Research

Personality Characteristics of Adult Children of Alcoholics

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A study that attempted to validate the characteristics of Adult Children of Alcoholics (ACOAs) as presented by Woititz (1983) was conducted. Male and female college students self-reported to be ACOAs, non-ACOAs, or individuals who had participated in an ACOA treatment group. These groups were compared on 12 of Woititz's 13 characteristics using objective personality measures. No significant differences were found among the groups on any of the characteristics measured. The results severely question the validity of Woititz's descriptions of ACOAs. The dangers of using these characteristics in the diagnosis and treatment of individuals are discussed.

The past few years have seen a tremendous growth in the number of self-help publications written for persons who are related to problem drinkers. 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 whom many believe are at risk for mental health problems (Owen, Rosenberg, & Barkley, 1985). With the number of United States children of alcoholics estimated at 34 million (Black, 1979), it seems wise to gather as much accurate information about this group as possible.

Although 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 the following:

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 usually feel they are different from other people.
11. ACOAs are super responsible or super irresponsible.
12. ACOAs are extremely loyal, even in the face of evidence that loyalty is undeserved.
13. ACOAs are impulsive (Woititz, 1983, p. 4).

Goodman (1987) has made the point that these characteristics read like a "checklist of mental health complaints" (p. 163) that fail to distinguish ACOAs from other diagnostic groups. In fact, this list may be a twisted example of the "Barnum effect," the tendency to interpret a description that applies to everyone as being particularly valid to one's self (see Myers, 1989). Despite these criticisms, the abundance of ACOA groups that operate on the basis of Woititz's characteristics speak to how widely accepted these impressions have become.

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 reveal expected differences between individuals with alcoholic parents and "normals," whereas others have revealed some group differences, but also reveal the preponderance of ACOAs to be no different from non-ACOAs. For example, Venugopal (1985) used the Mooney Problem Checklist and found differences between children of alcoholics and normals on the dimensions of home and family problems, personality growth problems, and financial problems, but no differences on the dimensions of health and physical development, school problems, and self-concept. Barnard and Spoentgen (1986) found that treatment-seeking ACOAs differed from non-ACOAs on the Personality Orientation Inventory scales of inner-directedness, feeling reactivity, self-regard, self-acceptance, and capacity for intimate contact. The same study, however, found that ACOAs who were not seeking treatment were no different from normals on these same scales except that they had a significantly higher capacity for intimate contact. Another study (Calder & Kostyniuk, 1989) used the Personality Inventory for Children and found that the scores of children of alcoholics (COAs) were significantly higher than were the scores of non-COAs on 15 of the 16 scales, but that the "typical profile [of COAs] was that of a reasonably well-adjusted

individual" (p. 418). Finally, a study by Alterman, Searles, and Hall (1989) found no differences between children of alcoholic fathers and control participants on several alcohol-related measures, mental health problems, and personality variables (such as various sensation-seeking scales). These researchers and others warn against stereotyping individuals with alcoholic parents as necessarily having certain problems or characteristics (Goodman, 1987).

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

Because there seems to be some doubt about the validity of Woititz's description of ACOAs, it is imperative that objective evaluations 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 to view themselves in a way that may not only be inaccurate but may even be maladaptive. Our study is an initial attempt at assessing differences between nontreatment ACOAs, treatment ACOAs, and non-ACOAs along the 12 remaining characteristics described by Woititz (1983). In addition, we attempted to discover which of Woititz's characteristics (if any) predict membership in these three groups.

METHOD

Participants

The participants included in this study were 147 undergraduate students from a state university located in the midwestern United States. The participants were all drawn from introductory classes in several disciplines of academic study. A total of 52 men (35.4%) and 94 women (63.9%) participated, with 1 student failing to report his or her sex on the questionnaire. The mean age of the participants was 23.5 years (SD=6.47), and they ranged in age from 18 (n=14) to 54 (n=1) years. A total of 116 (78.9%) of the participants were freshmen, 20 (13.6%) were sophomores, and 8 (5.4%) reported they were juniors. Three participants 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 this study. Objective scales were selected that seemed to measure each of the remaining 12 characteristics of ACOAs as outlined by Woititz. From the Personality Research Form-E (PRF) (Jackson, 1984), the following items were included: (a) Abasement—ACOAs judge themselves without mercy. (b) Affiliation—ACOAs are extremely loyal, even when loyalty is undeserved. (c) Defendence—ACOAs lie when they could just as easily tell the truth. (d)Dominance—ACOAs overreact to changes over which they have no control. (e) Endurance—ACOAs have difficulty following a project through from beginning to end. (f) Impulsivity—ACOAs are impulsive. (g) Play—ACOAs take themselves very seriously, and ACOAs have difficulty having fun. (h) Social Recognition—ACOAs desire approval and affirmation.

