LEVELS OF SELF ACCEPTANCE IN ADULTS WHO
WERE RAISED IN ALCOHOLIC FAMILIES

A Thesis

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by

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ABSTRACT

Studies of adults who grew up in alcoholic families makes the assumption that these individuals have lower levels of self-acceptance than do adults in the general population. Using the Michigan Alcoholism Screening Test and the Self-Acceptance Scale by Berger, two groups of adult children of alcoholics were tested. Group one (without treatment) was comprised of thirty individuals without counseling or self-help group involvement. Group two (treated) was comprised of individuals with two or more years of continued counseling or self-help group involvement. The results indicate lower levels of self-acceptance in the group without treatment at the .05 level compared to the general population. The levels of self-acceptance in the treated group were not significantly different from the general population.
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INTRODUCTION

A growing concern among professionals in the field of alcoholism is the effect growing up in a family with one or more alcoholic parents has on an individual both as a child and later as an adult. During the last several years an increasing amount of research has been done on the disease of alcoholism. Much has been learned about the disease process, the recovery process, and the effect on the family system.

While it is difficult to obtain accurate statistics about individuals affected by alcoholism there is an estimated 10 million persons (Fact on Alcoholism) who suffer from the disease. Other estimates indicate each individual with an alcohol problem affects four additional family members (Kinney pg. 25).

By the most reliable estimates there are between twenty-eight million and thirty-four million people in the United States growing up or have grown up in a home with an alcoholic parent (Booze, Allen, Hamilton pg. 14c). Of this total about twelve to fifteen million are under the age of eighteen (Black, Alcoholism, Jan-Feb. 1981). The remaining thirteen to twenty-two million are over the age of eighteen and are considered adults. It is this large group of individuals, adults who grew up in alcoholic homes, which professionals are beginning to research. The research is less than ten years old. The first therapy group was started by Sharon Wegscheider in 1974. The Booze, Allen, and Hamilton Report, An Assessment of the Needs and Resources for
the Children of Alcoholic Parent, was submitted by the United States Government in 1974. The leaders in the field, Sharon Wegscheider, Claudia Black, Robert Ackerman, and Janet Woititz have based their theories on clinical observation of clients and studies in related research of human behavior. Few theories or generalizations have been scientifically tested. An acknowledged need is vigorous experimental research comparing children of alcoholics to children of non-alcoholics to more clearly delineate characteristics which differentiate children of alcoholics from the general population. Credibility for these individuals as a discrete population deserving of special treatment can only be built this way.

The purpose of this paper is to review the literature concerning adults who grew up with one or more alcoholic parents and to measure, using a controlled experimental measure, individual levels of self-acceptance in admitted adults from alcoholic families compared to the general population and determine if the data obtained supports the literature.

**RESEARCH QUESTION**

Does the results of testing the level of self acceptance in individuals who grew up in a family with one or more alcoholic parents support the literature which states these individuals have a lower level of self acceptance than the general population.

Do individuals who grew up in a family with one or more alcoholic parents have a lower level of self-acceptance than the general
population? Does the level of self-acceptance in these individuals increase with treatment?

Hypothesis A: \( H_0 \) Growing up in a home with one or more alcoholic parents does not decrease levels of self-acceptance compared to the general population. \( H_1 \) Growing up in a home with one or more alcoholic parents decreases levels of self-acceptance compared to the general population.

Hypothesis B: \( H_0 \) Treatment will increase levels of self-acceptance in individuals who grew up with one or more alcoholic parents. \( H_1 \) Treatment will not increase levels of self-acceptance in individuals who grew up with one or more alcoholic parents.

Assumptions and Limitations

Untreated individuals are those people who have six months or less of counseling or self-help group involvement. The assumption is made, based on clinical evidence, no significant improvement is made in self-acceptance with less than one year of treatment. Treated individuals are those people with at least two years of continuous counseling or self-help group involvement. The assumption is made, based on clinical evidence, that the level of self-acceptance increases with length of treatment.

The control group is the general population obtained from prior research by E. Berger.

A fourth assumption made is individuals are often unaware or reluctant to admit to an alcoholic parent. The Michigan Alcoholism Screening Test (third person form) controls for this assumption.
Study limitations include:

1. no effort made to control or match groups for sex, age, race, or ethnic group.
2. no control or comparison of length of treatment greater than two years.
3. no control or comparison of type of treatment, counseling or self-help involvement.

**SUBSIDIARY QUESTIONS**

1. How is self-acceptance developed in an individual?
2. What influence does the family have on the development of self-acceptance?
3. How does a family with an alcoholic parent differ from a functional family?
4. What influence does an alcoholic family have on individual development of self acceptance?

**TERMS**

Adult child- (ACOA) a descendant or individual over the age of eighteen who grew up in a family with at least one alcoholic parent.

Alcoholic- an individual whose use of alcohol causes problems in one or more areas of their life; social, mental, physical, spiritual, or emotional.

Chemically dependent/Alcoholic family- one or more family members are physically or psychologically dependent on a mood altering chemical.

Normal family/functional family- a family system without severe disturbance in function (not alcohol dependent).
RELATED RESEARCH

Functional Family Systems

In recent years a number of researchers have focused on the alcoholic family. The findings of people such as Claudia Black, Janet Woititz, and Sharon Wegscheider have lead to the formulation of a description of the alcoholic family, the roles the members play, and the residual effects of these roles. The study of scions grew out of the observations and research on the alcoholic family system and comparisons to the normal family. Sharon Wegscheider, basing her work on that of Virginia Satir and others, describes a family as a system made up of individual family members linked together by family rules. Wegscheider lists four broad functions which rules perform for the family system (Wegscheider pg. 47):

1. To establish attitudes, expectations, values, and goals for the family.

2. To determine who will hold the power and authority, how they will be used, and how family members are expected to respond to them.

3. To anticipate how the family will deal with change in itself as a unit, in its members, and in the outside world.

4. To dictate how members may communicate with one another and what they may communicate about.

The family rules are rarely written and may not even be recognized consciously. But they exist and are passed on to each family member by word and action. Wegscheider continues by discussing three dimensions of healthy rules versus unhealthy rules.
The first dimension is human rules versus inhuman rules. Human rules: 1. Are made for the benefit of the whole family, not just the rule maker, 2. Accept each person for who he is—human, possessed of feelings, well-meaning but sometimes fallible, 3. Validate the worth of everyone involved. Inhuman rules: 1. Are made for someone else's benefit or to uphold some impersonal principle or institution, not for the good of the person who must keep them, 2. Are often unrealistic and impossible to keep, 3. Encourage one to be dishonest and manipulative with others to avoid punishment or rejection, 4. Encourage one to be dishonest with oneself to avoid feelings of guilt (Wegscheider pg. 51).

The second dimension is flexible versus rigid rules. Flexible rules are applied with appreciation for the inevitable differences in circumstances in needs and capabilities of people. Flexible rules accept and even encourage change as a potential source of growth for the individual and the family unit. One the other hand, rigid rules make no allowance for the differences in people or circumstances and discourage change, seeing it as a potential threat to the status quo.

