non-conforming behavior as well. Perhaps the difference for this group of ACOA's, given that they did not have significantly higher scores on the Alienation Scale than did the general population, is they may have the social support systems necessary to assist them in adequately dealing with their emotions and the consequences of their behavior.

The study also revealed some other interesting findings. ACOA's who were in treatment were more likely to have come from a home where the parents were divorced, reported having experienced domestic violence at some time in their lives more than the other participants, and reported having been victims of incest more frequently than did the participants in the other groups. This might suggest that being an ACOA alone does not increase the likelihood that an individual will experience life problems or discomfort significant enough to compel
him or her to seek treatment. Perhaps the compounded traumas of other stressors, such as domestic violence or incest, are the experiences that differentiate those who are referred for help and those who are not.

Implications

This study demonstrates that there are some differences in measured personality traits between ACOA’s who seek treatment and the population at large. There were measured differences in personality between ACOA’s who do not seek treatment and the general population as well. The data suggests that ACOA’s, both those seeking treatment and those who do not, report more symptoms of anxiety and depression than the general population. Likewise, both ACOA groups may tend to exhibit behaviors that can be interpreted as socially non-conforming, such as impulsivity and acting-out behavior. The ACOA treatment group also tended to report more feelings of isolation as well as difficulty relating to people. Such a response might impede someone from engaging in the necessary social support that might enhance treatment or stabilize an otherwise vulnerable individual. It may in fact be these issues that compel this subgroup of ACOA’s to seek treatment in an effort to obtain the support they do not have, thus substituting the counselor/client relationship for a social support network.
Future Research

This study has endeavored to make a contribution to the research literature on ACOA's. The data demonstrates that there are indeed measured personality traits differences between ACOA's and non-ACOA's which corroborates previous research in this area. Whatever the determining factor is in the decision to seek treatment by some ACOA's, more research is needed to help better understand the nature of the problems they face.

Certain limitations of this study should be kept in mind when considering these results; sample size was comparatively small (n = 52); the clinical ACOA group consisted of eleven participants while the non-clinical ACOA group was comprised of eight participants. The non-ACOA group with mental health counseling experience consisted of ten participants. The final group, the non-ACOA's with no counseling history, included twenty-three participants. A larger sample might well yield different results. Another consideration is the differences in the mean ages of the clinical groups and the non-clinical groups. Participants for the non-clinical groups were selected from students attending college and are likely to be younger than their clinical counterparts. It has been suggested that there is a latent onset of problems for ACOA's; problems generally do not manifest until later, often during the mid 30's. Therefore, samples of individuals who are closer in age could also yield different results.

Additional research on this topic with larger a sample would surely be a much needed contribution in the field. As a result, perhaps interventions and
treatment strategies can be developed that will assist ACOA's in achieving their treatment objectives as quickly and as effectively as possible, enhancing the quality of life for many ACOA's.
References


