LOCUS OF CONTROL AMONG FEMALE ADULT CHILDREN OF ALCOHOLICS: A TREATMENT APPROACH

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CHAPTER I

INTRODUCTION

Alcoholism, alcohol abuse and alcoholics have been the focus of countless research studies. However, only in the past ten years have researchers directed their studies towards the children of alcoholics and more recently towards the adult children of alcoholics (ACOA). The purpose of this study was to determine if locus of control levels differ significantly between female ACOA's and adult females from non-alcoholic families (ANAF). A further purpose was to determine the effect of a selected treatment on locus of control levels of the female ACOA group.

More than ten percent of the population of the United States is being raised or was raised in an alcoholic home (Ackerman, 1979). There are an estimated 29 million American ACOA's. Another 12 to 15 million children of alcoholics are under the age of 18. Chafetz (1979) found that children of alcoholics may suffer severe psychological consequences as a result of growing up in a home with an alcoholic parent. Research to address the specific needs of this large population of ACOA's has begun to appear only recently (Black, 1979, 1981b; Brown & Cermak, 1984; Wegscheider, 1981).

The recognition of alcoholics as individuals with a

primary, chronic, progressive and ultimately, fatal disease has taken centuries. The explicit realization that adults who grew up in families where at least one parent was alcoholic are at significant risk of becoming alcoholics has taken even longer. ACOA's may become alcoholic, marry an alcoholic, or develop significant physical or emotional problems themselves (Ackerman, 1986). However, only five percent of this population are being identified and treated (Whitfield, 1981).

Theoretical Foundations

The theoretical foundations of this study are based on Bowen's (1978) systems model of family therapy and Rotter's (1966) generalized expectancy concerning reinforcement. A brief discussion of each theoretical approach follows.

Bowen's (1978) systems model of family therapy provides the theoretical base for the treatment modality utilized in this study. Bowen (1978) believes that a person's current behavior is caused by a transference process that inappropriately applies past history and behaviors to present situations.

Bowen (1978) further arrived at a theory of homeostasis. He noticed that this was the family's defense against crisis or tension. Family members pull together when they feel stress and isolate themselves from any outside influence to restore balance. This system and its members are subject to change when even one member changes. If self-destructive

behaviors, such as substance abuse, help maintain balance, the family tolerates them. Families with a high degree of togetherness produce children who are unable to differentiate themselves from their parents. This appears to be true of most ACOA's (Chafetz, 1979; Wood, 1984).

The writing and discussion of a life history by the ACOA utilizes the system's theory in this study. The ACOA's behavior was discussed in terms of the lack of differentiation of family members in the family of origin, repression of individuality and an inability of the ACOA to differentiate from the parents' past behaviors.

Locus of control is an individual's generalized expectancy concerning reinforcement (Rotter, 1966). An internal locus of control is the perception that individuals' capacity, behavior or traits effect and control reinforcement. An external locus of control perceives reinforcement as noncontingent upon the individual but upon external factors. Social learning theory provides the theoretical background for the nature and effects of reinforcement contingency in locus of control (Rotter, 1966).

In social learning theory, a reinforcement strengthens an expectancy that a particular behavior will be followed by that reinforcement in the future. However, after the expectancy is built up, the failure of the reinforcement to occur reduces or extinguishes the expectancy. Additionally, when the reinforcement is seen as not contingent on the individual's behavior that its occurrence will not increase

an expectancy as much as when it is seen as contingent (Rotter, 1966). This nonoccurrence will not reduce an expectancy so much as when it is seen as contingent. Therefore, past reinforcements in an individual's life differ in the degree to which they attribute reinforcements to their own actions (Rotter, 1966).

In terms of assessing the degree of an individual's generalized expectancy concerning reinforcement, individuals scoring lower (more internal) on locus of control measures describe themselves as assertive, powerful, independent and effective. Those who score higher (more external) do not see themselves in such positive light (Hersch & Scheibe, 1967).

Joe (1971) found that externals tend to be more anxious, have more neurotic symptoms, are more dogmatic, less trustful and lack self-confidence to a greater degree than internals. Hjelle (1976) found internality and self-actualization to be significantly related.

O'Gorman's (1975) study revealed adolescent children of alcoholic fathers had significantly lower self-esteem than youngsters from families where no alcoholism was present. Additionally, children of alcoholic parents showed a more external locus of control than the other groups in this study. Werner (1986) further indicated that children of alcoholic parents who exhibited serious coping problems and low self-esteem also exhibited a more external locus of control than others.

Change in locus of control levels have been observed in

a number of studies. Different reasons are given to explain the changes in locus of control levels and a variety of methods have produced changes (Diamond & Shapiro, 1973; Founds, Guinan & Warhime, 1974; Parks, Becks, Chamberlain & Crandall, 1975). Smith (1970) found that changes of locus of control occur as a function of life crisis resolution.

Based on the research presented, internals appear to be less anxious than externals; describe themselves in more positive personality terms and are characterized as having better personal adjustment and coping skills than externals. Therefore, it would appear that internal locus of control, as well as treatment to increase the internal locus of control level are both to be desired.

Statement of the Problem

Research has documented children/youth of alcoholic parents have a significantly lower internal locus of control level than children from families where no alcoholism was present (O'Gorman, 1975). However, in a review of the literature no research was found in regard to locus of control levels and adult children of alcoholics.

Smith (1970) established that changes of locus of control occur as a function of life crisis resolution. As individuals resolve life crisis they learn and begin to use more effective coping mechanisms. Smith (1970) further stated since the usual coping mechanisms have failed, individuals are ready for positive change in a short amount

of time.

A crisis point for the ACOA may occur at approximately age 25. Black (1981a) states, "It is about this time, when a young person reaches the mid-twenties that the effects of growing up in an alcoholic home begin to become apparent (p. 32)."

The crisis resolution for ACOA's begins with the awareness that one or both of their parents is alcoholic. This awareness is often a catalyst for the ACOA to seek treatment. Various treatment methods have been recommended (Cermak & Brown, 1982; Kendall, 1987; Schaef, 1986; Woititz, 1983). However, there is a lack of research to validate specific treatment methods and outcomes (Ludwig & Waite, 1983; Schaef, 1986).

This study involves female ACOA's who receive a selected treatment, a group of female ACOA's who do not receive treatment and a group of ANAF females. This study is designed to answer the following questions: (a) Do locus of control levels differ significantly between female ACOA's and female ANAF's? (b) Do locus of control levels change significantly among female ACOA's receiving a selected treatment, female ACOA's who do not receive the treatment and female ANAF's over the treatment period?

Significance of the Study

Control for ACOA's has been described as a core issue (Cermak, 1986), a dominant dynamic in ACOA groups (Brown &

Cermak, 1984) and a central feature of ACOA personalities (Lerner, 1986). While recent research (Cermak, 1986; Lerner, 1986) has determined that control is an issue for ACOA's, these studies have not addressed measurement of specific levels of locus of control in this population. Further, while the implication for need of treatment based on the control issue has been addressed (Cermak, 1986), no specific treatment modalities nor outcomes have been researched. This study attempts to address this apparent gap in the research of control as an issue for ACOA's.

This study also attempts to contribute insight to the value of measuring locus of control levels of ACOA's. Specifically, determinations are made, using Rotter's (1966) I-E Scale, regarding ACOA's locus of control. Also, a determination was made as to the effect the selected treatment had on locus of control. Further, this study serves as an encouragement for future evaluation of various treatment modalities provided ACOA's.

Definition of Terms

The following terms are of particular relevance to this study.

Adult Females from Non-Alcoholic Families. Adult females from non-alcoholic families are females 25-59 years of age who answer yes to fewer than six items on the CAST (Jones, 1981).

Adult Female Children of Alcoholics. Adult female

children of alcoholics are female subjects 25-59 years of age who answer yes to six or more items of the Children of Alcoholics Screening Test (CAST) (Jones, 1981).

Locus of Control. Individuals with an internal locus of control have an expectancy that reinforcement is contingent on personal behavior (internality) versus an expectancy that reinforcement is determined by luck, chance, fate or powerful others (external locus of control or externality) (Rotter, 1966). For the purpose of this study locus of control will be determined by the score obtained on Rotter's (1966) 29 item Internal vs External Control Scale (I-E). The lower the score, the higher the internal locus of control. The higher the score, the higher the external locus of control.

Life History. The treatment provided the female ACOA's began with completion of a life history outline. Treatment session objectives and the outline were developed from specific examples in the first two chapters of Black's (1985) workbook for ACOA's, Repeat After Me. Treatment session objectives are provided in Appendix B. The life history was discussed giving acknowledgement to those personal issues resulting from being reared in a family with an alcoholic parent. Writing and discussing the life history was conducted by a Certified Alcoholism Counselor whose special emphasis is counseling ACOA's.

Limitations

The following limitations are inherent in the design of

this study.

1. The female ACOA's receiving treatment were evaluated based on only one treatment approach, the writing and discussion of an ACOA's life history with a certified alcoholism counselor within an eight week time period. Other treatments and time periods are not a part of this study.

2. Due to time limitations for completion and to reduce the drop out rate of subjects, those individuals identified as alcoholic after completing the Mortimer-Filkens Test were not included in this study.

3. In order to provide a matching procedure for control, only females between the ages of 25 and 59 were utilized as subjects.

4. Only one certified alcoholism counselor provided the selected treatment for female ACOA's. Other counselors and other treatment methods may produce differing results.

Therefore, the generalizability of the results are limited to female non-alcoholic ACOA's between the ages of 25 and 59. No reason was found to assume the results are not generalizable to this group.

Hypothesis

The .05 level of significance was utilized in testing the following hypotheses:

Ho: There is no difference between the locus of control levels of female ACOA's and female ANAF's.

Ho: There are no differences among the changes in locus

of control levels over the treatment period for female ACOA's receiving family of origin treatment, female ACOA's not receiving family of origin treatment and female ANAF's.

Organization of the Study

This chapter has provided an introduction, theoretical foundations, statement of the problem, significance of the study, definition of terms, limitations, and the hypothesis for the study. Chapter II includes a review of related literature. The research design and procedures are presented in Chapter III. Chapter IV contains the results of the study. The summary, conclusions and recommendations for future research are included in Chapter V.

CHAPTER II

REVIEW OF LITERATURE

Adults who grow up in families where at least one parent is alcoholic, present issues to clinicians that until recently have been inadequately diagnosed and treated. Untreated adult children of alcoholics (ACOA's) contribute to the multigenerational pattern of alcoholism and meaningless suffering of millions of people (Ackerman, 1986). Not only is it appropriate that attention be focused on the issues of the ACOA's population, but it is also time to begin research on the outcomes of specific treatment modalities.