The third dimension of family rules concerns communication. Every family has rules regarding what may be talked about and what must be kept secret. Families with areas of life closed to discussion are also likely to discourage expression of feelings, particularly unpleasant feelings. These family systems with communication limited by rules is a closed system. Each family member is closed off from one another. Information and feelings are kept inside each member to be handled alone. The closed system usually does not admit much information from the outside. Thus the family receives little new information for
growth, learning, or change. An open system encourages a free flow communication of feelings, information, and needs. The family members can be sure of being heard. There is no need for dishonesty or secrets.

The following chart summarizes the three dimensions of family rules (Wegscheider, pg. 50).

Table 1

<table>
<thead>
<tr>
<th>RULE</th>
<th>DIMENSION HEALTHY</th>
<th>DIMENSION UNHEALTHY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish attitudes, expectations, values and goals</td>
<td>Human</td>
<td>Inhuman</td>
</tr>
<tr>
<td>2. Regulate use of authority</td>
<td>Human</td>
<td>Inhuman</td>
</tr>
<tr>
<td>3. Deal with changes</td>
<td>Flexible</td>
<td>Inflexible</td>
</tr>
<tr>
<td>4. Set up communication patterns</td>
<td>Encourage open system</td>
<td>Enforce closed system</td>
</tr>
</tbody>
</table>

Family rules are bound up with the self worth of each individual in the family. Family rules grow out of the self worth of the rule maker and determine the self worth of the rule keepers.

The person who feels good about himself sets up human, flexible, and realistic rules. He communicates with family members and nurtures the self worth of family members and self. The person who feels inadequate with a low level of self worth, places impossible, rigid standards of self and others trying to earn self worth. Feeling so empty himself, he is unable to nurture family members and may even erode what little self worth is present in family members.
Dolores Curran, based on work by Dr. Jerry Lewis and other researchers, conducted a survey of 551 professionals who work with families on traits commonly perceived in healthy families. The respondents identified fifteen traits and supporting hallmarks of a healthy family. "These are a healthy family... (Curran, pg. 23)

1. Communicates and listens. This trait was most often selected as evident in a healthy family. It is hallmarked by a relationship between parents which complements each other and where each parent is of equal power.
   a. exhibits an unusual relationship between the parents.
   b. has control of television.
   c. listens and responds.
   d. recognizes non-verbal messages.
   e. encourages individual feelings and independent thinking.
   f. recognizes turn-off words and put-down phrases.
   g. interrupts, but equally.
   h. develops a pattern of reconciliation.
   (Curran, pg. 55)

2. Affirms and supports one another. Family affirmation and support are necessities for survival and growth. If we don't experience them as children, we spend the rest of our lives seeking them from strangers. The hallmarks of a supportive, affirming family are:
   a. parents have good self-esteem.
   b. everyone is expected to affirm and support.
   c. the family realizes support doesn't mean pressure.
   d. the family's basic mood is positive.
   e. the family supports it's institutions but not automatically.
   (Curran, pg. 77)

3. Teaches respect for others. This trait is hallmarked by:
   a. the family respects individual differences within the family.
   b. the family knows self-respect means respect for self.
   c. the family accords respect to all groups.
   d. the family respects individual decisions.
   e. the family shows respect to those outside the family.
   f. the family respects the property of others.
   (Curran, pg. 97)
4. Develops a sense of trust. Trust is an inner certainty that we are loved. Trust is recognized as a precious possession beginning at birth in response to an outer predictability. The family that trusts is hallmarked by:
   a. the husband and wife trust each other deeply.
   b. the children are gradually given more opportunity to earn trust.
   c. family members do not play the trust-trap game.
   d. the family does not break trust for the amusement of others.
   e. the family realizes broken trust can be mended.
   f. parents as well as children are trust worthy.
      (Curran, pg. 155)

5. Has a sense of play and humor.

6. Has a balance of interaction among members.

7. Shares leisure time.

8. Values table time and conversation.

9. Exhibits a sense of shared responsibility. Responsibility in a healthy family is understood to be more than chores. It is geared to capability and paired with recognition. Responsibility is related to self esteem and does not necessarily mean perfection. Family members are expected to live with the consequences of irresponsibility.

10. Has a strong sense of family in which rituals and traditions abound.

11. Teaches a sense of right and wrong.

12. Has a shared religious core.

13. Respects the privacy of others. Privacy in healthy families means the right to have a private being, allowing and encouraging family members to be who they are at a given age.

14. Values services to others. The family is basically empathetic and altruistic. It is generously hospitable.

15. Admits to and seeks help with problems. Healthy families expect problems, consider them to be a normal part of family life and develops problem-solving techniques. They don't become hooked into one way of responding."

Barnhill (Walsh, pg. 33) identifies eight dimensions of healthy families. He lists these as:
1. Individuation versus enmeshment.
2. Mutuality versus isolation.
3. Flexibility versus rigidity.
4. Stability versus disorganization.
5. Clear versus unclear or distorted perceptions.
6. Clear versus unclear roles or role conflict.
7. Role reciprocity versus unclear or conflicted roles.
8. Clear versus diffused or breached boundaries.

(Foren, pg. 6-63)

Barnhill's dimensions deal not only with rules but also with roles in the family system. Roles played by family members and the interaction between family has been an area of research and discussion. A primary focus has been the roles children play in the family system.

Dr. Alfred Adler stated the interaction between a child with parent and/or siblings tends to develop certain traits which would not be present if the birth order was different. Birth order is only one of the many environmental factors important in developing and maintaining life roles. The position of birth is not what is important but rather the experience with other family members as a result of being in the position. According to Adler, the environments are not the same for different children in the same family. In general, the oldest child identifies more strongly with the parents and may play a parent-surrogate role. The first-born is more conscientious and has a strong sense of responsibility. He or she has a higher need for achievement and approval, may be more conforming and avoid conflict. The oldest child is often conservative, and more introverted. They are creative and task oriented. Emotionally, the first-born has higher levels of jealousy, anger, tension, and anxiety.

The middle child demands more attention, is more active, and less dependable than the olders. The middle child learns to adjust and is friendlier and diplomatic. This may be due to the fact that they were
never "only" children and had less time with the parents and also had to "fit" into an already existing family system with children.

The youngest child is characterized by being lighthearted, cheerful, playful, and charming. They expect others to care for and protect them. They are frequently dependent and have low levels of ability to accept responsibility.

Adler's hypotheses are not completely supported by empirical evidence. Behavioral and experimental data does support hypotheses concerning the first-born, however the other roles are not well established (Walsh, pg. 50).

Timberman in his study on relationships between birth order and personality found the eldest child generally more controlled in emotional expression, better disciplined, and more achievement-oriented. The second child was found, in general, to exhibit more affective openness, more spontaneity, less concern with achievement or personal discipline. The youngest child was found to be slightly slower in social development.

