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ABSTRACT

This study attempted to validate the characteristics of adult children of alcoholics (ACOAs) as presented by Woititz (1983). Male (N=52) and female (N=94) college students completed the Personality Research Form, a 352-item measure of personality variables; the Responsibility and Social Adroitness Scales of the Jackson Personality Inventory; the Imposter Phenomenon Scale; and a questionnaire designed to provide demographic information and answer questions concerning their own and their parents' drinking behavior. Based on these self-report instruments, subjects were determined to be either an ACOA, a non-ACOA, or an individual that had been in an ACOA treatment group. Based on these personality measures, groups were compared on 12 of Woititz' 13 characteristics of ACOAs. No significant differences were found among the groups on any of the characteristics measured. The results severely question the validity of these characteristics. (The dangers of employing these characteristics in the diagnosis and treatment of individuals are discussed. Data are tabulated and references are included.) (TE)

PERSONALITY CHARACTERISTICS OF ADULT CHILDREN OF ALCOHOLICS: FACT OR FICTION?

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ABSTRACT

A study which attempted to validate the characteristics of Adult Children of Alcoholics (ACOAs) as presented by Woititz (1983) was conducted. Male and female college students were determined by self-report to be either an ACOA, a non-ACOA, or an individual that had been in an ACOA treatment group. Groups were compared on 12 of Woititz's 13 characteristics through objective personality measures. No significant differences were found among the groups on any of the characteristics measured. The results severely question the validity of these characteristics. The dangers of employing these characteristics in the diagnosis and treatment of individuals is discussed.

PERSONALITY CHARACTERISTCS OF ADULT CHILDREN OF ALCOHOLICS: FACT OR FICTION?

The past few years have seen a tremendous growth in the number of self-help publications written for persons who are related to individuals exhibiting problem drinking behaviors. Evidence for this growth can be found in popular bookstores which have entire sections devoted to topics such as "recovery" and "co-dependency".

It has been argued that any individual related to an alcoholic may have problems related to that alcoholism, even the grandchildren of alcoholics (Thanepohn, 1986). Of particular interest has been a group referred to as Adult Children of Alcoholics (ACOAs). There seems to be growing concern for these individuals that many believe are at risk for mental health problems (Owen, Rosenberg, & Barkley, 1985). With the number of American children of alcoholics estimated at 34 million (Black, 1986), it seems wise to gather as much accurate information about this group as possible.

Though research on children of alcoholics has existed for some time, a self-help book by Woititz (1983) seems to have fostered the growth of the ACOA treatment industry. In this publication, Woititz describes 13 characteristics of ACOAs. These descriptions were apparently based on summaries of clinical impressions made during ACOA treatment. The characteristics are: 1) ACOAs guess at what normal behavior is; 2) ACOAs have difficulty following a project through from beginning to end; 3) ACOAs lie when it would be just as

easy to tell the truth; 4) ACOAs judge themselves without mercy; 5) ACOAs have difficulty having fun; 6) ACOAs take themselves very seriously; 7) ACOAs have difficulty with intimate relationships; 8) ACOAs overreact to changes over which they have no control; 9) ACOAs constantly seek approval and affirmation; 10) ACOAs are super responsible or super irresponsible; 11) ACOAs are extremely loyal, even in the face of evidence that loyalty is undeserved; and 13) ACOAs are impulsive (Woititz, 1983, p.4). The point has been made that these characteristics read like a "checklist of mental health complaints" that fail to distinguish ACOAs from other diagnostic groups (Goodman, 1987, p.153). In fact, this list may be a twisted example of the so-called "Barnum effect", the tendency to interpret a description which applies to everyone as being particularly valid to one's self (see Meyer, 1989, p.439). Despite these criticisms, the abundance of ACOA groups which operate on the basis of Woititz's characteristics speaks to how widely accepted these impressions were and are.

This acceptance seems to be growing in the face of mounting evidence that the description of the category, ACOA is not as clear-cut as Woititz described. In fact, some studies have failed to find expected differences between individuals with alcoholic parents and "normals" (i.e. Alterman, Searles, and Hall, 1989: Venugopal, 1985). Other researchers have found some group differences, but also find the preponderance of ACOAs to be no different from

non-ACOAs. These researchers and others warn against stereotyping individuals with alcoholic parents as necessarily having certain problems or certain characteristics (Calder & Kostyniuk, 1989; Barnard & Spoentgen, 1986; Goodman, 1987).