The literature review is divided into five sections. The first section focuses on alcoholism and the family. Sections two and three present a discussion of children of alcoholics and adult children of alcoholics. Treatment of ACOA's is the focus of section four and the final section emphasizes literature relative to locus of control. An overall summary concludes the chapter.

Alcoholism and the Family

Alcoholism currently ranks third behind cancer and heart disease as America's leading health problem. In terms of suicide, divorce, crime, economic loss, mental and physical

problems, alcoholism affects the entire society (Lawson, Peterson & Lawson, 1983). However, the group most affected by alcoholism is the family.

One of the generally accepted clinical beliefs regarding alcoholism is the negative and often destructive impact it has on family life. Specifically, alcoholism is viewed as affecting patterns of communication, interpersonal relationships, personal growth and structural arrangements of the family (Berenson, 1976a; Bowen, 1974; Filstead, 1977; Steinglass, 1975).

Filstead, McElfresh and Anderson (1979) utilized the Family Environment Scale (FES) to compare the family environments of alcoholic and "normal" (p. 24) families. This instrument was selected for their study because it appeared to cover adequately various dimensions of family life and was not pathologically focused. Further, there were comparative data on normal families, as well as other populations.

A total of 42 alcoholic family units volunteered to participate in this study upon admission to an Alcoholism Treatment Center (ATC). A family unit was defined as the patient, non-alcoholic spouse and at least one child nine years of age or older still living at home. The 285 normal families represent the population used to develop the FES.

A comparison between the 42 alcoholic families' FES scores and those of the 285 normal families revealed significant differences on seven of the ten subscales. The alcoholic families perceived their family environments to be

less cohesive, and expressive, perceived less emphasis on independence, intellectual-cultural activities and active-recreational concerns ($p.<001$). The importance of order and organization in regard to family rules and responsibilities indicated the alcoholic families perceived less organization ($p.<05$) than the nonalcoholic families. The alcoholic family perceived a higher level of conflict ($p.<001$) than normal families. These results support speculation regarding the types of family dimensions reported previously to be affected by alcoholism and inferentially not affected in normal families.

Comparison of alcoholic couples during periods of intoxication and abstinence support the belief that couples' behavior during intoxication has adaptive consequences for the family (Davis, Berenson, Steinglass & Davis, S., 1974; Steinglass, Davis & Berenson, 1977). Steinglass (1981) conducted a study of the relationship between degree of alcoholism and psychiatric symptomology using 31 families. Each family included one alcoholic and one non-alcoholic spouse. The history of alcoholism was confirmed by a positive score on the Self-Administered Alcoholism Screening Test (SAAST). The SAAST is a 30 item instrument covering a wide range of physical, behavioral and social aspects as well as treatment history.

A second assessment tool utilized was the SCL-90, a 90 item, self-administered checklist of psychiatric symptoms. Scores obtained on the SCL-90 indicate the degree of

symptomology on nine traditional psychiatric dimensions. The psychiatric dimensions are somatization, obsessive-compulsive symptoms, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. This instrument was administered separately to each spouse.

The scores of the alcoholics and non-alcoholic spouses on the SCL-90 were compared with norms derived from a sample of psychiatric out patients and a sample of normal subjects. The SCL-90 scores indicated that both alcoholics and their non-alcoholic spouses reported levels of symptomology higher than those of a normal comparison group but lower than those of psychiatric out-patients.

A correlational analysis of SAAST and SCL-90 scores demonstrated significant correlations between SAAST social-behavioral subscores and the symptom levels of the alcoholic spouse and the non-alcoholic spouse. This association suggests that spouses of alcoholics are sensitive not so much to the severity of drinking as to the extent to which the consequences of alcoholism invade the family, work and social aspects of life.

The extent to which the family uses alcohol for adaptive purposes and the direction this behavior takes may determine the negative impact of alcoholism on other aspects of family life, such as these reflected in the SCL-90 scores and the SAAST scores. The family's use of alcohol for adaptive purposes is an example of a family-level variable influencing

the impact of alcoholism on the various members of the family and on the health of the family itself (Steinglass, 1981).

Jacob, Ritchey, Cvitkovic, and Blane (1981) conducted a study based on the assumption that the quantity, distribution and nature of communications of alcoholic and non-alcoholic families differ. A group of families with an alcoholic husband and a demographically matched group of non-alcoholic families were recruited to evaluate communication patterns. All families were observed in drinking and non-drinking conditions.

The interactions of the families were videotaped in subgroups consisting of (a) mother-father, (b) mother-children and (c) father-children. The interactions of the subgroups were analyzed by means of reliable and theoretically relevant measurement procedures (Jacob et al., 1981).

Analyses of marital interactions involving personally relevant problems indicated that alcoholic couples expressed greater negative affect and less positive affect than did non-alcoholic couples. Further, the introduction of alcohol increased negative affect and disagreement among the alcoholics but not among the controls. Finally, alcoholic wives contributed more interactionally relevant communications to a problem-solving discussion than did their husbands. Spouses in the control group were relatively equal on this variable.

Interactions of the mother-children and father-children were found to differ in regard to instrumental behavior.

Mothers were more instrumental than children in the alcoholic group while alcoholic fathers and their children were similar. Non-alcoholic fathers made considerable more problem-solving verbalizations than did their children.

These findings suggest an opposite influence structure in alcoholic and non-alcoholic families. The alcoholic family is characterized by a father who exhibits less leadership, assertiveness and problem solving behavior than does the non-alcoholic father. In the alcoholic family, the mother exhibits more direct influence in her family than the mother in the non-alcoholic family.

The results of this study (Jacob et al., 1981) present a view of the alcohol-spouse interaction. The interaction is characterized by a general pattern of negative affect and an imbalance in the expression of instrumental, task-relevant communication. The alcoholic engages in less problem solving than his spouse. Further, the differences in parent-child influence structure may involve both a general family disturbance effect as well as the influence of specific to role relationships with the alcoholic father. Over-all these findings are consistent with earlier, clinically derived dysfunctional descriptions of the family relationships of alcoholics (Gorad, 1971; Hanson, Sands & Sheldon, 1968).

The literature review on alcoholism and the family clearly denotes the negative impact of alcohol use on various family members. Communication in the alcoholic family is impaired and a negative affect was shown to be present

between the alcoholic and the non-alcoholic spouse. Finally, an opposite influence structure appears to exist more often in an alcoholic family than in the non-alcoholic family.

Children of Alcoholics

Life in a family where alcohol abuse is present affects all the family members. Alcoholism in the home is equally damaging to the children. Children of alcoholics have been ignored while treatment centers focused their efforts on the alcoholic and the non-alcoholic spouse (Ackerman, 1986). Child guidance agencies typically refer families to alcohol treatment centers when they discover alcoholism is present in one or both of the parents. This typical referral process indicates that only individuals specializing in the treatment of alcoholism can treat the family. However, Booz-Allen and Hamilton (1982) found that treatment of the alcoholic parent does not, in fact, reduce the problems of the children of alcoholics.

Cork (1969) was the first to take an in-depth look at the children of alcoholics. She interviewed 115 children who lived in alcoholic families. While the data was not obtained using quantifiable research data, the results indicated insight into the child's perspective. She found the children to be enmeshed in the family problems, unable to develop a sense of self, a sense of responsibility, or an ability to solve problems. The children complained of a lack of fun and laughter in their families and tended to contrast them

negatively with families of their friends.

Cork (1969) concluded that the children were dealing with adult problems but had not discussed them with anyone. Role reversals were common with the children performing the role of the adult and the alcoholic acting childlike. The children were responsible for household tasks and often the care of younger siblings. They reported feeling neglected by the non-alcoholic parent and expressed feelings of resentment towards mothers working outside the home. Some children had attempted to run away to avoid the overwhelming responsibilities.

The main concern expressed by the children was parental fighting or quarreling. They reported fear of the alcoholic parent and confusion towards both parents. She noted that some children reacted by becoming overly self-reliant and unable to trust people.

The prevalent feelings of the children were those of insecurity, confusion, frustration, anger, rejection and isolation. There also existed a sense of hopelessness about the future (Cork, 1969). She concluded that all the children were affected traumatically to some degree by virtue of being the child of an alcoholic.

Orford and Wilson (1978) conducted a study to elicit information regarding life in an alcoholic family. Their findings supported many of those found by Cork's (1969) study.

Parental quarreling was reported as a main family problem (Orford & Wilson, 1978). Children reported a variety

of reactions to parental conflicts. Some would intervene while others adopted a strategy of withdrawal or ignoring provocative remarks hoping to avert potential arguments. Often children left home or at least went into their own rooms when arguments began. Others were involved in trying to separate or pacify their parents. They also would tend to any injuries inflicted and clean up after the fights. Orford and Wilson (1978) stated that the most common recurring feelings in the children interviewed were fear and worry of violence, attitudes of hostility, distance and rejection from one or both parents.

The plight of children of alcoholics is affected by many factors. One of these factors is the family's socioeconomic level. An empirical study by Booz-Allen and Hamilton (1974) indicated that children from upper socioeconomic level alcoholic homes suffered more seriously from depression than children from lower socioeconomic levels. High expectations, a great need for conformity and better educational opportunities sensitized these children to their negative situation. Upper-income children of alcoholic parents tended to experience more difficulty in cultivating relationships with the opposite sex and attempted suicide more frequently than those from lower-income families.

Kearney and Taylor (1969) conducted a study of 40 adolescents seen for one to four years in a Connecticut psychiatric clinic. Twenty of the adolescents were from homes with an alcoholic parent and 20 were from non-alcoholic

homes. The offspring of alcoholics received more serious psychiatric diagnosis and were more likely to act out internal conflicts. Further, they attempted suicide more often and experienced legal difficulties and were institutionalized more often than the adolescents from non-alcoholic homes. Kearney and Taylor noted that these results must be interpreted cautiously because the two groups were poorly matched for age and were not matched for sex, race or socioeconomic level.

Chafetz, Blane and Hill (1971) found that instability in marriages, prolonged separations and divorce were considerably more prevalent in alcoholic families. In a comparison of 100 alcoholic families and 100 non-alcoholic families, 40% of alcoholic families and only 11% non-alcoholic families chose divorce in an attempt to resolve conflicts.