**Alcoholic Family Systems**

Families under stress exhibit characteristics of unhealthy families: Rigid and inhuman rules, unclear boundaries, inflexible roles, etc. The roles discussed by Adler and Timberman are present, even more so. As with other rigid aspects the roles of family members are inflexible and rigid. Satir identified role behavior played by family members when the family is under stress. Family members work
hard to maintain the equilibrium of the family system often at the expense of individual physical and emotional health.

Alcoholic families are families in severe stress. They have all the characteristics of unhealthy families but usually more severe plus other characteristics uniquely different. Wegscheider, in the following chart, compares families in stress, one with stress caused by alcoholism and one with another cause of stress (Wegscheider, pg. 55).

Table 2

Comparison of Dysfunction Families

<table>
<thead>
<tr>
<th>NON-ALCOHOLIC</th>
<th>ALCOHOLIC</th>
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<td><strong>Their Problem</strong></td>
<td></td>
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<tr>
<td>Identifiable. Family members often know the source of their distress when they come for help, or at least admit it when it's brought to their attention.</td>
<td>Denied. Family members show sincere delusions. &quot;We're in trouble, but alcohol has nothing to do with it.&quot;</td>
</tr>
</tbody>
</table>

| **Their Feelings** |          |
| Painful, unexpressed and to some extent repressed. | Acutely painful and generally totally out of awareness—part of a larger pattern of denial and delusion. |

| **Their Defenses** |          |
| Highly developed to protect individual members from even greater pain and lower selfworth. | So highly developed that they are rigid and compulsive. Repressed feelings have become locked in as attitudes: anger has become resentment, fear has become withdrawal, guilt has become avoidance. |
Their Self-Worth

Low. Even lower, because all the worth-destroying factors in the family are intense.

Their Behavior

Fixed in predictable patterns. Rigidly fixed and compulsive. The defensive roles are the same, but family members have become locked into them because of the compulsion and denial in the system.

Family members assume an array of defensive roles in an effort to survive, both individually and as a family unit.

Their Communication

Severely restricted family rules. Similarly restricted by family roles, but also totally blocked in many areas by denial and delusion.

Not only are characteristics of alcoholic families those of a family in stress, only more severe, but role behaviors are also similar. The roles present in any family are also present in the alcoholic family only more rigidly fixed and played with greater intensity, compulsion, and delusion. In the alcoholic family the individual gets trapped into one role and slowly becomes the role. Each role has its own symptoms, its own pain, its own payoff and its own price for both the individual playing the role and the family.

Wegscheider, in Alcoholism and the Family (Lawson, pg. 18), has identified role behaviors specific to the alcoholic family. These roles behaviors are:

1) The dependent (the alcoholic) who is angry, rigid, perfectionist, charming, righteous, and grandiose but feels guilt, shame, fear, and pain.

2) The chief enabler (a spouse, parent, or co-worker) who provides responsibility but feels hurt, angry, guilty, and afraid.
3) The family hero (usually the oldest child) who provides self-worth for the family with hard work, achievement, and success but feels lonely, hurt, and inadequate. The achievement is for others; the hero is not rewarded with self-worth.

4) The scapegoat, the child who acts out and takes the focus off the family problem of alcoholism. The scapegoat feels lonely, rejected, hurt and angry.

5) The lost child who offers relief by not being a problem. These children are quiet, withdrawn, and independent but they feel lonely, hurt and inadequate.

6) The mascot (often the youngest child) who provides comic relief and distracts family members. They are protected from what is happening but feel the tension and are insecure, frightened and lonely.

Claudia Black divides the role behavior of children in alcoholic families into two main categories; the misbehaving children and the less obvious mature, over-achieving, behaving children which she believes are the majority. These behaving children learn survival roles to provide their own stability. They learn the rules of an alcoholic family - don't talk, don't trust, don't feel (Black pg. 31). These rules and roles serve them well until their mid-twenties when they find themselves unable to cope with adulthood. Black divides these behaving children into three types of behavior (Lawson, pg. 182):

1) "Responsible" one, usually the oldest, who feels responsible for everyone. These children are adultlike, serious, rigid, and inflexible. They have little time for play or fun. They become angry at themselves if they are not in control. They are self-reliant which leads to loneliness.

2) "Adjustors" who are flexible. They feel they have no power over their lives. They deny their own feelings.

3) "Placators" are emotionally sensitive children. They take care of others first to reduce their own pain. They are peace makers and neglect their own needs and feelings.

Booze-Allen and Hamilton (Lawson, Pg. 183) identified four coping
mechanisms which correspond to the role behavior of children in alcoholic families:

1) Flight—avoid the alcoholic, physically leave home, emotionally withdraw.

2) Fight—aggressive, rebellious, acting out, often seen as a behavior problem.

3) Perfect child—never does anything wrong.

4) Super Coper—usually the oldest, feels responsible for the other family members.

A comparison chart (Lawson, pg. 184) shows the similarities of behavior roles of children in the alcoholic family.
Table 3
Comparison of Children's Roles in an Alcoholic Family

<table>
<thead>
<tr>
<th>BLACK</th>
<th>BOOZE-ALLEN &amp; HAMILTON</th>
<th>WEGSCHEIDER</th>
<th>SATIR</th>
<th>CHARACTERISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustor</td>
<td>Flight</td>
<td>Lost Child</td>
<td>Irrelevant (no place for me)</td>
<td>Loneliness, isolation, escapes, never complains</td>
</tr>
<tr>
<td>(no role) Fight</td>
<td>Scapegoat</td>
<td>Blame (lonely &amp; un-successful)</td>
<td>Hurt, anger, rejection, takes focus of alcoholic, feelings close to surface</td>
<td></td>
</tr>
<tr>
<td>Placator</td>
<td>Perfect Child</td>
<td>Mascot</td>
<td>Placator (worthless)</td>
<td>Provides relief, emotionally related, makes other feel good</td>
</tr>
<tr>
<td>Re-sponsible</td>
<td>Super-coper</td>
<td>Family hero</td>
<td>Super-responsible (vulnerable, no feeling)</td>
<td>Loneliness, over-achiever, parentified</td>
</tr>
</tbody>
</table>

These role behaviors of the children are not exclusive categories. Each child has a blend of several with one dominant. The roles can change as different children use different roles, switch roles, or take on roles as family members leave home.

However, these learned role behaviors do not change as the child grows older and eventually leaves home. Adult children repeat the stress reduction process that worked in the family of origin. Outside this family system there are many negative consequences for continuing to play the roles. Adult children of alcoholics are unable to trust their own feelings and are afraid of not being in control. They have
problems with intimacy, responsibility, identification and expression of feelings.

**CHARACTERISTICS OF ADULT CHILDREN OF ALCOHOLICS**

Wortitz has developed a list of characteristics which adult children have in common; adult children: (Wortitz pg. 95-99)

1) guess at what normal behavior is.

2) have difficulty following a project through from beginning to end.

3) have difficulty following a project through from beginning to end.

4) judge themselves without mercy.

5) have difficulty having fun.

6) take themselves very seriously.

7) have difficulty with intimate relationships.

8) over react to changes over which they have no control.

9) seek approval and affirmation.