Only one of the above studies has attempted to measure any of Woititz's characteristics directly utilizing objective measures. In that study, ACOAs who were in treatment scored significantly lower than normals on "capacity for intimate contact" (Woititz characteristic number 7 above). Ironically however, ACOAs who were not seeking treatment scored significantly higher than both treatment-seeking ACOA and normal groups (Barnard & Spoentgen, 1986).

Because there seems to be some doubt as to the validity of Woititz's description of ACOAs, it is imperative that objective evaluation of these characteristics be conducted to validate the label of ACOA. Without this kind of validation, it is possible that we are encouraging up to 30 million individuals and their therapists to view themselves and their problems in a way that may not only be inaccurate, but even maladaptive. Our study is an initial attempt at assessing differences between non-treatment ACOA, treatment ACOA and non-ACOA groups along the 12 remaining characteristics described by Woititz (1983). In addition, we will attempt to discover which of Woititz's characteristics (if any) predict membership into these three groups.

Method

Subjects

The subjects participating in this study were 147 undergraduate students from a state university located in the midwestern United States. The subjects were all drawn from introductory classes in several disciplines of academic study. Fifty-two males (35.4%) and 94 females (63.9%) participated, with one student failing to report his or her sex on the questionnaire. The mean age of the subjects was 23.5 years (SD = 6.47) and they ranged in age from 18 (n = 14) to 54 (n = 1) years. One-hundred and sixteen (78.9%) of the subjects were freshmen, 20 (13.6%) were sophomores, and 8 (5.4%) reported they were juniors. Three subjects failed to report this information on the questionnaire.

Instrumentation

As noted earlier, the primary purpose of this study was to evaluate differences between self-identified ACOAs and non-ACOAs on 12 of Woititz's (1983) 13 characteristics. One characteristic, intimacy, was addressed in a previous study by Barnard and Spoentgen (1986); hence it was not included in the present study. Empirical scales were selected which appeared to measure each of the remaining 12 characteristics of ACOAs as outlined by Woititz. These included: from the Personality Research Form (PRF) (Jackson, 1984), (1) Abasement - ACOAs judge themselves without mercy, (2) Affiliation - ACOAs are extremely loyal, even when loyalty is undeserved, (3) Defendence - ACOAs lie when they could

just as easily tell the truth, (4) Dominance - ACOAs overreact to changes over which they have no control, (5) Endurance - ACOAs have difficulty following a project through from beginning to end, (6) Impulsivity - ACOAs are impulsive, (7) Play - ACOAs take themselves very seriously, and ACOAs have difficulty having fun, (8) Social Recognition - ACOAs desire approval and affirmation; from the Jackson Personality Inventory (JPI) (Jackson, 1976) (9) Responsibility - ACOAs are either super responsible or super irresponsible, (10) Social Adroitness - ACOAs usually feel "different" from others; and (11) the Imposter Phenomenon Scale (Harvey & Katz, 1985) - ACOAs tend to guess at what constitutes normal behavior.

Personality Research Form. The PRF is a 352-item objective measure of personality variables, "broadly relevant to the functioning of individuals in a wide variety of situations" (Jackson, 1984, p.4). The instrument yields scores for 20 personality traits and contains two validity scales. The various scales on the PRF provide measures of impulse control and expression, orientation toward work and play, orientation toward direction from other people, intellectual and aesthetic orientations, degree of ascendancy, degree and quality of interpersonal orientation, and test-taking attitudes. Jackson reports internal consistency estimates of reliability (odd-even) ranging from .50 to .91 for form E and test-retest reliabilities (one-week interval) ranging from .69 to .90 for form AA.

For the 8 PRF scales used in this study, internal consistencies range from .50 to .86 (median r = .72) and test-retest reliabilities range from .72 to .88 (median r = .80). Ample evidence of construct validity is provided for the PRF via factor analysis of the content scales, which supports the basic structure of the scales, and correlations of PRF scores with expert behavioral ratings of psychiatrists, psychologists, and persons familiar with PRF respondents (see Jackson, 1984).