Family theory views marital disruption as a major contributor to children's symptoms (Chafetz et al., 1971). Additionally, these researchers reported more serious illnesses and accidents, as well as more school problems in alcoholic families. Children from alcoholic homes were more often involved with the police and the judicial system. Chafetz et al. (1977) concluded that children of alcoholics tend to externalize conflict and have a difficult time becoming socially mature and responsible adults.

Chafetz (1979) expanded his conclusion based on clinical work (Chafetz et al., 1971) with children of alcoholics. He

found only children tend to be more depressed and confused. They also tend to experience greater difficulty developing relationships with the opposite sex than do children with siblings. Apparently, there is a diffusion of emotional intensity when there are siblings who can share a mutual problem or at least take turns being the focus of the alcoholic's irrationality.

Chafetz (1979) described the eldest child as being most vulnerable to negative effects of parental alcoholism. Eldest children seem to adopt adult roles rather than experience a dependency on parental care. The eldest child is often independent from an earlier age and may, in fact, provide emotional support for one or both parents. For this reason, as adults, the older child may often continue to find themselves in a supportive role in relationships.

Chafetz (1979) also discovered that children of alcoholics often marry or, at least, befriend dependent persons, alcoholics or emotionally deprived individuals. Finding themselves once again with someone dependent on them and having their own needs unmet or suppressed, ACOA's continue to suffer the consequences of being a child of an alcoholic. Often alcohol or drug dependence is a final result.

Another alternative for children of alcoholics is to become a model individual. Children of alcoholics try to say the right thing, do whatever is asked of them and never complain. To escape their situations they may become

isolates, seek early marriage or submerge themselves in education or the pursuit of success.

Chafetz (1979) concluded that ACOA's may become involved with alcoholics, suffer from periodic states of depression, experience difficulties in relationships or become chemically dependent themselves. Further, he pointed out that few agencies focused on identifying or meeting the needs of this special population.

The concepts of role theory of ACOA's have been discussed by several researchers (Black, 1979; Nardi 1981; Wegscheider, 1976, 1981). Nardi (1981) viewed the family as a system of interacting roles which change as alcoholism becomes an issue. He suggested that not every child is affected by the alcoholic parent in the same way. Each family member has certain rights and responsibilities on the basis of their position in the family. The role an individual plays changes as situations change during family interactions. Alcoholism is a major cause in the modification of traditional role definitions in a family system. Thus a child's perception becomes confused due to inconsistent demands of the parents expectations on a day to day basis.

An emergence of family roles was outlined by Wegscheider (1976, 1981). She stated that the roles were said to be born of a compulsion to accomodate the needs of the alcoholic parent. Based on her belief that the family operates as a system which is interdependent, each individual role works to

establish equilibrium in the family. She discusses four roles of the children. The family hero is the person who has a clear perception of what is actually happening within the family. The hero begins to feel responsible for the family pain. In an attempt to provide self-esteem and alleviate the pain for the family, the hero becomes a popular and successful individual.

The scapegoat, a second role of children of alcoholics (Wegscheider, 1976), provides a distraction from what is actually happening in the family. Through rebellion and often delinquent behavior, the scapegoat gets much needed attention. The lost child, a third role, has no close ties with the family. Instead this child offers relief to the family by quietly withdrawing and making no demands on any family member. The last role outlined by Wegscheider (1976) was the mascot. The mascot provides fun and humor for the family. This child provides a distraction through charm and entertainment.

Wegscheider (1976) believes that each of these children are in roles for the sole purpose of survival. They provide a way of escape from the pain the alcoholism promotes. In each role the individual is driven by compulsion and must live with personal self delusion established through defenses. The defense system and repressed feelings of each individual are then carried into adulthood and affect each relationship of the ACOA's.

Black (1979) also discusses the acquisition of roles by

children of alcoholics. The roles create strengths needed for survival within the family system. However, they also hide the scars that develop while living in an alcoholic family system. She stressed the importance to recognize the deficit in each role, to emphasize the need to address all children of alcoholics.

The tendency is to focus only on the child who is a behavior problem or one who exhibits potential for becoming an alcoholic. High risk characteristics include (a) low self-esteem, (b) poor academic performance, (c) easily frustrated, and (d) exhibits poor adjustment. However, Black (1979) believes these children are in the minority.

The labels used by Black (1979) are (a) The Responsible One, (b) The Adjuster, and (c) The Placater. A child may adopt one or any combination of these roles. The responsible one accepts responsibility for self and other family members. This child often excels in school and has learned to get things done that need to be taken care of, develops leadership traits and becomes goal oriented.

The adjuster follows directions well and becomes very flexible and able to adapt to a variety of situations. This child will do anything necessary to maintain order. Finally, the placater is the one who smooths over conflicts, helps others feel good, listens attentively and is willing to be a mediator in stressful situations (Black, 1979).

Each child has adopted a role to help maintain peace and order in the family. However, as a result, these children

have built up defenses which inhibit the expression of their true feelings. As they enter adulthood and begin making life decisions, children of alcoholics usually are unaware of the negative effects of their childhood. They often recognize their strengths because they have been told how well they cope in an unhealthy environment. However, the learned behavior does not change just because they have grown up and left the alcoholic environment.

As children of alcoholics begin to settle into adulthood they realize the old mechanisms of coping are no longer working for them. These ACOA's find themselves depressed, lacking in a meaningful life and often do not understand why. Their childhood rules of don't talk, don't trust and don't feel have left them with an inability to determine within themselves the source of their unhappiness. Due to this progression, Black (1979) stresses the need to assist ACOA's in the differentiation of self from family and in the ongoing education of children at an earlier age to prevent carrying their difficulties into adulthood.

Historically, alcoholics rather than the children of alcoholics, have been the focus of clinicians and treatment centers. The children of alcoholics report a lack of fun and laughter in their homes and contrast their families negatively with the families of their friends. Role reversals between parents and children often are present resulting in children facing adult problems they are unprepared to deal with. The children are extremely anxious about fighting and

quarreling between their parents.

The most prevalent feelings of children of alcoholics are insecurity, confusion, frustration, anger, rejection and isolation. More serious psychiatric diagnosis were present in children of alcoholics when compared to children of non-alcoholics. They also attempted suicide more often. Finally, children adopt roles in an attempt to stabilize and as a means of coping with the alcoholic environment.

Adult Children of Alcoholics

Despite the size of the population of children of alcoholics indicated earlier, only recently have ACOA's been acknowledged as having specific therapeutic issues which need to be addressed. ACOA's are at risk of becoming alcoholic, marrying an alcoholic or developing significant physical or emotional problems (Ackerman, 1986). Therefore, it is appropriate to focus attention on ACOA's and to begin to explore their individual characteristics and the clinical issues they face.

An Associate Dean for Problems of Chemical Dependency at Brown University, Donovan (1981) recognized that ignorance and isolation were two primary problems faced by ACOA's. He started a group of ACOA's consisting of individuals identified by a variety of helping professionals on campus. The group met for five formal sessions and one follow-up session. During the five formal sessions the ACOA's were given literature on children of alcoholics, viewed films, discussed

the roles of ACOA's and the individual role they played in their family of origin.

The follow-up session was an evaluation of the group sessions. The ACOA's were given a five point scale ranging from not at all helpful to extremely helpful. Half the group members answered very helpful, while the other half checked extremely helpful. In response to whether new information had been acquired on a five point scale ranging from almost none to a great deal, almost half checked a great deal. Information gained by the group members varied. New information on personal involvement and reactions to alcoholism, prevalence of alcoholism in their families and the acquisition of new feelings were mentioned by the group members. Emotional insights ranged from anger to trust and increased self-esteem.

As co-facilitator of the group, Donovan (1981) considered it a success. The breakdown of isolation and development of sensitivity to isolation appeared to provide the ACOA's with a sense of freedom to be themselves apart from family expectations and family history. The potential to initiate and sustain personal growth through stimulation provided by new information reinforces the need to provide special provisions for the ACOA's.

The belief that relatives of alcoholics are legitimate candidates for treatment in their own right, independent of the alcoholic, led Cermak & Brown (1982) to create an interaction therapy group for ACOA's. The ACOA's reported a

variety of reasons for joining the group. Some joined as a commitment to face realities ignored by their families. Others joined with the hope of breaking their own identification with the alcoholic parent and to face the possibility of their own potential alcoholism. Several hoped the group would provide a means of prevention. Members also joined to break strong emotional ties with their family of origin which they believed contributed directly to their inability to create close intimate relationships.

Observations of the issues and dynamics which characterized the group meetings were summarized into issues of control. Issues of control were often viewed in the context of dealing with trust, acknowledging personal needs, responsibility and personal feelings. The concern for control appeared to be the most significant source of anxiety (Cermak & Brown, 1982).

Cermak and Brown (1982) found group members expressed fear of either being too controlling of the group or that others would take over. The expression of any feelings were seen as a lack of control. Therefore, the ACOA's used denial, suppression and repression as a means to control outward expression of inner awareness. All group members acknowledged fear of expressing anger which they avoided by projecting a facade of being in control. The facade appeared to be an attempt to project themselves as different from their parents. Further, any intense feelings such as depression, sadness or even joy were experienced as being out

of control and were accompanied by feelings of anxiety, panic and vulnerability. More frightening than the actual emotions was the sense of lack of control.

ACOA's believe they have self-control to the extent that their feelings are revealed only for the specific effect they have on others. ACOA's distrust their own feelings often as a result of having been raised in denial and rejection of the truth of the family situation. Further, any expression of need was accompanied with guilt and dependence. This resulted from their childhood memories of only expressing a need when their parents might have the time and energy to address them (Cermak & Brown, 1982).

These clinical observations do suggest the existence of a recognizable pattern of conflicts in ACOA's. Obviously, within the pattern of conflicts, control is a central issue. Cermak and Brown reported that dealing with issues of control will be met with great intensity by the ACOA's. Further, understanding the intensity should begin with examination of the family of origin.

The patterns of dysfunction in ACOA's was addressed by Wood (1984) who attempted to summarize characteristics and conflicts of ACOA's. Wood (1984) noted, in support of others (Black, 1979; Nardi, 1981; Wegscheider, 1976, 1981), that children of alcoholics often adopt roles to defend against family instability. Thus, the ACOA's attempt to bring a semblance of stability into the family.

The ACOA's may adopt one role or a combination of roles

may be seen within the same individual. The change in family needs may alter the individual role of an ACOA. The ACOA's often exhibit swings in mood and behavior similar to the exchanges of roles they made as a child.