10) usually feel 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) are impulsive. They tend to lock themselves in a course of action without giving serious consideration to alternative behaviors or possible consequences. This impulsivity leads to confusion, self-loathing, and loss of control over their environment. In addition, they spend an excessive amount of energy cleaning up the mess.

Children of alcoholics (C.O.A.) of the AlAnon Family Groups have a list of characteristics group members seem to have in common. (1979)

1) We become isolated and afraid of people and authority figures.

2) We become approval seekers and lose our identity in the process.
3) We are frightened by angry people and any personal criticism.

4) We either become alcoholics, marry them or both or find another compulsive personality such as a workaholic to fulfill our sick abandonment needs.

5) We live life from the viewpoint of victims and are attracted by that weakness in our relationships.

6) We have an overdeveloped sense of responsibility and it's easier for us to be concerned with others rather than ourselves.

7) We get guilt feelings when we stand up for ourselves instead of giving in to others.

8) We become addicted to excitement.

9) We stuff our feelings from our traumatic childhoods and lose the ability to feel or express feelings.

10) We judge ourselves harshly and have a low sense of self-esteem, sometimes compensated for by trying to appear superior.

11) We confuse love with pity, and tend to "love" people we can "pity" and "rescue".

12) We are dependent personalities who are terrified of abandonment. We will do anything to hold onto a relationship in order not to experience painful abandonment feelings.

13) Alcoholism is a family disease and we became para-alcoholics who took on the characteristics of the disease even though we did not pick up the drink.

14) Para-alcoholics are reactors rather than actors.

Theories of Growth and Development

Living in an alcoholic family definitely affects the development of the member's individual personalities. Erikson's stages of development can be used as a guide to understand the residual problems of scions of alcoholic parents.
Table 4

**Erickson's Psychosocial Stages of Development**

<table>
<thead>
<tr>
<th>Success</th>
<th>Failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Early Infancy (birth to 1 Year)</td>
<td></td>
</tr>
<tr>
<td>TRUST: Child receives</td>
<td>MISTRUST: Child abused or</td>
</tr>
<tr>
<td></td>
<td>neglected.</td>
</tr>
<tr>
<td>II. Later Infancy (1-3 Years)</td>
<td></td>
</tr>
<tr>
<td>AUTONOMY: Child encouraged to develop self-control and is provided respect by parents.</td>
<td>SHAME AND DOUBT: Child made to feel inadequate and not worthy of respect.</td>
</tr>
<tr>
<td>III. Early Childhood (4-5 Years)</td>
<td></td>
</tr>
<tr>
<td>INITIATIVE: Child encouraged to use imagination and test reality on own.</td>
<td>GUILT: Child made to feel guilty about fantasies. Reality testing is discouraged.</td>
</tr>
<tr>
<td>IV. Middle Childhood (6-11 Years)</td>
<td></td>
</tr>
<tr>
<td>INDUSTRY: Child has developed a sense of duty and accomplishment.</td>
<td>INFERIORITY: Child does not value accomplishment. Exhibits sense of failure.</td>
</tr>
<tr>
<td>V. Puberty and adolescence (12-20 Years)</td>
<td></td>
</tr>
<tr>
<td>EGO IDENTITY: Individual has now developed a sense of self-concept, a sense of what they are not, can do, cannot do.</td>
<td>ROLE CONFUSION: Individual has no real sense of being. Confused about self and relation to world.</td>
</tr>
<tr>
<td>VI. Early Adulthood</td>
<td></td>
</tr>
<tr>
<td>INTIMACY: Individual has ability to form close relationships.</td>
<td>ISOLATION: Individual remains apart from others, may even be antagonistic toward them.</td>
</tr>
<tr>
<td>VII. Middle Adulthood</td>
<td></td>
</tr>
<tr>
<td>GENERATIVITY: Time of productivity in work and family.</td>
<td>STAGNATION: Time of non-productivity and wandering. No real accomplishments in any area.</td>
</tr>
</tbody>
</table>
VIII. Late Adulthood


Initiative vs. guilt - In the alcoholic home the child's curiosity is often treated as inappropriate. His questions are ignored and normal playful activities stopped. Erikson believes guilt emerges in the child when the responses to his behavior are unpredictable. In alcoholic homes inconsistency is a dominating factor. This stage is also characterized by observing and imitating adult behavior. An alcoholic provides inappropriate concepts of adult roles.

Industry vs. inferiority - The child begins to develop a need to feel useful. In the alcoholic home feelings of useless can emerge which may carry over into the school setting. The parents may value education but be unable to provide the behavior necessary for the child to succeed in school.

Learning identity vs. identity diffusion - "Who am I?" The normal crisis evolves from attempts to establish a clear sense of identity. In the alcoholic family the negative attitudes and previously developed sense of inferiority may intensify this problem. A sense of personal identity is overshadowed by family identity.

The child emerging into the world as a young adult has used all they have to survive. The new adult is faced with psychological impoverishment. They are hindered in forming relationships, in sharing and communicating with others. They find themselves socially isolated. They have not developed the life skills that are necessary. They are forced to remain within themselves. They are unable to accept
responsibility for their own life without blaming others. They find it hard to accept life as it is.

**Trust vs. mistrust** - Erikson sees a sense of trust as the most important element of a healthy personality. In an alcoholic family the needs of an infant may be ignored, attended to as a last resort, or begrudgingly administered. Even if physical needs are met, trust may not be established because of lack of emotional stability. The emotional drain on the parents is so great, little emotional support is left for the child.

**Autonomy vs. shame and doubt** - A child must be able to achieve autonomy and yet accept the useful guidance of others. In the alcoholic home the desire to protect the child from the home environment may limit childhood growth. The child does not develop a sufficient autonomy resulting in a self-concept of inadequacy and shame.

As the child in the alcoholic home grows they are influenced by their parents and develop similar personality characteristics: While alcoholics have no singular "alcoholic personality" it has been established that many alcoholics share certain personality characteristics, such as anxiety, dependency, immaturity, inferiority, depression and low self-esteem (Ackerman, pg. 76). Children of alcoholics have many of the same personality traits and score similarly to alcoholics on the MMPI.

The problems seen in adult life may vary based on the childhood family role played. Using Wegscheider's family roles as a guide the following results are frequently seen:
The Hero - He feels inadequate and angry, his successes make him feel guilty. He may be admired and popular but feels lonely. His high standards make him hypercritical of others. He is goal orientated and hasn't learned to trust and relate openly to others. He is ill prepared for marriage and finds it difficult to set suitable limits for his children. It is safer not to get too close to anyone. He is even in danger of overextending himself and often pays with his health. His suppressed feelings often manifest themselves in physical illness. He is prone to stomach ulcers, migraine headaches, heart attacks, strokes, hypertension, and drug dependency. Whatever the hero's pain it rarely shows. He appears to function well and more likely to be seen later in life for help with the medical complication of ignoring his inner needs and of a stressful, success driven life style.