Jackson Personality Inventory. The JPI is a 320-item objective measure of personality, "reflecting a variety of interpersonal, cognitive, and value orientations likely to have important implications for a person's functioning" (Jackson, 1976, p.9). The instrument is arranged in true-false format and yields scores for 15 substantive scales and one validity scale. All scales on the JPI were constructed from large item pools and explicit definitions of what each scale was intended to measure. The scales are also bipolar; hence, an interpretation of either extreme responsibility or irresponsibility can be obtained from the Responsibility scale, and social maladroitness can be evaluated on the Social Adroitness scale, which were the primary concerns of this study. Jackson (1977) reports internal consistency estimates of reliability (coefficient alpha) for the JPI ranging from .62 to .88 on two samples of subjects. Coefficient alphas for the Responsibility and Social Adroitness scales ranged from .67 to .70, and .62 to

.65, respectively. Seefeldt, Barnett, and Lord (unpublished manuscript) reported test-retest reliabilities (six-week interval) for the JPI ranging from .68 to .88 for a sample of college students. Test-retest coefficients for the Responsibility and Social Adroitness scales were both .78. Ample evidence exists for the construct validity of the JPI through factor analytic findings, multitrait-multimethod studies, and other convergent and discriminant validity studies (see Jackson, 1976).

Imposter Phenomenon Scale. The Imposter Phenomenon Scale (Harvey & Katz, 1985) is a 14-item self-report form, purporting to measure the tendency of some persons to deprive themselves of joy in their accomplishments due to a fear of being "unmasked" and found to be a phony or fake. According to Harvey and Katz, the problem is prevalent among high-achieving individuals who may harbor intense, secret feelings of fraudulence in the face of their achievement and success. Three basic symptoms tend to characterize those who experience the imposter phenomenon: (1) a sense of having fooled people into overestimating their ability, (2) a tendency to attribute success to some non-intelligence/ ability factor, and (3) an intense fear of being exposed as a fraud. The scale was used in the present study to examine feelings of fraudulence, which Woititz (1983) suggests undermines ACOAs feelings of normalcy. She states, "throughout life, to keep others from finding out that they

don't know what they're doing, they guess at what is appropriate" (p. 25).

Procedure

Packets of materials were prepared for each subject which contained the following items: (1) the entire PRF, (2) the Responsibility and Social Adroitness scales of the JPI, (3) the Imposter Phenomenon Scale, and (4) a questionnaire designed by the authors. The author-designed questionnaire required the respondents to provide selected demographic information and answer questions concerning their own and their parents' drinking behavior. The ACOA group was comprised of those subjects who responded on the questionnaire that one or both of their parents was an alcoholic; a treatment subgroup was also comprised of those subjects who responded that they had actively participated in an ACOA treatment group.

The materials were presented to classes of students who had consented to participate in the study by one of the two authors. Subjects were informed that the purpose of the study was to collect information on a variety of contemporary issues and problems and that their responses were completely confidential. They were instructed to complete the inventories in the order presented, omit no items, and then given approximately 60-75 minutes in which to respond.

Data Analysis

The primary research question concerning differences between self-identified ACOAs and non-ACOAs on 12 of Woititz's 13 characteristics was addressed by performing t tests for independent samples on raw scores from the PRF, JPI, and Imposter Phenomenon Scale. Since a subgroup of students also identified themselves as having participated in treatment groups for ACOAs, ANOVAs for independent samples were also performed on these same scores for non-ACOAs, non-treatment ACOAs, and treatment ACOAs. Finally, a discriminant function analysis was performed using scores from the various scales as predictors of membership in each of the three groups defined.

Results

The descriptive results of the study are presented in Tables 1 and 2. As can be seen, mean scores on the PRF scales, JPI scales, and Imposter Phenomenon Scale are remarkably similar among the non-ACOA (n = 93), non-treatment ACOA (n = 36), and treatment ACOA (n = 18) groups. Variation in scores among the three groups was also quite similar. This sample of subjects also reported that they consume alcohol an average of 2 times per week (SD = 0.78) and have an average of 3 drinks (SD = 1.16) on each occasion. There were no differences among the three groups regarding these drinking behaviors.

Initially, the subjects were divided into two groups (non-ACOAs, n = 93; ACOAs, n = 54) based on their report of

having an alcoholic parent. The results of t-tests for independent samples between these two groups of subjects are presented in Table 1. There were no significant differences

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Insert Table 1 about here

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found between the non-ACOA and ACOA groups on any of the variables examined, suggesting that ACOAs and non-ACOAs were undifferentiable in their levels of self-criticism, need for affiliation (producing over-loyalty), levels of defendence (need to lie), need to control their environment, perseverance on tasks, impulsivity, capacity for having fun, need for approval and affirmation, levels of responsibility, perceptions of social adeptness, and feelings of fraudulence. We would argue that these scales are adequate measures of 12 of Woititz's characteristics, and provide a good empirical test of her clinical hypotheses about ACOAs. Our data clearly do not support these hypotheses.