Wood's (1984) list of behavioral and emotional characteristics of ACOA's included low self-esteem, constant need for approval, self criticism and difficulty in interpersonal relationships. These characteristics were associated with the failure of the developmental process of separation and individuation. She believed forces in the alcoholic family restrict children's efforts to separate from their parents and grow into mature adults. Due to the inability to differentiate self from the family of origin, a distorted false self develops. This false self is unstable and vulnerable to breakdowns or shifts in ego states. Further, it appears to be a collection of reactions to, and partial incorporation of disappointments in parents and compensatory ideal figures.

In response to this inability of differentiate of self from family, Wood (1984) noted some positive traits in ACOA's. The ACOA's capacity for attachment and love often keep them tied to their family. Also, loyality is seen through their extraordinary ability to empathize with the suffering of their parents. In conclusion, Wood (1984) viewed the ACOA's as having resources to become well adjusted adults. She projected their positive characteristics to be valuable tools for use in a treatment process.

Therapeutic issues of ACOA's were viewed by Gravitz and

Bowden (1984) as a clearly delineated continuum of developmental stages. Their view of ACOA's issues were grouped into four stages seen as unfolding in a sequential manner. Initially, ACOA's expend much energy maintaining survival skills learned in childhood. Thus, Stage One is the Survival Stage. For a child growing up in an alcoholic family, life is inconsistent, arbitrary, unpredictable, chaotic and possibly even dangerous and terror filled. To survive, ACOA's had to learn coping skills at an early age. They carry these coping strategies into adulthood. Unfortunately, these skills so necessary in childhood become inappropriate and inadequate in adulthood.

Therefore, in the Survival Stage ACOA's are in varying degrees of psychological stress. However, they attribute little, if any, of their suffering to the alcoholism in their family of origin. The pain they are experiencing is significant while the source is typically unknown (Gravitz & Bowden, 1984).

After becoming aware of psychological vulnerabilities, the ACOA's may begin to enter the second stage, the Emergent Awareness Stage. During this stage the adult children begin to identify themselves as ACOA's. This identification provides the permission ACOA's require to accept themselves, to learn new coping strategies, to ask for and receive what they want. The previously isolated individual now possesses new identity. The ACOA's realize, often for the first time, that there are legitimate and external reasons for their

suffering. The isolation is reduced as they realize others have survived childhoods similar to their own. Sharing this experience begins to alleviate some of the pain associated with being an ACOA (Gravitz & Bowden, 1984).

Once ACOA's have acknowledged and accepted the influence of the past, an examination of patterns of feelings, thoughts and behaviors begin. Stage Three is thus termed the Core Issues. Just as Brown and Cermak (1984) contended that the issue of control permeated all other issues, Gravitz and Bowden (1984) agreed that control is of paramount importance at this particular stage. Further, Gravitz and Bowden (1984) noted an all or none behavior to be equally important and to pervade all other issues. The all or none phenomenon is the tendency for the ACOA's to think in mutually exclusive terms. For example, things are either all right or all wrong. Therefore, they can not see their own strengths and assets. Because of their all or none behavior, a self-evaluation often results in only the perception of their weaknesses.

Further, due to the all or none behavior, trust is either present or absent; individuals are either viewed as good or bad; and in relationships they exhibit either complete commitment and loyalty often leading to being rejected or they refuse to care for anyone for fear of becoming dependent. This lack of an inappropriate belief system must be dealt with before further progress can be made.

The final stage outlined by Gravitz and Bowden (1984) is Integration. Integration begins as the breakdown of the all

or none belief system fades. In this stage the ACOA's begin to develop a belief system which legitimizes self-acceptance. Once ACOA's adopt a set of personal rights and beliefs, they are able to begin taking care of themselves.

The ability to take care of themselves can be seen during stage Four when ACOA's begin to play and have fun without being overwhelmed by feelings of guilt. ACOA's begin to establish appropriate boundaries between themselves and others, particularly their parents. ACOA's can now accept their parent's alcoholism and recognize that it is not their problem or their fault. Thus, as they allow others to be themselves they can now allow themselves to be who they are.

The intent of Gravitz and Bowden (1984) was to articulate and establish clinical issues faced by ACOA's. The authors worked with more than 1,500 ACOA's over a period of four years. Their observations resulted in the continuum of common personal and clinical issues in the recovery or healing process of the ACOA's they worked with. The developmental continuum presented was not intended to be given as a definitive statement of ACOA's. Rather, the intent was to stimulate consideration of thinking conceptually about a population of approximately 30 million Americans in need of clinical services and treatment for the specific issues of ACOA's.

The purpose of a study conducted by Black, Bucky and Wilder-Padilla (1986) was to compare adults raised in an alcoholic home with adults raised in a non-alcoholic home. A

comparison was made of their perceptions of alcohol-related differences in the home, violence, sexual abuse, communication and interpersonal differences experienced as adults. There were 409 subjects identifying themselves as having been raised in an alcoholic family. The comparison group consisted of 179 subjects identifying themselves as not having been raised in a home with parental alcoholism. Subjects were solicited via notices in professional magazines from 1980 through 1982. Thus, all subjects had at least some professional or personal interest in alcoholism to be reading these journals.

The subjects were asked to complete a questionaire that focused on their perceptions about the following, (a) family history; (b) past and present drug and alcohol use; (c) problems growing up in an alcoholic family; (d) communication with significant others; and (e) physical and sexual abuse. For the purpose of having more time to develop into their own alcoholism, alcohol-related relationship or other emotional problems, and to be able to determine the long range effects of alcoholism, subjects were required to be 28 years or older.

The data were analyzed by means of frequency counts, percentages, chi-square tests, t tests, and z tests for proportionality. The results indicated the ACOA's (a) reported significantly less utilization of interpersonal resources as a child; (b) had significantly more family disruptions characterized by a higher divorce rate and premature parental and sibling death; (c) reported more

emotional and psychological problems in adulthood; (d) experienced more physical and sexual abuse as children; and (e) more frequently became alcoholic and married alcoholics when compared to adults raised in non-alcoholic families.

A clinical overview of the ACOA's was outlined by Kendall (1987) who equated normalcy with happiness. Thus, the supposition is that happy is normal. Therefore, in seeking normalcy the ACOA's are seeking happiness. Happiness is later defined as the direct result of positive self-worth, personal attitudes, risk taking and the way an individual relates to other people. However, the learned response to living in an alcoholic home is lack of communication, lack of trust and lack of understanding of feelings. Thus, the child of an alcoholic emerges into adulthood feeling continually unsafe and unsure of self and other people. The ACOA's really do not know how to cope with many of the emotional and functional demands of adult life and are, therefore, continually seeking normal.

ACOA's bring many unresolved conflicts from childhood into adulthood. The roles and coping strategies necessary for survival at a young age become ineffective as adults. ACOA's, in young adulthood, may experience depression and unhappiness without the realization that their emotional state is a direct result of being raised in a home with an alcoholic parent. To combat the pervading emotional distress ACOA's continuously struggle with control. At the costs of repressed emotions and overall good mental health they try to

give the appearance of being happy and in complete control of their lives.

The failure to separate and gain their own identity suggests a need to deal with family of origin issues. Further, strong emotional ties with the family of origin hinder the ACOA's ability to form and maintain intimate relationships. ACOA's may exhibit low self-esteem, constant need for approval and self criticism due to the lack of support and encouragement given from their family of origin.

ACOA's are viewed as having the capacity to become well adjusted adults. Providing education regarding ACOA's issues will penetrate the isolation, ignorance and emotional confusion currently prevalent in this population. The need for treatment of ACOA's issues is apparent from this review of the literature.

Treatment Programs

Treatment programs for alcoholics are inadvertently breeding a second and third generation of alcoholics. Nassau County Department of Drug and Alcohol Addiction implemented an education/prevention program for women who had completed a spouse program and their children (Kern, Tippman, Fortang & Paul 1977). The program members included only three families; three mothers and eight children. Two families had two children each and the other family had four. The age of the children ranged from 13 to 18 years. The entire program was a communication workshop consisting of eight meetings

once a week for two hours each.

Progress was self-reported and came primarily from the mothers. The children seemed unsure whether or not they had derived any substantial benefits. However, group leaders reported the children realized the possibility that anger directed toward mothers was really intended for their alcoholic father.

Evaluation of the program was purely subjective. Thus, the awareness of need for an assessment instrument was obvious. However, the program leaders did confirm the need for treatment of children in alcoholic homes. This confirmation was based on clinical observation of the lack of communication and inability of the children to express feelings or needs appropriately. Further, poor communication between mother and child was observed.

Hawley and Brown (1981) also attempted to meet the treatment needs of children by forming interaction groups. The groups were divided into latency-age groups (6-12 years) and adolescent groups (12-17 years). Each group was limited to 12 members and consisted of both boys and girls. Some groups lasted only 12 to 16 weeks while others lasted for an entire school year. Utilizing a dydactic and dynamic approach, the group was designed to provide a place where the children could make alliances with other children to get beyond their isolation, to develop boundaries (cognitively and effectively), to deal with their parents behavior and projections and to cope more adaptively in the alcoholic

family.

Education about alcoholism was also a group goal. Learning that alcoholism is a disease, the children were provided with cognitive means by which to understand a confusing, often traumatizing, emotional experience. Relabeling the parent's behavior helped the children feel less out of control. The realization that alcoholism is a disease also helped the children improve their reality testing and reduced anxiety, anger and guilt.

Similar to Kern et al. (1977), Hawley and Brown (1981) limited their assessment to clinical observation. However, considering the duration of the groups and the large number of children involved, this report did add creedance to the use of groups as an effective means of treatment for children of alcoholics.

Alanon family groups, until recently used primarily by wives of alcoholics, are also a source of help for ACOA's. A study conducted by Cutter and Cutter (1987) describes the perceptions of change in self, personal problems, relationships and spirituality of ACOA's after participation in an ACOA Alanon group. Twelve sessions of ACOA Alanon were observed. The ACOA's were interviewed and a coding system to assess the content of the meetings was developed. In contrast to small psychotherapy groups, where membership is highly stable, there were no consistently active members there for all 12 sessions.

Members of the ACOA Alanon group reported positive

changes in self, less depression and more assertion. Changes in relationships with alcoholics were few, as were changes in perceptions of the program. Members felt positive about the program from the beginning. The spirituality offered in the program was reported as one of the most valued components of the Alanon group (Cutter & Cutter, 1987).