The Lost Child - Loneliness is the characteristic feeling of this adult child. He cannot get past his solitary habits and social inexperience to be involved in human relationships. Along with the loneliness he feels confusion, sadness, and fear. He has never experienced intimacy and added to his sexual doubts this makes his chances for satisfying and lasting love relationships slim. He may marry several times or not at all. Because of his lack of involvement with other people he may place great value on materialistic things. The lost child role provides him with no way to release his negative feelings, so instead he represses them. Physical symptoms are frequent; allergies, asthma, accidents, illness, bed wetting, eating disorders and drugs. The lost child seldom seeks help but can be recognized by his
low profile, independence,aloneness, materialism, overindulgence and problems with sexual identity.

The Mascot - Fear is the characteristic emotion of the mascot. He suffers from the same sense of inadequacy, unimportance, guilt, and loneliness as the lost child. He covers by being a clown. He relates only with humor and he is never taken seriously. He manipulates those around him. He is immature, never grows up, forever the child. He never learned to deal with stress. He never learned to deal with stress. He escapes from his problems. He has difficulty expressing his feelings and accepting feelings of others. His hypersensitivity can lead to physical illness, diagnosed as hyperkinetic, phobias, may feel schizophrenic, and chemical dependency. Fears for his sanity may drive him to suicide.

The Scapegoat - The scapegoat is often angry as a cover for more painful feelings of rejection and loneliness. The primary feeling is one of hurt. He may also feel guilty for his anti-social behavior. His primary relationship is with his peer group and the skills he acquires are shallow and self-centered. They lack honesty and genuine concern for others. His anger and low self-esteem leave him with little motivation for school. The scapegoat knows he is capable of more but feels compelled towards trouble by some unseen force beyond his control. The physical affects of the scapegoat are a result of his acting out behavior, drug use, accidents, venereal infection, pregnancy and the ultimate in self-hatred, suicide.

In general, the adult child from an alcoholic family will be dysfunctional in many areas of life - from difficulty with intimacy and
relationships, sexual confusion, anti-social behavior or conformity, to a wide range of physical stress related illnesses. These illnesses include but are not limited to: Allergies, asthma, ulcers, colitis, headaches, backaches, hypertension, heart disease, irritability, depression, high accident rates, unplanned pregnancy, eating disorders, phobias, chemical abuse, schizophrenia, and suicide.

Children of Alcoholic Families

Children of alcoholics are a special population with special needs. It has been estimated that as many as 60 percent of alcoholics in treatment grew up in alcoholic homes. Many of those who do not become alcoholics marry an alcoholic and the pattern is known to repeat itself in second and third generations. Yet many ACOAs do not relate their current difficulties to the alcohol use in their family of origin. They frequently fail to recognize or deny that parental alcoholism has any relationship to their current life. ACOAs may not even be aware that they grew up in an alcoholic home. Black found at least 49 percent of children of alcoholic parents had yet to identify parental alcoholism at the time they left home. They perceived only the physical illness, difficulty at work, and problems in their marriage or with their children. Often they are unaware that any other way of life exists. They are unaware of their own feelings.

Definitive data on the prevalence and nature of problems affecting ACOA are not available. However, a recent study by Claudia Black (1985) comparing 400 ACOA to a sample of controls not raised in alcoholic homes provides some verification of the clinical profiles. Results indicated
71 percent of ACOA were unable to "accurately identify what one needs particularly as this relates to emotional needs" (Changing Legacies, pg. 73). 65 percent of ACOA were unable to "place themselves first" on their priority lists. Intimacy was viewed as a major problem by 72 percent of ACOA compared to 40 percent of the controls. 45 percent of ACOA identified depression as a major problem compared to 23 percent of controls. 53 percent of ACOA never talked to anyone about what was happening at home. 27 percent of ACOA did indicate they made use of friends, however 68 percent of the controls shared with friends. 60 percent of ACOA had difficulty identifying and talking about feelings compared to 32 percent of the control group.

Black's study also provides some information about the roles which ACOA identify with. 60 percent identified themselves as responsible with hero behaviors. What they didn't learn was:

1. how to have fun/laugh.
2. how to separate identity from achievement.
3. how to negotiate.
4. how to be flexible.
5. how to listen.
6. how to ask for help.
7. how to follow.
8. how to problem solve.
9. how to be creative and spontaneous.

Forty-four percent of ACOA identified with the adjustor role (lost child). What adjustors didn't learn was:

1. how to initiate.
2. how to make decisions.
3. how to see choices, options, alternatives.
4. how to question.
5. how to lead.
6. how to think.

Black described adjustors as having no investment in their life and knowing that they are powerless.

Sixty-three percent of ACOA identified with the caretaking role, taking responsibility for the emotional pain in the home. Caretakers are warm, caring, and empathetic but did not learn:

1. how to care for self.
2. how to separate self-identity from others.
3. sense of self-worth.
4. how to meet own needs.
5. selfishness.

Twenty percent of ACOA identified with the problematic child (scapegoat). This is the individual most likely to get help since the problems are more obvious. This is the most honest family member and has less denial, including denial of feelings.

Booze, Allen, and Hamilton in their study identified many significant areas of difficulty. These are summarized on the following table (Booze, Allen, Hamilton, pg. 44a).
Table 5

Range and Frequency of Outcomes Experienced by ACOA

<table>
<thead>
<tr>
<th>OUTCOMES</th>
<th>f</th>
<th>percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems in relationships (opposite sex)</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>Left home early</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Problems in relationships (same sex)</td>
<td>17</td>
<td>34</td>
</tr>
<tr>
<td>Lacks self-confidence</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Young marriage</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Over-achievement</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Early independence/maturity</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Lacks direction</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Under achievement</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Depression</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>89</td>
<td>16</td>
</tr>
<tr>
<td>Delinquency</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Suicidal tendencies or attempts</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Felt was crazy</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Teetotalism</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Dead end emotions</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Running away</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Confused sexual identity</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Truancy/absenteeism</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Unwed pregnancy</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Promiscuity</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>207</strong></td>
<td></td>
</tr>
</tbody>
</table>

average number per child 4.14

While some children suffer more disabling effects of parental alcoholism than others and while adverse childhoods may have surprisingly successful outcomes without help, even the so called "survivors" have personality deficiencies, gaps in social skills, and a lack of understanding of what is normal in a family, work and social situations. Thus Booze, Hallen, Hamilton states; "there are, in fact, no real success stories among scions of alcoholic parents—in one way or another they have all lost" (Booze, Allen, Hamilton, pg. 53).
Dr. Felton Earls, Director of Child Psychiatry at Washington University in St. Louis, found in a study of 125 families that alcoholism in a family dramatically increases the prospect for emotional disorders among the children. "Normally, one of four children will display such disorders. This increases to nearly two of three children when there is one alcoholic parent in the home. Overall prevalence of emotional disorders reaches 80-87 percent in children with two alcoholic parents and 90-100 percent when parents have alcoholism combined with anti-social personality disorder (Columbus Dispatch).