Because a number of the scales on the PRF and JPI yield different scores for males and females, differences between ACOAs and non-ACOAs were also examined for males and females separately. These analyses produced only one significant difference between the groups, but in the opposite direction of that predicted by Woititz. On the Social Recognition scale of the PRF, female non-ACOAs scored significantly higher (M = 9.35; SD = 3.41) than female ACOAs (M = 7.89; SD = 3.60) ($t(92) = -1.98$; $p < .05$), suggesting they were more interested in social approval and affirmation.

As noted earlier, a subgroup of ACOAs identified themselves as having participated in group treatment because of their ACOA status; hence, one-way ANOVAs for independent samples were performed on PRF, JPI, and Imposter Phenomenon scores for non-ACOAs, non-treatment ACOAs, and treatment ACOAs. These results are presented in Table 2. Again, no

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Insert Table 2 about here

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differences were found among the groups, indicating that even those ACOAs who had sought treatment were undifferentiable from non-ACOAs, and from ACOAs who had never sought treatment.

As a final means of evaluating the practical utility of Woititz's characteristics of ACOAs, a step-wise discriminant function analysis was performed. Only two of the measured characteristics (Social Recognition and Affiliation)

satisfied the F-to-enter criterion of 1.0; however, neither was significant (F = 1.97, p = .14; and F = 1.72, p = .14, respectively). The resulting Wilks' lambda was .953, indicating that nearly all the variance in group membership was unaccounted for by these two variables.

The classification results of the discriminant analysis are presented in Table 3. As can be seen, a large number of

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Insert Table 3 about here

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false positives were produced in which non-ACOAs were predicted as members of one of the ACOA groups, and the total percentage of cases correctly classified was only 39.5%. Assuming Black's (1986) estimate that 34 million Americans have alcoholic parents is reasonably accurate, and approximating the U.S. population at 240 million, one could achieve nearly 86% accuracy simply by labeling all persons non-ACOA. Classification accuracy is more than doubled by using this naive procedure rather than Woititz's characteristics, as measured in the present study.

Discussion

Recent research has cast a measure of doubt on the validity of the popular perception of Adult Children of Alcoholics as a homogeneous group. The purpose of our study was a simple one. We wanted to evaluate whether the traits believed to be characteristic of ACOAs were indeed more prevalent in that group. Based on this preliminary study,

we would conclude that they certainly are not. No significant differences were found on any of the 12 characteristics between the ACOA, non-ACOA and treatment ACOA groups. In fact, the only difference found was on the Social Recognition scale in female subjects. Here, however, the difference found was in the direction opposite of what Woititz would predict. This would suggest that a serious reconsideration of the group referred to as ACOAs must be undertaken. This is especially important because so many individuals self-identify as an ACOA and find a plethora of information in the popular press on what it means to be one. Unfortunately, what they are being told may be inaccurate and perhaps damaging.

Being told by experts that one has certain characteristics (especially negative ones) because he/she is an ACOA is made much more believable both by the social status of the "expert" and by the "Barnum effect" quality of the descriptions. The result may be that many individuals are misled into perceiving that they have special problems which require treatment, (or at least another self-help book or two), when in fact they may do just as well never having stumbled upon the information. This possibility should be carefully investigated in future research.

Another implication of this study is that therapists, particularly those who specialize in the treatment of ACOAs and/or co-dependents, may be falling prey to what several researchers have referred to as an illusory correlate.

This phenomenon occurs when, "preconceptions lead us to preferentially accept and, occasionally, seek out data that support our assumptions" (Leary & Miller, 1986, p. 137). For example, therapists may begin treatment with a client expecting that the client's status as an ACOA is the primary cause of their problems, and selectively attend to information that varifies this expectation. One obvious pitfall of proceeding in this manner is that more significant etiological factors may be ignored. Further, they expect to find that these individuals have certain characteristics, and because these characteristics could apply to almost anyone, have no difficulty "discovering" them in their clients.

Though we recognize that our numbers were relatively small, that our measures are not perfect measures of ACOA characteristics, and that our subjects were all college students [redacted], we believe this to be the most objective analysis of Woititz's characteristics to date. Further research, using other groups and other measures should be done to validate our findings. However, our present data suggest that it might behoove the treatment industry to stop advertising certain problems and characteristics as though they go hand in hand with being the child of a problem drinker. If this group does have special problems or characteristics, they do not seem to be the ones currently utilized in the ACOA treatment community and popular

literature. It seems that we may have put the proverbial cart before the horse by building treatment groups based on certain differences and problems that may not exist prior to being treated for them. More research should be done to delineate what significant pre-therapy differences (if any) do exist, before we attempt to persuade people that they need to be in treatment solely because they are the child of a problem drinker.