Due to irregular and shifting attendance, this study did not permit evaluation of people who might have found the meetings unhelpful and consequently stopped coming. Cutter and Cutter (1987) suggest that socialization through attendance at Alanon was a major factor in the ACOA's improvement. Meeting with others who have experienced the trauma of growing up with an alcoholic parent provides a positive environment for reassessing self and relations with others. Thus, the ACOA Alanon meetings may meet many of the therapeutic needs of those suffering from parental alcoholism.

The ACOA's often are categorized as co-dependent. Co-dependency is a term for the disease that affects people involved in a relationship with an alcoholic. Schaef (1986) deals with co-dependency issues and treatment approaches based on clinical observations. Rather than recommending one specific treatment modality, Schaef (1986) prescribes a combination of treatment models. Cognitive treatment alone is not adequate for the recovery of co-dependence. To deal only with the analytical, rational and logical risks perpetuating the disease. To recover, ACOA's need to experience

their own deep process in a noncognitive way.

A necessary part of the recovery process is dealing with the family of origin. The goal is to help the individuals take responsibility for themselves and to relieve them of a false sense of responsibility for their family situation. Finally, Schaef (1986) believes it is necessary for the ACOA's to be involved in a Twelve Step program such as ACOA Alanon which are both modeled after the traditional Alcoholics Anonymous

Most recently Wegscheider-Cruse and Johnson (1987) discuss breaking the co-dependency cycle through experiential treatment of ACOA's. They characterize co-dependence of ACOA's by preoccupation with and dependence on someone or something outside ourselves.

A support network is a vital element in a recovery program for ACOA's. Twelve Step programs provide the ACOA's a place to end the isolation they have lived with for years. Identifying with others in similar situations with similar feelings is a significant source of relief and support (Wegscheider-Cruse & Johnson, 1987).

Individual therapy is also extremely valuable. For many ACOA's it offers the first opportunity for honest self examination and focusing on their own needs. However, Wegscheider-Cruse and Johnson (1987) found an experiential small group therapy provides the ACOA's a safe environment to work through issues quickly.

The experiential group therapy is an eight day, live-in

treatment program. Treatment is designed as a supportive, structured self help program. Most of the time is spent in small groups where the ACOA's are able to discharge feelings through gestalt, psychodrama and structuring approaches.

Education about the disease of alcoholism and their own disease of co-dependency is provided. Specifically, ACOA's are taught what alcoholism is, why it develops, its complications and the long term impact. They find out that healing comes through forgiveness, how to make choices and how to assume responsibility for their own lives.

The literature on treatment for ACOA's is extremely limited. However, clinicians appear to be in agreement that more than one treatment modality is necessary for the recovery of ACOA's. Individual therapy needs to include work on family of origin issues. Also, the need for a support group, such as ACOA Alanon is recommended. To add structure to the ACOA's recovery, group therapy is also recommended.

Clearly, ACOA's are in need of treatment. Clinicians in the field of alcoholism are currently attempting to meet the needs of ACOA's. However, final conclusions regarding treatment outcomes can be made only after controlled research studies on specific treatment modalities have been undertaken.

Locus of Control

Locus of control is an individual's generalized expectancy concerning reinforcement (Rotter, 1966). An internal locus of control is the perception that an individual's

capacity, behavior or traits effect and control reinforcement. An external locus of control perceives reinforcement as noncontingent upon the individual but upon external factors. The following review of literature will discuss locus of control in regard to personal adjustment, capacity for intimacy, self-concept and children of alcoholics.

Hersch and Scheibe (1967) conducted a study on the test-retest reliabilities and personality scale correlates of the internal-external control dimension (I-E). Subjects for the study were members of the Service Corps. A battery of tests and questionaires was administered to the Service Corps inductees in a group session and readministered at a seven week interval. The I-E was found to relate consistently to measures of maladjustment, with internal scorers less maladjusted. The I-E is also consistently related to a variety of personality scales. The internal scorers described themselves as more active, striving, achieving, powerful, independent and effective. The data in this study support the conclusion that internality is consistently associated with indexes of social adjustment and personal achievement.

Locus of control as affected by age was studied by Lao (1974). She found an increase in internality from youth to adulthood. Internality reached its peak during the ages of 30-39 and leveled off. Internality remained consistent until ages 50-59. These findings were consistent with earlier studies conducted by Penk (1969), Milgram (1971) and Statts (1974).

Self-concept and locus of control were studied by O'Gorman (1975) in adolescents from alcoholic and non-alcoholic homes. Subjects included 29 adolescents from alcoholic homes and 27 from non-alcoholic homes. The subjects were administered the Piers-Harris Children's Self Concept Scale and the Nowicki and Strickland Personal Reaction Survey for Children. Adolescents from alcoholic homes exhibited a poorer self-concept (t = 2.609; df = 76, $p<.02$) and more external locus of control (t = 3.944; df = 76, $p<.001$) than the control group. They also perceived themselves as experiencing less love and attention ($p<.001$) than the control group.

Kern, Hassett and Collipp (1981) conducted a replication of an earlier study by Nylander (1960) indicating apparent decreased mental ability in children of alcoholics. Another purpose of the study was to investigate whether the I-E scale, which indicates alcoholics are externals, is also descriptive in their children. The final aim of the study was to determine if children of alcoholics, prior to alcohol ingestion, exhibited any zinc deficiency which is manifested in the chronic adult alcoholic.

The independent variable was the presence or absence of at least one biological parent who was in treatment at a licensed alcoholic treatment facility. The dependent measures were (a) scores on the Otis-Lennon Mental Abilities Test; (b) scores on the Nowicki-Strickland Locus of Control Scales for Children; and (c) zinc levels determined by hair

and urine samples.

The subjects were 40 volunteer children between the ages of 8 and 13. The 20 children of alcoholics were drawn from the Youth Education Series conducted by the Nassau County Department of Drug and Alcohol Addiction. The control group of 20 children were drawn from non-alcoholic parents. The absence of alcohol was verified by using both self-reports by parents and children.

Results indicate no significant differences in mental ability ($F = 3.7$, $p > .05$) between the groups. The second hypothesis predicting a positive relationship between living in an alcoholic home and externality was supported ($F = 4.1$, $p = .05$). Hence, the children of alcoholics were found to be more externally oriented in terms of their locus of control ($\bar{X} = 14.75$) in comparison to the control group ($\bar{X} = 11.75$) which is widely considered a deficit in terms of psychological functioning. Zinc levels in the urine of both groups was not significantly different. However, the zinc level of their hair as measured by the zinc:copper ratio technique was significantly different ($F = 4.2$, $p < .045$).

The higher score of externality in children of alcoholics suggests that this population is a mental health risk. They view rewards and reinforcements in life as being controlled by others. This may lead to lack of initiative and achievement in learning to manipulate the environment to one's advantage.

The study by Kern, Hassett and Collipp (1981) also

raises the question that zinc deficiencies may have been present in alcoholics when they were children. It supports the concept of a metabolic etiology contributing to the cause of alcohol.

In a study conducted by Wright and Obitz (1981), alcoholic and non-alcoholic subjects rated the degree of control that they and others possess over future life events. Alcoholics attributed less personal control over events to themselves than non-alcoholics did. Alcoholics also attributed less control to themselves than to others, whereas non-alcoholics attributed more control to themselves than to others. These differences prevailed despite the similar socioeconomic and demographic characteristics, recent life experiences and beliefs concerning the general controllability of events of both alcoholics and non-alcoholics.

The purpose of a study conducted by Prager (1986) was to determine whether individuals who have a fully developed capacity for intimacy, as assessed by an intimacy interview and rating, could be determined from those with a lesser capacity based on their locus of control orientation. As predicted, intimate-status women had a significantly more internal orientation of locus of control than women in other intimacy statuses. The trend of decreasing externality with increasing intimacy is consistent with the hypothesis that women who allow depth in their relationships experience life events as more in control than women with more superficial relationships.

A high internal locus of control level is reported to be an indicator of social adjustment and personal achievement. Conversely, the higher the external locus of control indicates maladjustment. Externally oriented individuals are also viewed as having a limited capacity for intimacy. Internality was proven to increase with age. However, adult alcoholics did not perceive themselves as having control over future life events. A relationship was established between poor self-concept and external locus of control in children of alcoholics. This population was thus viewed as a high mental health risk.

Summary

Literature in five categories; (a) alcoholism and the family, (b) children of alcoholics, (c) ACOA's, (d) treatment, and (e) locus of control was reviewed in this chapter. Alcoholism clearly has a negative impact on the family and is multigenerational in nature. Children of alcoholics and ACOA's exhibit many characteristics found in adult alcoholics. While internal locus of control has been proven to increase with age, adult alcoholics exhibit a higher external locus of control than non-alcoholics. Research also indicates children of alcoholics have a higher external locus of control than children of non-alcoholics. There is a need for research investigating locus of control in the ACOA's population. Futher, while clinical observations have outlined characteristics of ACOA's and the need for treatment of

their issues, little research investigating specific treatment outcomes has been conducted. Therefore, a need also exists for research on specific treatment of ACOA's. This study is intended to investigate locus of control in female ACOA's as compared to female ANAF's and the effect of a selected treatment on female ACOA's level of locus of control.

CHAPTER III

METHODS AND PROCEDURES

This chapter presents a discussion of the subject selection procedures and description of subjects, instrumentation, procedures and statistical design. The chapter concludes with a summary.

Subjects

The 54 subjects for this study were selected from individuals seeking treatment for the first time with a certified alcoholism counselor and those enrolled in special education classes at a southwestern university. Participation in the study was limited to Caucasian females between the ages of 25-59.

The race, gender and age are specified in an attempt to conduct a controlled research study. Caucasians were chosen due to anticipated availability of subjects. Females were chosen as a special interest group. The age range chosen was based on two different sources. First, according to Black (1981a), during the mid-twenties a crisis point for ACOA's may occur when they begin to realize the effects of growing up in an alcoholic family. This may be the age ACOA's first seek treatment. Additionally, Lao (1974) found internal

locus of control to increase with age. She stated internality reached its peak during ages 30-39 and leveled off, remaining consistent until ages 50-59. Thus, the age span from 25-59 should lend itself to similar locus of control levels among the groups identified in this study.