Effects of growing up in an alcoholic family shows in the defenses used by ACOA including; denial, projection, ambivalence, testing, grandiosity, all-or-none thinking, conflict minimization and avoidance, rationalization, self-centered attention, subjective perceptions, and passivity. These defenses contribute to the individual's avoidance of personal responsibility for his action and life.

A major problem involving these defenses is control. ACOA fear not being in control of themselves and their environment including other people around them. Intense feelings are experienced primarily as a feeling of being out of control and are accompanied by feelings of anxiety, panic, vulnerability, and most of all, a sense of being out of control. The other side of the control issue - feelings of deprivation, depression, loss and intense dependency needs - are well hidden. The intense emphasis on control is a rigid defense to protect against acknowledging the threat of underlying neediness.

The issue of responsibility is one of super-responsibility for the feelings and actions of others. ACOA need other people to remain in
control of their emotions and feel responsible to help combat any deviation from such control.

Trust is a two way issue. ACOA distrust others and also distrust themselves. They continually question the validity of their own feelings and perceptions. They are unable to feel their true feelings much less express them. The difficulty with trust makes an open, honest relationship impossible.

The open acknowledgement of personal needs and feelings are a source of guilt, vulnerability, and dependence for these adults. Feelings in general are seen as bad. This view is understandable when anger, abandonment, loss, rejection, and deprivation are the major feelings first uncovered by pulling away the denial. These individuals seldom experience feelings of joy and happiness until these other emotions are worked through.

The anger, loss, and abandonment are real feelings based on the individual's experience as a child of not having basic needs met on a consistent basis. Maslow's theory of personality development is based on the need of the individual for satisfaction, happiness, and growth. Maslow identified needs of each individual and placed them in a hierarchy leading from basic physical needs up toward self-actualization (see table #6).
Table 6

Maslow’s Hierarchy of Needs

<table>
<thead>
<tr>
<th>Need</th>
<th>If Met</th>
<th>Result of Absence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-actualization</td>
<td>develop to full potential</td>
<td></td>
</tr>
<tr>
<td>esteem</td>
<td>self-worth, positive self-image, self-acceptance</td>
<td>lack of self-confidence, dissatisfaction with life role</td>
</tr>
<tr>
<td>love &amp; belonging</td>
<td>family, friends social acceptance, enduring intimacy</td>
<td>loneliness, isolation</td>
</tr>
<tr>
<td>safety</td>
<td>stability, freedom from anxiety</td>
<td>fear, pain, physical danger</td>
</tr>
<tr>
<td>physical</td>
<td>food, air, water, rest, sexual gratification, physiological equilibrium, lack of pain</td>
<td>death</td>
</tr>
</tbody>
</table>

Maslow has described physical, safety, love and belonging needs as deficiency needs. Absence of having these needs met leads to tension in the individual. These deficiency needs must be first met before the growth needs, esteem and self-actualization can be focused on. The individual strives to meet the most pressing need first and may not recognize other important needs.

Growth, as viewed by Maslow, is a never ending series of free choice situations where the individual must choose between the attraction and known of the familiar and the attraction and unknown fear of growth.
While Maslow lists self-acceptance as a component of esteem, he does little to define what self-acceptance is or to describe it. Webster defines accept as 1) to receive with consent, to be able to take or hold; 2) give admittance or approval to; 3) to endure without protest; 4) to regard as normal, proper, or inevitable, regard as true; 5) to undertake responsibility of. Acceptance has been defined as the end of a struggle to overcome, to accept without anger, despair or remorse. Acceptance is not resignation.

Rogers defines self-acceptance as regard for one's self with a realistic concept of strengths and weakness. An individual demonstrates self-acceptance by the presence of the following characteristics; preserving, minimizing weakness, seeing reality, testing and accepting others, continuing growth towards self-actualization, recognizing and accepting one's own behavior, reaching out to others, increasing strengths, and learning from mistakes (Flynn, pg. 165-178).

In general, an individual with self-acceptance accepts their own strengths and weaknesses and is positive about their self. An individual with low levels of self-acceptance can be characterized as self-rejecting, critical of self and others, more anxious, insecure and depressed.

Self-acceptance is dependent on how one thinks he or she is viewed by others. If an individual is told verbally and non-verbally that he or she is worthless or that their value in a family is dependent upon the role they play then as an adult they will continue to hold that self-concept. If a family fails to meet basic needs of a child then the child will not feel they are of enough value to be cared for in a
healthy, nurturing manner. Based on Erikson, self-acceptance is a result of the growth process and although not directly referred to, is definitely implied in the stages of individual growth (Tribe, pg. 33-34).

A child growing up in an alcoholic home would certainly have little consistency in having basic needs met and because of the family structure, the roles played and the family disease process, would have a poor self-concept. As a result of the negative or mixed messages received as a child an individual from an alcoholic home would have negative or mixed beliefs about himself as an adult. Thus an ACOA would be expected to have a low level of self-acceptance.
METHOD, RESULTS AND RECOMMENDATIONS

This study tested levels of self-acceptance in adults who grew up with one or more alcoholic parents and compared the results to standardized results of the general adult population. Hypothesis A: \( H_0 \)
Growing up in a home with one or more alcoholic parents does not decrease levels of self-acceptance compared to the general population. \( H_1 \)
Growing up in a home with one or more alcoholic parents does decrease levels of self-acceptance compared to the general population.

Hypothesis B: \( H_0 \) Treatment will increase levels of self-acceptance in individuals who grew up with one or more alcoholic parents. \( H_1 \) Treatment will not increase levels of self-acceptance in individuals who grew up with one or more alcoholic parents.

Selection of participants

Two groups of subjects were utilized, experimental groups of adults who grew up in alcoholic homes. Each group consisted of thirty individuals. Criteria for selection of members of group one were:

1. between the ages of eighteen and fifty.
2. self admission of ACOA status or scoring as adult children on the Michigan Alcoholism Screening Test (third person form).
3. less than six months of continuous counseling or self-help group involvement.
4. voluntary participation.

Criteria for selection of group two were:

1. between the ages of eighteen and fifty.
2. admission of ACOA status or scoring as adult children on the Michigan Alcoholism Screening Test (third person form).
3. two or more years of continuous counseling or self-help group involvement.
4. voluntary participation.

Individuals were located by the researcher asking personally for volunteers at community alcohol education programs and adult education groups. Volunteers were then approached individually and consent given verbally. The first sixty individuals which responded and met the criteria for either group were selected.

Instrument

Adult children of alcoholics status was determined by the use of the Michigan Alcoholism Screening Test (third person form). The MAST is a frequently used diagnostic screening tool with a high capacity for differentiation of alcoholics from non-alcoholics (see Appendix B). The MAST was developed by Selzer in 1971 and consists of twenty-five "yes-no" items related to the frequency, pattern, and consequences of drinking. Statistically the MAST has been shown to satisfy basic psychometric requirements eg. validity, reliability, and internal consistency. The MAST has a correlation of 78 percent at the .001 level and identifies 98 percent of alcoholics. Keyser and Sweetland, editors, describe the MAST in Test Critiques as a screening tool for alcoholism with a reliability of .95 as reported by Selzer in 1975 (Moore, pg. 117).