From the Jackson Personality Inventory (JPI) (Jackson, 1976), the following scales were included: (i) Responsibility—ACOAs are either super responsible or super irresponsible. (j) Social Adroitness—ACOAs usually feel "different" from others.

Finally, the Imposter Phenomenon Scale (Harvey & Katz, 1985) was used to assess (k) the notion that ACOAs guess at what constitutes normal behavior.

Personality Research Form. The PRF (Form-E) is a 352-item objective measure of personality "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 has reported internal consistency estimates of reliability (odd-even) ranging from .50 to .91 for form E and test-retest reliabilities (1-week interval) ranging from .69 to .90 for form AA. For the eight 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). Convergent and discriminant validity of the PRF have been demonstrated by correlating scores on PRF scales with scales on the Bentler Psychological Inventory (BPI), the Bentler Interactive Psychological Inventory, the Cattell High School Personality Questionnaire, the JPI, and the California Psychological Inventory, as well as other instruments (Jackson, 1984). Other validity studies of the PRF have been done correlating test scores with peer ratings (Jackson, 1984; Jackson & Guthrie, 1968; Kusyszyn, 1968). A study (Jackson, 1984) done on Form-E using a single rater who was a roommate of the person being assessed resulted in correlations ranging from .34 (Defendence) to .74 (Play), with a median correlation of .51 for the eight PRF scales used in the study. Additional evidence for validity (including a multimethod factor analysis of self-ratings, peer-ratings, and PRF scores) is provided in the test manual (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 1 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) reported internal consistency estimates of reliability (coefficient alpha) for the JPI ranging from .62 to .88 on two samples of participants. Coefficient alphas for the Responsibility and Social Adroitness scales ranged from .67 to .70, and .62 to .65. Seefeldt, Barnett, and Lord (in press) reported test-retest reliabilities (6-week interval) for the JPI ranging from .68 to .88 for a sample of college students. Test-retest coefficients for the

TABLE 1

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

Variable	*M*	*SD*	*F*	*p*
Abasement				
Non-ACOA	7.06	3.01		
ACOA	7.07	2.30	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 Recognition				
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
Social Adroitness				
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

Note. ACOA = Adult Children of Alcoholics.

Responsibility and Social Adroitness scales were both .78. Multitrait-multimethod means of determining construct validity have been completed on the JPI. As an example of the evidence for the validity of the scales used in this study, the Responsibility scale has been shown to correlate significantly with such measures as the BPI's Law Abidance scale (.77) and with scores on an adjective checklist (.46) and peer-ratings (.33), whereas the Social Adroitness scale correlated with the Ambition scale of the BPI (.26) and the Social Recognition scale of the PRF (.36) (see Jackson, 1976). The PRF and JPI were selected because they were psychometrically sound instruments and had scales that most closely matched the characteristics proposed by Woititz. A presentation of the interpretive descriptions of the PRF and JPI scales used in the study can be found in Appendix A.

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 because of a fear of being "unmasked" and found to be a "phony." According to Harvey and Katz (1985), 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: (a) a sense of having fooled people into overestimating their ability, (b) a tendency to attribute success to some nonintelligence or ability factor, and (c) an intense fear of being exposed as a fraud. The scale was used in this study to examine feelings of fraudulence, which Woititz (1983) suggested undermine ACOAs feelings of normalcy. She stated, "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 participant that contained the following items: (a) the entire PRF Form-E, (b) the Responsibility and Social Adroitness scales of the JPI, (c) the Imposter Phenomenon Scale, and (d) a questionnaire designed by the authors. The author-designed questionnaire required the respondents to provide selected demographic information and