Initially, 31 subject requesting therapy for the first time and 52 students voluntarily completed questionaires. Of those subjects requesting treatment, 18 met requirements of race, gender, CAST and Mortimer-Filkins cut-off scores to participate. Of the 52 student volunteers, 20 met the requirements to be included in the ACOA group not receiving treatment and 24 met the requirements to be included in the ANAF group. To equalize the number of subjects in each group, two were randomly selected and deleted from the ACOA group and six were randomly deleted from the ANAF group. The groups were generally equivalent in regard to the number of older siblings ($\overline{X}$ = 2), younger siblings ($\overline{X}$ =3), educational level at the Masters level ($\overline{X}$ = 5), Bachelors level ($\overline{X}$ = 5) and income levels ($\overline{X}$ = $25,000 - $45,000) as indicated in Appendix E.

Instrumentation

Demographic Information Sheet

The Demographic Information Sheet (See Appendix D) is a self report screening device used to identify race, age, number of older and younger siblings and gender. Although Lao (1974) found that education levels and socioeconomic

status does not affect locus of control levels; education level, personal income and household income was included on the Demographic Information Sheet to assess the equivalence of the three groups of subjects.

Children of Alcoholics Screening Test (CAST)

The Children of Alcoholics Screening Test (CAST) is a self-reported inventory developed to aid in the identification of children of alcoholics (Jones, 1981). In an attempt to prevent bias of answers, the title was changed to "Survey of Family Alcohol Use" for this research study. The CAST is a 30 item inventory that measures individual's feelings, attitudes, perceptions and experiences related to their parents' drinking behavior. The test items were formulated from real-life experiences that were shared with the author by clinically diagnosed children of alcoholics during group therapy and from published case studies (Jones, 1981).

Validity. Jones (1981) found that all 30 items on the CAST significantly discriminated children of alcoholics from control group children. Two validity studies which have been conducted with the CAST used the method of contrasted groups. In the first study, Jones (1981) administered the CAST anonymously to 82 children of clinically-diagnosed alcoholics, 15 self-reported children of alcoholics, and 118 randomly selected control group children. It was hypothesized that the children of alcoholics would score signifi-

cantly higher on the CAST, meaning more yes answers, compared to the control group children.

An analysis of variance showed that the clinically diagnosed children of alcoholics and the self-reported children of alcoholics scored significantly higher on the CAST compared to the controls (F (2/212) = 166.5, $p \leq .0001$). Chi-square analysis indicated that all 30 CAST items significantly discriminated children of alcoholics from control group children. Since the two children of alcoholics groups did not reliably differ in their total CAST scores, Jones (1981) grouped these children into an overall children of alcoholics group. The 118 control group children were categorized as a 1 and the 97 children of alcoholics were categorized as a 2. Correlating these group categories with the total CAST scores yielded a validity coefficient of .78 ($p \leq .0001$).

Reliability. A split-half (odd vs. even) reliability coefficient of .98, corrected using the Spearman-Brown formula, was computed with both a sample of 82 latency-age and adolescent children of alcoholics and with a sample of 133 latency-age adolescent children randomly sampled from the Chicago school system. A split-half (odd vs. even) reliability coefficient of .98, corrected using the Spearman-Brown formula, was also computed with a random sample of 81 adults who reside in Chicago. Hence, the CAST has high internal reliability (Jones, 1981).

Finally, Jones (1981) found that a cutoff score of six

or more (items answered yes) identified 100 percent of the clinically diagnosed children of alcoholics. The cutoff score also identified 100 percent of the self-reported children of alcoholics.

The Internal Versus External Control Scale

The Internal Versus External Control Scale (I-E) (Rotter, 1966) is a 29 item, forced choice test which includes six filler items intended to disguise the purpose of the test. The items assess the subject's belief regarding their own ability to affect and control the events in their lives. The score is the total number of items selected. The I-E is scored in the external direction, therefore, the lower the score the more internal the individual (See Appendix A).

Validity. The items for the I-E were chosen by Rotter and Crowne from a 60 item scale developed by Jane and Phares (Rotter, 1966). Items were eliminated from the scale if any of the items were highly correlated with the Marlowe-Crowne Social Desirability Scale; had non-significant relationship with the other items; had a correlation approaching zero with both validation criteria.

Reliability. Internal consistency reports are moderately high. Split-half correlations, corrected using the Spearman-Brown formula are .73. Kuder-Richardson reliabilities range from .69 to .73. Test-retest correlation coefficients for a one month period are also consistent at .55 to .83 for two different samples. The samples consisted

of 60 psychology students at Ohio State University and 28 prisoners in a Colorado Reformatory.

The Mortimer - Filkins Test

The Mortimer - Filkins Test (M-F) (Mortimer, Filkins, Kerlan & Lowes, 1973) was administered to all subjects to identify social drinkers versus problem drinkers. As stated in the Limitations in Chapter I, problem drinkers were not included in this study.

The M-F Test was developed to establish a set of procedures to aid in the identification of problem drinkers versus social drinkers. The identification was needed to base recommendations for long-term versus short-term treatment plans.

Originally, 452 items were developed for the test based on literature review, biographical information from alcoholics and their medical records. These items were reduced once to 135 and a second time to 58 items by using stringent item analysis and administering the test to alcoholics and control groups. The cut-off scores were statistically obtained in order to minimize false positives. Recommended cut-off scores are 11 or less for classification as a social drinker and 16 or greater for classification as a problem drinker (Mortimer et al., 1973).

The initial studies were based on data from 192 alcoholics and 297 control subjects. The split-half correlation coefficient, corrected by the Spearman-Brown, was .91. The

validity coefficients, expressed as a point-biserial correlation coefficient between test scores and membership in the alcoholic or control group, was .849 (Mortimer et al., 1973).

Procedure

The researcher was allowed 30 minutes of class time to recruit volunteers. All students chose to participate. Volunteers were asked to sign a consent for participation form (See Appendix C). Upon collection of consent forms, the subjects were given a set of materials including a demographic information sheet (See Appendix D), the CAST, the Mortimer - Filkins, and the I-E. Those individuals not participating in the study were dismissed from class.

Both control groups (ACOA & ANAF) completed the materials in a group session. They were administered in a graduate class twice with an eight week interval between the two administrations.

The treatment group of non-alcoholic ACOA's completed the materials in an individual therapy session with a Certified Alcoholism Counselor. The counselor has been active in the field of chemical dependency for the past ten years and in a private practice with an emphasis on AOCA's for the past five years.

Upon their initial visit for therapy, clients were asked to voluntarily participate in this study. Volunteer subjects were then required to complete a life history for the

following week. The life history was written utilizing an outline provided based on Black's (1985) outlines in Repeat After Me. Weeks two through eight of therapy were then devoted to family of origin work consisting of reading and discussing the life history.

The purpose of treatment was to allow subjects to deal with their lack of differentiation from family members in their family of origin, the repression of their individuality and their inability to differentiate from parents' past behaviors. Thus a more conscious and realistic identification of self and the power of self might have been realized.

Statistical Design

A t-test and an alpha level of .05 was utilized to test the following hypothesis: There is no difference between the locus of control levels of the female ACOA's and the female ANAF's.

A 2 x 3 mixed ANOVA design and an alpha level of .05 were utilized to test the following hypothesis: There is no difference among the changes in locus of control level over the treatment period for female ACOA's receiving family of origin treatment, female ACOA's not receiving family of origin treatment and female ANAF's. The independent variables have three levels of treatment: female ACOA's receiving the specified treatment, female ACOA's who do not receive the treatment and female ANAF's who do not receive

the treatment, and two levels of time of collection of data; prior to and following treatment.

Summary

Chapter III has discussed the selection and description of subjects. Descriptions also were included for the CAST, the Mortimer - Filkins, the Internal versus External Locus of Control Scale and the Demographic Data Sheet. Methods and procedures used in this study were presented. Finally, procedure and statistical design were discussed.

CHAPTER IV

RESULTS

The results of the statistical analyses for the hypotheses are presented in this chapter. A summary of results is provided at the conclusion of the chapter.

The subjects for this study were comprised of adults from non-alcoholic families, a control group of adult children of alcoholics and a treatment group of adult children of alcoholics. Pretest, posttest means and standard deviations of locus of control levels of the three groups of females are presented in Table 1.

Hypothesis 1. There is no significant difference between the locus of control levels of female ACOA's and female ANAF's. The results of the t-test analysis of locus of control of female ACOA's are reported in Table 2. They indicate a statistically significant difference exists between the scores of adult children of alcoholics and the scores of adults from non-alcoholic parents in this female population. The female ACOA's scored in a more external direction than did the female ANAF's, ($t = 7.61$, $df = 52$, $p = .001$). Thus Hypothesis 1 is rejected.

Hypothesis 2. There are no differences among the changes in locus of control levels over the treatment period

for female ACOA's receiving family of origin treatment, female ACOA's not receiving family of origin treatment and female ANAF's. The results of the 2 x 3 mixed ANOVA utilized to test this hypothesis are reported in Table 3. An overall significant difference from pre-to-posttest was not found across the three groups, ($F = .48$, $df = 1/51$, $p = .49$). However, there was an overall significant difference among groups, ($F = 17.53$, $df = 2/51$, $p = .001$) across the two testing times and a significant interaction between the group variable and time of testing, ($F = 4.65$, $df = 2/51$, $p = .014$). Thus, Hypothesis 2 is rejected.

The Tukey's HSD multiple comparison test was used to examine each of the significant effects reported in Table 3. The results of the Tukey HSD multiple comparison analyses of group differences on the pretest and posttest are reported in Table 4. A graph of the group means at the pretest and posttest are reported in Figure 1.

The female ANAF's pretest mean locus of control ($M = 6.0$) is significantly ($p < .01$) different from the means of the female ACOA's assigned to the control group ($M = 11.6$) and to the female ACOA's assigned to the treatment group ($M = 11.1$). However, no significant difference ($p = .84$) was found between the pretest means of the female ACOA's assigned to the treatment group ($M = 11.1$) and the female ACOA's assigned to the control group ($M = 11.6$). At the posttest, no significant ($p = 3.2$) difference was found between the mean locus of control of the female ANAF's ($M = 6.9$) and the

ACOA's assigned to the treatment group (M = 8.7). However, significant posttest differences were found between the mean of the female ACOA's assigned to the control group (M = 12.1) and both the means of the female ANAF's and the female ACOA's assigned to the treatment group.

Table 1

Pretest, Posttest Means and Standard Deviations of the Three Groups

Group	Pretest	Posttest
ANAF[a] n=18	6.0(1.78)[d]	6.9(3.88)
C-ACOA[b] n=18	11.6(3.12)	12.1(3.52)
TR-ACOA[c] n=18	11.1(3.65)	8.7(3.19)

[a]Adults from non-alcoholic families.
[b]Adult children of alcoholics, control group.
[c]Adult children of alcoholics, treatment group.
[d]Mean (Standard Deviation).