Table 1

Means, Standard Deviations, and t Values for ACOA (n = 54) and Non-ACOA (n = 93) Groups

Variable	M	SD	t	p
Abasement				
Non-ACOA	7.06	3.01		
ACOA	7.07	2.80	0.02	.98
Affiliation				
Non-ACOA	9.58	3.86		
ACOA	8.98	3.54	-0.94	.35
Defendence				
Non-ACOA	7.33	3.05		
ACOA	6.61	3.12	-1.37	.17
Dominance				
Non-ACOA	8.78	4.20		
ACOA	8.28	4.53	-0.69	.49
Endurance				
Non-ACOA	9.35	3.30		
ACOA	9.37	3.40	0.03	.98
Impulsivity				
Non-ACOA	7.32	3.71		
ACOA	6.89	3.77	-0.68	.50
Play				
Non-ACOA	9.29	3.62		
ACOA	8.67	3.38	-1.03	.30
Social_Recog.				
Non-ACOA	9.16	3.23		
ACOA	8.09	3.46	-1.89	.06
Responsibility				
Non-ACOA	12.48	3.20		
ACOA	12.67	2.95	0.34	.73

Table 1 (con't.)

Variable	M	SD	t	p
Social Adroit.				
Non-ACOA	10.63	3.46		
ACOA	10.67	2.82	0.06	.95
Imposter				
Non-ACOA	42.40	8.97		
ACOA	41.33	9.12	-0.69	.49

Table 2

Means, Standard Deviations, and F Values for Non-ACOA (n = 83), Non-Treatment ACOA (n = 36), and Treatment ACOA (n = 18) Groups

Variable	M	SD	F	p
Abasement				
Non-ACOA	7.06	3.01		
Non-Treat. ACOA	6.94	2.59		
Treatment ACOA	7.33	3.25	0.10	.90
Affiliation				
Non-ACOA	9.58	3.87		
Non-Treat. ACOA	9.50	3.57		
Treatment ACOA	7.94	3.06	1.50	.23
Defendence				
Non-ACOA	7.33	3.05		
Non-Treat. ACOA	6.42	2.98		
Treatment ACOA	7.00	3.45	1.15	.32
Dominance				
Non-ACOA	8.73	4.20		
Non-Treat. ACOA	8.33	4.90		
Treatment ACOA	8.17	3.81	0.24	.79
Endurance				
Non-ACOA	9.35	3.35		
Non-Treat. ACOA	9.56	3.36		
Treatment ACOA	9.00	3.50	0.16	.85
Impulsivity				
Non-ACOA	7.32	3.71		
Non-Treat. ACOA	6.70	4.06		
Treatment ACOA	7.28	3.20	0.38	.69
Play				
Non-ACOA	9.29	3.62		
Non-Treat. ACOA	8.94	3.13		
Treatment ACOA	8.11	3.88	0.86	.42

Table 2 (con't.)

Variable	M	SD	F	p
Social Recog.				
Non-ACOA	9.16	3.22		
Non-Treat. ACOA	7.89	3.71		
Treatment ACOA	8.50	2.94	1.98	.14
Responsibility				
Non-ACOA	12.48	3.20		
Non-Treat. ACOA	12.72	3.03		
Treatment ACOA	12.56	2.87	0.08	.93
Social Adroit.				
Non-ACOA	10.63	3.46		
Non-Treat. ACOA	10.89	2.78		
Treatment ACOA	10.22	2.94	0.25	.78
Imposter				
Non-ACOA	42.40	8.97		
Non-Treat. ACOA	40.06	8.65		
Treatment ACOA	43.89	9.74	1.33	.27

Table 3

Discriminant Function Analysis Classification Results

Actual Group	n	Predicted Group Membership: Non-ACOA	Non-Treat. ACOA	Treatment ACOA
Non-ACOA	93	35 (37.6%)	28 (30.1%)	30 (32.3%)
Non-Treat. ACOA	36	15 (41.7%)	15 (41.7%)	6 (16.7%)
Treatment ACOA	18	3 (16.7%)	7 (38.9%)	8 (44.4%)

Percent of grouped cases correctly classified 39.46%

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