TABLE 2

Means, Standard Deviations, and *F* Values for Non-ACOA (*n* = 93), Nontreatment ACOA (*n* = 36), and Treatment ACOA (*n* = 18) Groups

Variable	*M*	*SD*	*t*	*p*
Abasement				
Non-ACOA	7.06	3.01		
Nontreatment ACOA	6.94	2.59		
Treatment ACOA	7.33	3.25	0.10	.90
Affiliation				
Non-ACOA	9.58	3.87		
Nontreatment ACOA	9.50	3.57		
Treatment ACOA	7.94	3.06	1.50	.23
Defendence				
Non-ACOA	7.33	3.05		
Nontreatment ACOA	6.42	2.98		
Treatment ACOA	7.00	3.45	1.15	.32
Dominance				
Non-ACOA	8.78	4.20		
Nontreatment ACOA	8.33	4.90		
Treatment ACOA	8.17	3.81	0.24	.79
Endurance				
Non-ACOA	9.35	3.35		
Nontreatment ACOA	9.56	3.36		
Treatment ACOA	9.00	3.50	0.16	.85
Impulsivity				
Non-ACOA	7.32	3.71		
Nontreatment ACOA	6.70	4.06		
Treatment ACOA	7.28	3.20	0.38	.69
Play				
Non-ACOA	9.29	3.62		
Nontreatment ACOA	8.94	3.13		
Treatment ACOA	8.11	3.88	0.86	.42
Social Recognition				
Non-ACOA	9.16	3.22		
Nontreatment ACOA	7.89	3.71		
Treatment ACOA	8.50	2.94	1.98	.14
Responsibility				
Non-ACOA	12.48	3.20		
Nontreatment ACOA	12.72	3.03		
Treatment ACOA	12.56	2.87	0.08	.93
Social Adroitness				
Non-ACOA	10.63	3.46		
Nontreatment ACOA	10.89	2.78		
Treatment ACOA	10.22	2.94	0.25	.78
Imposter				
Non-ACOA	42.40	8.97		
Nontreatment ACOA	40.06	8.65		
Treatment ACOA	43.89	9.74	1.33	.27

answer questions concerning their own and their parents' drinking behavior. This questionnaire was presented last to ensure that participants were naive as to the exact nature of the study until after completing the personality inventories. The ACOA group comprised those participants who responded on the questionnaire that one or both of their parents were alcoholics; a treatment subgroup also comprised those participants 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. Participants 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 and omit no items, and then they were given approximately 60 to 75 minutes 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. Because a subgroup of students also identified themselves as having participated in treatment groups for ACOAs, one-way ANOVAs for independent samples were also performed on these same scores for non-ACOAs, nontreatment 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-ACOAs (n=93), nontreatment ACOAs (n=36), and treatment ACOAs (n=18). Variation in scores among the three groups was also similar.

Initially, the participants 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 participants are presented in Table 1.

There were no significant differences 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 overloyalty), 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 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 many of the scales on the PRF and JPI yield different scores for men and women, differences between ACOAs and non-ACOAs were also examined for men and women 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 did female ACOAs (M=7.89, SD=3.60) [$t(92)$=–1.98, p<.05], suggesting that they were more interested in social approval and affirmation.

TABLE 3
Discriminant Function Analysis Classification Results

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

Note. Percentage of grouped cases correctly classified = 39.46%.

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, nontreatment ACOAs, and treatment ACOAs. These results are presented in Table 2. Again, no 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 use 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; neither, however, was significant (F=1.97, p=.14; F=1.72, p=.14). The resulting Wilks's lambda was .953, indicating that nearly all of 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 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 this study.

DISCUSSION

Recent research has cast doubt on the validity of the popular perception of ACOAs as a homogeneous group. The purpose of our study was a simple one. We wanted to evaluate whether the traits outlined by Woititz as characteristic of ACOAs were indeed more prevalent in that group. Based on this preliminary study, we conclude that they are not. No significant differences were found on any of the 12 characteristics among the ACOA, non-ACOA, and treatment ACOA groups. In fact, the only difference found was on the Social Recognition scale of the PRF for female participants. Here, however, the difference found was in the

opposite direction of that which Woititz would predict. These findings 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 this label presumably means. Unfortunately, the information being provided to such individuals may be inaccurate and even damaging.