Table 2

Means, Standard Deviations and T-test of Female ACOA's and Female ANAF's Locus of Control Levels

Group	n	M	SD	t
ACOA[a]	36	11.33	3.36	
ANAF[b]	18	6.0	1.78	7.611*

[a]Female adult children of alcoholics.
[b]Female adults from non-alcoholic families.
*p = .001

Table 3

Analysis of Variance of Locus of Control of the Three Groups Before and After Treatment

Between Subjects

Source	SS	DF	MS	F	p
Group	529.4	2	264.7	17.53	.001
Subjects within Groups	770.3	51	15.1		

Within Subjects

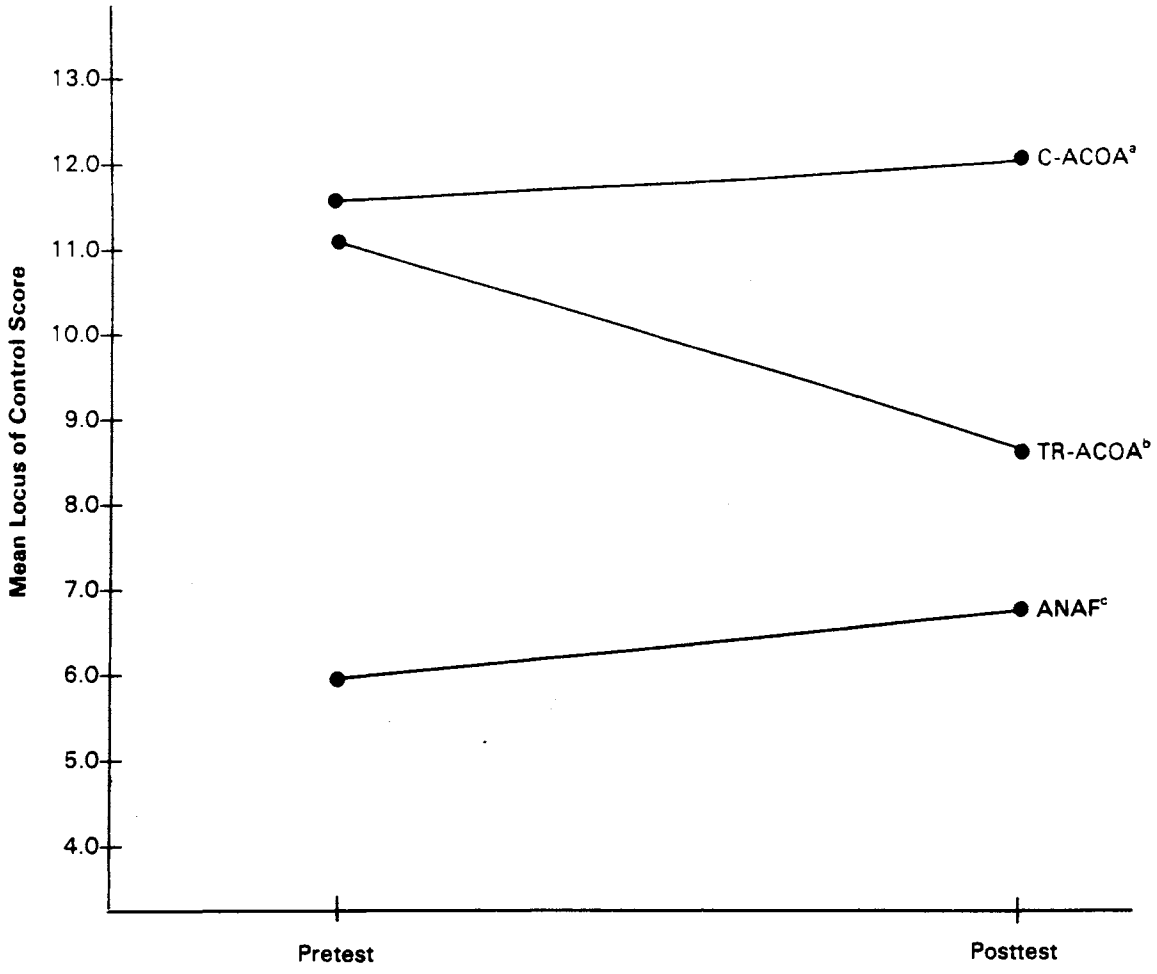
Source	SS	DF	MS	F	p
Pre-Post (Time)	3.00	1	3.00	.48	.49
Group x Time	58.2	2	29.08	4.65	.014
Time by subject within groups	318.83	51	6.25		

Table 4

Results of the Tukey HSD Multiple Comparison of Pairwise Absolute Mean Differences at the Pretest and Posttest

	Pretest			Posttest		
	ANAF	C-ACOA	TR-ACOA	ANAF	C-ACOA	TR-ACOA
ANAF[a]	0.00			0.00		
C-ACOA[b]	5.61**	0.00		5.11*	0.00	
TR-ACOA[c]	5.05**	0.56	0.00	1.72	3.38*	0.00

[a]Adults from non-alcoholic families.
[b]Adult children of alcoholics, control group.
[c]Adult children of alcoholics, treatment group.
*$p<.05$.
**$p<.01$.



[a]Adult children of alcoholics, control group.

[b]Adult children of alcoholics, treatment group.

[c]Adult from non-alcoholic families.

Figure 1. Mean locus of control scores of female adult children from non-alcoholic families (ANAF), female adult children of alcoholics assigned to the control group (C-ACOA) and female adult children of alcoholics assigned to the treatment group (TR-ACOA).

Summary

The results of the statistical analyses completed to test the hypothesis formulated in this study were presented in this chapter. The t-test performed identified a significant difference between the mean locus of control level scores of female ACOA's and ANAF's resulting in the rejection of null Hypothesis 1. The 2 x 3 mixed ANOVA yielded a significant interaction between the groups and time of testing. Significant differences between the mean locus of control scores of the female ANAF's and both the female ACOA's assigned to the treatment group and the female ACOA's assigned to the control group were found on the pretest. Also, the two groups of ACOA's were not found to be significantly different on the pretest. However, at the posttest no significant difference was found between the female ANAF's and the female ACOA's receiving treatment. Additionally, mean locus of control level scores of the female ANAF group and the female ACOA's receiving treatment were both found to differ significantly from the ACOA's not receiving treatment. Based on these findings, null Hypothesis 2 was also rejected.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purposes of this study were to determine if locus of control levels differed significantly between adult children of alcoholics (ACOA) and adults from non-alcoholic families (ANAF) in a female population, and to determine the effect of family of origin treatment on locus of control levels of the female ACOA group. The subjects ranged in age from 25 to 59 based on studies by Black (1981a) and Lao (1974) and limited to the Caucasian ethnic group based on anticipated availability of subjects. The subjects were classified as ACOA if they answered yes to six or more items on the Children of Alcoholics Screening Test (CAST) (Jones, 1981) or as ANAF if they answered yes to fewer than six items on the CAST. Locus of control levels were determined for each group by the score obtained on Rotter's (1966) 29 item Internal vs External Control Scale (I-E). Those subjects identified as problem drinkers based on a score of 16 or more on the Mortimer-Filkins (Mortimer, Filkins, Kerlan & Lowes, 1973) were not included in this study.

This study involved 54 volunteer subjects comprising

three separate groups. The ANAF group (N = 18) and the ACOA group (N = 18) designated as not receiving treatment were enrolled in special education classes at one southwestern state university. The ACOA group (N = 18) assigned to receive treatment were clients requesting therapy for the first time from a certified alcoholism counselor specializing in treatment of ACOA's. All subjects were asked to complete a demographic information sheet. The three groups were compared on mean locus of control level scores before and after the treatment period.

The two hypotheses tested in this study and the results related to the statistical analysis are presented below.

Hypothesis 1. There is no significant difference between locus of control levels of ACOA's and ANAF's.

A t-test with an alpha level of .05 was utilized for analysis of the data to test Hypothesis 1. A statistical difference was found between the mean locus of control scores of the female ACOA group and the female ANAF group.

Hypothesis 2. There are no significant differences among the changes in locus of control levels over the treatment period for female ACOA's receiving family of origin treatment, female ACOA's not receiving family of origin treatment and female ANAF's.

A 2 x 3 mixed ANOVA design with an alpha level of .05 was utilized for analysis of the data collected to test Hypothesis 2. Statistically significant differences were found in the changes of locus of control level scores over the

treatment period for the female ACOA's receiving treatment, but the mean locus of control level scores of the female ACOA's in the control group and the female ANAF's did not change significantly over the treatment period. Therefore, both null hypotheses were rejected.

Conclusions

Based on the findings of this research the following conclusions are drawn:

1. The results of this study support similar studies reviewed in the literature. O'Gorman (1975) and Werner (1986) both conducted studies on adolescent children of alcoholic parents and found them to exhibit a more external locus of control than other children in their studies. The results of this study indicate that as these children grow into adults, they continue to have a more external locus of control than adults from non-alcoholic families.

These findings also support the clinical findings of Cermak (1986) and Lerner (1986) that control is an issue of concern for ACOA's. This is particularly alarming considering Joe (1971) found externals to be more anxious, have more neurotic symptoms, are more dogmatic, less trustful and lack self-confidence to a greater degree than internals. Thus, the need for treatment of adult female children of alcoholics has been validated. However, as reported by Whitfield (1981) only five percent of this population are being treated. Therefore, this study indicates a critical

need to address the awareness level of ACOA's in regard to the availability of treatment.

2. Treatment results in the review of literature were either purely subjective (Kern, Tippman, Fortrang and Paul, 1977) or based on clinical observations (Hawley and Brown, 1981). The pre-to-posttest significant difference in control level scores found in this study recognizes that treatment can make a difference in the issue of control for female ACOA's. The results suggest that once ACOA's differentiate themselves from their parents, as indicated by Bowen (1978), Chafetz (1979) and Wood (1984), they can begin to develop a sense of control in their lives and recognize their abilities to live their lives as they choose. The findings in this study indicate specifically, that doing family of origin work with female ACOA's is a viable treatment method toward achieving a sense of control.

Recommendations for Further Research

Based on these findings and the limitations outlined in Chapter I, the following recommendations for future research are made:

1. Replication of this study is advised. This would further validate the outcome as being directly attributable to the treatment.
2. Research should be conducted utilizing one or more treatment approaches other than the life history outline. Further research might determine if

treatment modalities other than family of origin work affect locus of control level scores.