McAuly, (McAuly, pg. 1627) in comparing the effectiveness of the first person and family forms of the MAST, found the self reporting scores and the family scores did not differ significantly. The family form was developed from the first person form by altering the pronouns to the second or third person. The family form uses the same point scoring system as the self reporting MAST. A score of three or less
indicates a non-alcoholic, a score of 4 is suggestive of alcoholism and a score of five or greater denotes alcoholism in the family system. McAuley found the family form to have more scores positive for alcoholism than the self reporting form. However the first person form had more false positive than the family form identified. McAuley found the second and third person form to be 70 percent correct for predicting alcoholism in a family member.

Levels of self-acceptance were measured by the use of a self-acceptance scale, (see Appendix A), developed by psychologist Emanuel M. Berger (Berger, pg. 778). He based this scale on previous research by Dr. Elizabeth Scheere and Dr. Carl Rodgers. Dr. Berger listed nine characteristics of the self-accepting person and developed a group of thirty-six rated items for the self-acceptance scale. The scale is described in the **Dictionary of Unpublished Experimental Measures** as follows:

- **Purpose:** to assess the relative presence or lack of self-acceptance
- **# items:** 36
- **format:** 5 point scale
- **reliability:** split half = .89 corrected
- **validity:** counseled compared with non-counseled were significantly different in response to scale


Shaw in *Scales for the Measurement of Attitudes*, describes this scale as "the most carefully developed scale to measure attitudes toward self found in the literature. Evidence of validity is more extensive than for most scales in this book" (Shaw, pg. 433).
The scale is scored by assigning point values to selected answers and adding these points together for the final total. This total is placed in one of three groupings: low scores (0-110 points), average scores (111-150 points), and high scores (151-180 points) which determines the level of self-acceptance.

**Administration of scale**

Both the MAST and the self-acceptance scale were administered individually by the researcher. Each participant was informed of confidentiality and no names were used. Directions were read aloud from the form and the researcher ascertained full comprehension before allowing the participant to complete the form. The participant was left alone as long as needed to complete the questionnaires. The form was collected by the researcher.

**Tabulation of results**

Each completed MAST and self-acceptance scale was hand scored by the researcher and totaled. Individuals were determined to meet the criteria of one of the groups based on the MAST score. Those MAST's with a total score of four or less were rejected as not coming from an alcoholic home. Those questionnaires with a score of five or more on the MAST or who were self-reporting to have one or more alcoholic parents were accepted. The accepted questionnaires were separated by the amount of continuous counseling or self-help programs as defined by the criteria.

After the groups were determined the self-acceptance scale was scored and totaled. Each total was placed in one of three groupings based on the final score obtained. These groupings were the same as
used by the author of the scale, low scores 0–110 points, average scores 111–150 points and high scores 151–180 points. The hypotheses was tested using chi square at the .05 level of significance.
### Table 7

**Group one - ACOA without counseling or self-help group**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>5</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>0</td>
<td>9</td>
<td>19</td>
<td>2</td>
</tr>
<tr>
<td>0-E</td>
<td>4</td>
<td>-1</td>
<td>-3</td>
</tr>
<tr>
<td>(0-E)²</td>
<td>16</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>(\frac{(0-E)^2}{E})</td>
<td>3.2</td>
<td>.05</td>
<td>1.8</td>
</tr>
</tbody>
</table>

\[ \chi^2 = \sum \frac{(0-E)^2}{E} = 3.2 + .05 + 1.8 = 6.85 > .05 \]

df=2  
males=5  
females=25

**Group two - ACOA with two or more years of counseling or self-help group**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>5</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>0</td>
<td>5</td>
<td>23</td>
<td>2</td>
</tr>
<tr>
<td>0-E</td>
<td>0</td>
<td>3</td>
<td>-3</td>
</tr>
<tr>
<td>(0-E)²</td>
<td>0</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>(\frac{(0-E)^2}{E})</td>
<td>0</td>
<td>.45</td>
<td>1.80</td>
</tr>
</tbody>
</table>

\[ \chi^2 = \sum \frac{(0-E)^2}{E} = .45 = 1.80 = 2.25 < .05 \]

df=2  
males=12  
females=18

E=expected outcome  
0=actual outcome
The distribution of the results of each group is shown in Table 7.

On group one the actual outcome differs from the expected outcome at the .05 level of significance. This does not support the null hypothesis. $H_0$, the alternative hypothesis is accepted at the .05 level. ACOAs do have measurably lower levels of self-acceptance than the general population.

Group two's actual outcome does not differ from the expected outcome at a significant level. This indicates ACOAs which receive treatment have self-acceptance levels similar to the general population and also have higher levels than untreated ACOAs.

**Analysis of Results**

While these results are supportive of the literature describing low levels of self-acceptance in ACOAs there are several additional factors to be considered. First neither group was matched for sex, age, or ethnic group. There was no effort to obtain matched groups and both groups were predominately caucasian females. This factor may have some influence on the scores obtained. Further studies would be necessary to determine if levels of self-acceptance differ among males compared to females and to take into consideration age and ethnic or cultural influence.

Second, other than a general statement regarding counseling or self-help group involvement there was no effort to determine a relationship between scores obtained on the self-acceptance test and length of time in counseling. A longitudinal study of self-acceptance determination at specific time intervals would be needed to determine if levels of self-acceptance do indeed change. A theory to be tested:
does the individual level of self-acceptance drop with initial self-awareness and then rise with consistent intervention?

Third, great difficulty in obtaining self-admitted ACOAs from the general population was obvious. All individuals who scored at a significantly high level on the MAST consistently denied parental alcoholism when asked directly. Further studies of non-treated ACOAs might consider using the MAST or a similar tool as a screening method.
SUMMARY

Conclusion

Experts in the field of family alcoholism have proposed a number of characteristics of adult children of alcoholics based on clinical observations. This study was developed to obtain baseline data on one described characteristic, self-acceptance. The information obtained supports the proposed characteristic of lower levels of self-acceptance in untreated ACOAs than the general population. Secondly, levels of self-acceptance do increase with consistent involvement in counseling or self-help groups and are higher than levels of untreated ACOAs.

Recommendations

The characteristics of adult children of alcoholics which differentiate them from the general population must be more clearly delineated. Current evidence for ACOA characteristics comes largely from case studies. These typologies must be supported by evidence from controlled experimental research comparing ACOA with non-ACOA. Specific traits must be individually described and tested using control groups of non-ACOAs for comparison. Only obtaining such basic information can prove a unique population deserving of individual indentification and intervention exists.

A related research issue concerns controlled studies of improvement in levels of specific traits obtained by different treatment protocols i.e. - individual counseling, group counseling, self-help group
involvement or a combination of these. It is studies concerned with treatment methods which will help determine the appropriate methods of intervention with AODAs for the optimal recovery.
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APPENDIX A

SELF ACCEPTANCE SCALE
SELF-ACCEPTANCE SCALE

Directions: On this page are a series of statements that ask about personal feelings. Read each statement and decide how true or false that statement is for you. Using the scale provided below, mark your answer on the answer sheet.
1 = completely true
2 = mostly true
3 = half true, half false
4 = mostly false
5 = completely false

1. I'd like it if I could find someone who would tell me how to solve my personal problems.

2. I don't question my worth as a person, even if I think others do.

3. When people say nice things about me, I find it difficult to believe they really mean it. I think maybe they're kidding me or just aren't being sincere.