Being told by an "expert" that one has certain characteristics or problems because he or she is an ACOA is rendered much more believable by both the social status afforded to the expert and to the Barnum effect quality of the descriptions. That is, many ACOAs might be persuaded that they possess certain characteristics simply because the information is presented in what they perceive to be an authoritative source by a person with expert status. Similarly, the characteristics presented are nebulous, facilitating ease of application to any person, in much the same way as reading and believing a horoscope. The result may be that many individuals are misled into perceiving that they have special problems that 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 of course is an empirical question and should be carefully investigated in future research.

Another implication of this study is that counselors, particularly those who specialize in the treatment of ACOAs codependents, or both, may be falling prey to what several researchers have called 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, a counselor may begin treatment with a client expecting that the client's status as an ACOA is the primary cause of his or her problems, and selectively attend to information that verifies this expectation. One obvious pitfall of proceeding in this manner is that more significant etiological factors may be ignored. Furthermore, because the counselor expects to find predetermined characteristics in the client (characteristics that we have already noted are nebulous), he or she will probably have no difficulty "discovering" them. Consequently, confirmation bias may occur, seemingly validating the application of the ACOA label.

We recognize, of course, that our study has several limitations. Our sample size was relatively small, we selected only a few of many potential measures of Woititz's characteristics, and our participants were all college students. Additionally, we wish to emphasize that our results do not preclude the probability that some ACOAs exhibit the characteristics described by Woititz. Rather, our results support the findings of previous researchers who have found the ACOA group to be heterogeneous. We do, however, believe this to be the most objective analysis of Woititz's characteristics to date. Woititz and others involved in ACOA treatment have presented these characteristics as generally universal in ACOAs; hence, they should theoretically apply to the ACOAs in our study even though the sample was restricted along several dimensions.

Although our findings must be interpreted tentatively while we await further research, it is our opinion 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 members of this group are homogeneous and have special problems or characteristics, they do not seem to be the ones currently examined in the ACOA treatment community and popular literature. It seems that the proverbial cart has been placed before the horse by building treatment groups based on certain differences and problems that may not exist prior to reading about or being treated for them. More research is needed to delineate what significant pretherapy differences (if any) exist before we attempt to persuade people that they need to be in treatment solely because they are the child of a problem drinker.

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APPENDIX A

Interpretive Descriptions of Personality Research Form (PRF) and Jackson Personality Inventory (JPI) Scales

Scale	*Description of High Scorer*
PRF—Abasement	Shows a high degree of humility; accepts blame and criticism even when not deserved; willing to accept an inferior position; tends to be self-effacing
PRF—Affiliation	Enjoys being with friends and people in general; accepts people readily; makes efforts to win friendships and maintain associations with people
PRF—Defendence	Ready to defend self against real or imagined harm from other people; takes

	offense easily; does not accept criticism readily
PRF—Dominance	Attempts to control environment, and to influence or direct other people; expresses opinions forcefully; enjoys the role of leader and may assume it spontaneously
PRF—Endurance	Willing to work long hours; doesn't give up quickly on a problem; persevering, even in the face of great difficulty; patient and unrelenting in work habits
PRF—Impulsivity	Tends to act on the "spur of the moment" and without deliberation; gives vent readily to feelings and wishes; speaks freely; may be volatile in emotional expression
PRF— Play	Does many things "just for fun"; spends a good deal of time participating in games, sports, social activities, and other amusements; enjoys jokes and funny stories; maintains a lighthearted, easy-going attitude toward life
PRF—Recognition	Desires to be held in high esteem by acquaintances; concerned about reputation and what other people think; works for the approval and recognition of others
JPI—Responsibility	Feels a strong obligation to be honest and upright; experiences a sense of duty to other people; has a strong and inflexible conscience
JPI—Social Adroitness	Is skillful at persuading others to achieve a particular goal, sometimes by indirect means; occasionally may be seen as manipulative of others, but is ordinarily diplomatic, socially intelligent

The appendix is adapted from Jackson (1984) and Jackson (1976).

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