4. If there is any criticism or anyone says anything about me, I just can't take it.

5. I don't say much at social affairs because I'm afraid that people will criticize me or laugh if I say the wrong thing.

6. I realize that I'm not living very effectively, but I just don't believe I've got it in me to use my energies in better ways.

7. I look on most of the feelings and impulses I have toward people as being quite natural and acceptable.

8. Something inside me just won't let me be satisfied with any job I've done—if it turns out well, I get a very smug feeling that this is beneath me, I shouldn't be satisfied with this, this isn't a fair test.

9. I feel different from other people. I'd like to have the feeling of security that comes from knowing I'm not too different from others.

10. I'm afraid for people that I like to find out what I'm really like, for fear they'd be disappointed in me.

11. I am frequently bothered by feelings of inferiority.
12. Because of other people, I haven't been able to achieve as much as I should have.

13. I am quite shy and self-conscious in social situations.

14. In order to get along and be liked, I tend to be what people expect me to be rather than anything else.

15. I seem to have a real inner strength in handling things.

16. I feel self-conscious when I'm with people who have a superior position to mine in business or school.

17. I think I'm neurotic or something.

18. Very often, I don't try to be friendly with people because I think they won't like me.

19. I feel that I'm a person of worth, on an equal plane with others.

20. I can't avoid feeling guilty about the way I feel toward certain people in my life.

21. I'm not afraid of meeting new people. I feel that I'm a worthwhile person and there's no reason why they should dislike me.

22. I sort of only half believe in myself.

23. I'm very sensitive. People say things and I have a tendency to think they're criticizing me or insulting me in some way and later when I think of it, they may not have meant anything like that at all.

24. I think I have certain abilities and other people say so too. I wonder if I'm not giving them an importance way beyond what they deserve.

25. I feel confident that I can do something about the problems that may arise in the future.

26. I guess I put on a show to impress people. I know I'm not the person I pretend to be.

27. I do not worry or condemn myself if other people pass judgement against me.

28. I don't feel very normal, but I want to feel normal.

29. When I'm in a group, I usually don't say much for fear of saying the wrong thing.

30. I have a tendency to sidestep my problems.
31. Even when people don think well of me, I feel sort of guilty because I know I must be fooling them—that if I were really to be myself, they wouldn't think well of me.

32. I feel that I'm on the same level as other people and that helps to establish good relations with them.

33. I feel that people are apt to react differently to me than they would normally react to other people.

34. I live too much by other people's standards.

35. When I have to address a group, I get self-conscious and have difficulty saying things well.

36. If I didn't always have such hard luck, I'd accomplish much more than I have.

Please answer the following questions as fully as possible.

37. sex

38. age

39. Did you grow up in an alcoholic home as a child?

40. Have you had any counseling?

41. If yes, how many months or years?

42. Have you been a member of any 12 step program?

43. If yes, how many months or years?

    Thank you for your help.
APPENDIX B

MICHIGAN ALCOHOLISM SCREENING TEST
MICHIGAN ALCOHOLISM SCREENING TEST (MAST)  
(Third Person Form)  

Instructions: Please answer the following questions based on your perceptions of the drinking behaviors of one of your parents during your childhood. Choose the parent whose drinking you consider most likely to have been a problem. If you consider both parents to have been problem drinkers, choose one parent and answer questions in terms of this parent's behavior. If you consider neither parent to have been a problem drinker, choose one parent and respond to the items anyway. In addition to your natural mother or father, also consider step-parents, adoptive parents or foster parents, provided you were in the same household as this person for what you consider to be a significant part of your childhood. Please answer all questions.

Yes ( ) No ( ) 1. Do you feel that your mother or father was a normal drinker?

Yes ( ) No ( ) 2. Did your mother or father ever awaken the morning after some drinking the night before and find that he/she could not remember a part of the evening before?

Yes ( ) No ( ) 3. Did your mother ever worry or complain about your father's drinking? Did your father ever worry about or complain about your mother's drinking?

Yes ( ) No ( ) 4. Was your mother or father able to stop drinking without a struggle after one or two drinks?

Yes ( ) No ( ) 5. Did your mother or father ever feel bad about her/his drinking?

Yes ( ) No ( ) 6. Did friends or relatives think your mother or father drank normally?

Yes ( ) No ( ) 7. Did your mother or father ever try to limit her/his drinking to certain times of the day or to certain places?

Yes ( ) No ( ) 8. Was your mother or father able to stop drinking when she/he wanted to?

Yes ( ) No ( ) 9. Did your mother or father ever attend a meeting of Alcoholics Anonymous (A.A.)?

Yes ( ) No ( ) 10. Did your mother or father ever get into fights when drinking?
Yes ( ) No ( ) 11. Did your mother's drinking ever create a problem between she and your father? Did your father's drinking ever create a problem between he and your mother?

Yes ( ) No ( ) 12. Did your father (or any other family member) ever go to anyone for help about your mother's drinking? Did your mother (or any other family member) ever go to anyone for help about your father's drinking?

Yes ( ) No ( ) 13. Did your mother or father ever lose friends because of her/his drinking?

Yes ( ) No ( ) 14. Did your mother or father ever get into trouble at work because of his/her drinking?

Yes ( ) No ( ) 15. Did your mother or father ever lose a job because of his/her drinking?

Yes ( ) No ( ) 16. Did your mother or father ever neglect obligations, family, or work for two or more days in a row because she/he was drinking?

Yes ( ) No ( ) 17. Did your mother or father ever drink before noon?

Yes ( ) No ( ) 18. Was your mother or father ever told she/he had liver trouble? Cirrhosis?

Yes ( ) No ( ) 19. Did your mother or father ever have delirium tremens (DTs) or severe shaking, hear voices, or see things that weren't there after heavy drinking?

Yes ( ) No ( ) 20. Did your mother or father ever go to anyone for help about her/his drinking?

Yes ( ) No ( ) 21. Was your mother or father ever in the hospital because of his/her drinking?

Yes ( ) No ( ) 22. Was your mother or father ever a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem?

Yes ( ) No ( ) 23. Was your mother or father ever seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or clergyman for help with an emotional problem in which drinking had played a part?

Yes ( ) No ( ) 24. Was your mother or father ever arrested, even for a few hours, because of drunk behavior?

Yes ( ) No ( ) 25. Was your mother or father ever arrested for drunk driving or driving after drinking?
26. I completed this questionnaire in terms of the behavior of (check one): ( ) my natural mother; ( ) my natural father; ( ) a step-mother; ( ) a step-father; ( ) an adoptive mother; ( ) an adoptive father; ( ) a foster mother; ( ) a foster father.