3. Additional research with the life history outline utilizing more than one therapist should be conducted. The therapist utilized in this study has considerable experience in working with adult children of alcoholics. A determination should be made regarding the impact of expertise, personality and experience as compared with a novice counselor.
4. Ackerman (1986) advised that a large percentage of adult children of alcoholics become alcoholics. Therefore, additional research to include this population should be considered.
5. Both males and females are found in the adult children of alcoholics population. Therefore, to enhance generalizability to the ACOA population as a whole, males should be included in subsequent research.
6. This study was limited to Caucasian females. Inclusion of individuals from other races would enhance generalizability of the study to the total population of female adult children of alcoholics.
7. Woititz (1983) and Wood (1984) have indicated a variety of issues for adult children of alcoholics. This study examined only one aspect of psychological well-being of the ACOA. Further research

utilizing scales to assess intimacy, self-concept, anxiety and depression levels and the effect of treatment on these behaviors might further validate both the need for treatment and specific outcomes of treatment.

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APPENDIXES

APPENDIX A

THE INTERNAL-EXTERNAL CONTROL SCALE

THE INTERNAL-EXTERNAL CONTROL SCALE

(ENVIRONMENTAL PREFERENCE SCALE)

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered A or B. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief: therefore, there are no right or wrong answers.

Please answer these items carefully, but do not spend too much time on any one item. Be sure to find an answer to every choice. Place an A or B which you choose as the statement more true in the blank to the right of each item. In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item independently when making your choice; do not be influenced by your previous choices.

1. A. Children get into trouble because their parents punish them too much. ____
   B. The trouble with most children nowadays is that their parents are too easy with them.

2. A. Many of the unhappy things in people's lives are partly due to bad luck. ____
   B. People's misfortunes result from the mistakes they make.

3. A. One of the major reasons why we have wars is because people don't take enough interest in politics. ____
   B. There will always be wars, no matter how hard people try to prevent them.

4. A. In the long run people get the respect they deserve in this world. ____
   B. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. A. The idea that teachers are unfair to students is nonesense. ____
   B. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. A. Without the right breaks one cannot be an effective leader. ____
   B. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. A. No matter how hard you try, some people just don't like you. ____
   B. People who can't get others to like them don't understand how to get along with others.

8. A. Heredity plays the major role in determining one's personality. ____
   B. It is one's experiences in life which determine what they're like.

9. A. I have often found that what is going to happen will happen. ____
   B. Trusting to fate has never turned out as well for me as making a decision.

10. A. In the case of the well prepared student there is rarely if ever such a thing as an unfair test. ____
    B. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. A. Becoming a success is a matter of hard work, luck has little or nothing to do with it. ____
    B. Getting a good job depends mainly on being in the right place at the time.

12. A. The average citizen can have an influence in government decisions. ____
    B. The world is run by a few people in power, and there is not much the little guy can do about it.

13. A. When I make plans, I am almost certain that I can make them work. ____
    B. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. A. There are certain people who are just no good. ____
    B. There is some good in everybody.

15. A. In my case, getting what I want has little or nothing to do with luck. ____
    B. Many times we might just as well decide what to do by flipping a coin.

16. A. Who gets to be boss often depends on who was lucky enough to be in the right place first. ____
    B. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17. A. As far as world affairs are concerned, most of us are the victim of forces we can neither understand or control. ____
    B. By taking an active part in political and social affairs the people can control world events.

18. A. Most people don't realize the extent to which their lives are controlled by accidental happenings. ____
    B. There really is no such thing as "luck".

19. A. One should always be willing to admit mistakes. ____
    B. It is usually best to cover up one's mistakes.

20. A. It is hard to know whether or not a person really likes you. ____
    B. How many friends you have depends upon how nice a person you are.

21. A. In the long run the bad things that happen to us are balanced by the good ones. ____
    B. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. A. With enough effort we can wipe out political corruption. ____
    B. It is difficult for people to have much control over the things politicians do in office.

23. A. Sometimes I can't understand how teachers arrive at the grades they give. ____
    B. There is a direct connection between how hard I study and the grades I get.

24. A. A good leader expects people to decide for themselves what they should do. ____
    B. A good leader makes it clear to everybody what their jobs are.

25. A. Many times I feel that I have little influence over the things that happen to me. ____
    B. It is impossible for me to believe that chance or luck plays an important role in my life.

26. A. People are lonely because they don't try to be friendly. ____
    B. There's not much use in trying too hard to please people, if they like you, they like you.

27. A. There is too much emphasis on athletics in high school. ____
    B. Team sports are an excellent way to build character.

28. A. What happens to me is my own doing. ____
    B. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. A. Most of the time I can't understand why politicians behave the way they do. ____
    B. In the long run the people are responsible for bad government on a national as well as on a local level.

APPENDIX B

TREATMENT SESSION OBJECTIVES

TREATMENT SESSION OBJECTIVES

Session 1: Initial client contact, initial administration of the CAST, Mortimer - Filkins and I-E Scale, Demographic Information Sheet, Life History Outline (Black, 1985) and Consent Form will be completed.

Assignment for next week's session: Complete the Family Tree.

Session 2: Determine recognized dysfunction within the family system utilizing the Family Tree. To break down possible denial of family dysfunction.

Assignment for next week's session: Complete the My House form.

Session 3: To begin to release feelings of pain and happiness to be expressed in regard to life in their childhood house utilizing My House.

Assignment for next week's session: Complete Family and Friends and Not Talking.

Session 4: To determine the level of isolation and support given during childhood and teenage years in order to begin to recognize the possible inability to label feelings and discuss them in the past.

Assignment: Complete Awareness of Feelings.

Session 5: To determine the value of identifying and expressing feelings. This process will hopefully assist the client in accepting feelings. It will be pointed out that feelings are neither good nor bad they just are. The client will begin to experience some positive

feelings as feelings are explored.

Assignment for next week's session: Complete Accepting Powerlessness As A Child.

Session 6: To gain realistic perspective of situations that the client had no power to effect as a child utilizing Accepting Powerlessness As A Child.

Assignment for next week's session: Complete Accepting Powerlessness As An Adult.

Session 7: To begin to differentiate self from the client's family and to recognize the power within the client to effect personal behavior not the behaviors of others.

Assignment for next week's session: Complete Present Day Self Esteem.

Session 8: To become aware how compliments and criticism can be of value and to recognize successes utilizing Present Day Self Esteem.

Upon completion of the eighth session the client will be given the CAST and I-E Scale to complete.

APPENDIX C

CONSENT FORMS

CONSENT FORM

I agree to voluntarily participate in this research study conducted by Patricia L. King for her doctoral dissertation. I understand that confidentiality will be maintained and that social security numbers will only be used to match pre-test and post-test scores. Further, a list of social security numbers of participants completing three standardized tests, the CAST, the Internal - External Control Scale and the Mortimer - Filkins Test and a second Internal - External Control Scale at an eight week interval will be given to the instructor of this course for 10 points extra credit.

Information regarding my scores and the research study proposal will be made available to me upon request. My request should be directed to Patricia L. King at 232-0888.

_____
Signature

CLIENT CONSENT FORM

I agree to voluntarily participate in this research study conducted by Patricia L. King for her doctoral dissertation. I understand that confidentiality will be maintained and that social security numbers will only be used to match pre-test and post-test scores. I agree to complete three standardized tests, the CAST, the Mortimer - Filkins Test and the Internal - External Control Scale (to be given a second time at an eight week interval). I understand my scores on the tests will be made available to me upon request with an explanation of the research study. My request should be directed to Patricia L. King at 232-0888.

I further agree to complete in writing the life history outline components given to me by my therapist each week and discuss them the following week. I understand these outlines and their contents will not be made available to Ms. King or anyone other than my therapist.

_____
Signature

APPENDIX D

DEMOGRAPHIC INFORMATION SHEET

DEMOGRAPHIC INFORMATION SHEET

SOCIAL SECURITY NUMBER: _____

AGE: _____ NUMBER OF SIBLINGS: _____

NUMBER OF OLDER SIBLINGS: _____ NUMBER OF YOUNGER SIBLINGS: _____

PLEASE CIRCLE ONE ANSWER IN EACH CATEGORY

SEX: M F

RACE:

Caucasian

Black

Hispanic

Oriental

American Indian

Other _____

EDUCATION:

Less Than 12 Years

Completed High School

Attended College

College Degree

Attended Graduate School

Completed Graduate School

Other Training: _____

PERSONAL INCOME:

$50,000 or more

25,000 - 49,000

20,000 - 24,000

15,000 - 19,000

10,000 - 14,000

Under 5,000

PRESENT HOUSEHOLD INCOME:

$50,000 or more

25,000 - 49,000

20,000 - 24,000

15,000 - 19,000

10,000 - 14,000

Under 5,000

APPENDIX E

DEMOGRAPHIC DATA

DEMOGRAPHIC DATA

Demographic Data of Caucasian Female
Adult Children of Alcoholics, Treatment Group

AGE	SIBLING ORDER	INCOME*	EDUCATION
37	Youngest	25-49	Masters
47	Oldest	50 +	Masters
28	Middle	25-49	Bachelors +
43	Oldest	25-49	Bachelors
41	Youngest	10-15	High School
54	Youngest	25-49	Bachelors +
43	Only child	20-24	Bachelors
54	Oldest	50 +	Bachelors +
44	Middle	15-19	High School
42	Middle	20-24	Bachelors +
46	Youngest	50 +	Masters
35	Youngest	25-49	High School +
37	Middle	25-49	Bachelors
36	Oldest	20-24	High School +
37	Middle	25-49	Bachelors +
35	Youngest	50 +	Masters
43	Middle	25-49	Bachelors +
41	Youngest	50 +	Masters

* Reported in thousands of dollars.

Demographic Data of Caucasian Female
Adult Children of Alcoholics, Control Group

AGE	SIBLING ORDER	INCOME*	EDUCATION
32	Oldest	25-49	Masters
26	Youngest	25-49	Bachelors +
37	Middle	25-49	Bachelors +
42	Youngest	20-24	Bachelors +
33	Only child	10-14	High School +
44	Youngest	50 +	Masters
46	Middle	25-49	Masters
35	Youngest	25-49	Bachelors +
30	Oldest	25-49	Bachelors +
44	Middle	25-49	Bachelors +
38	Youngest	25-49	Bachelors +
38	Youngest	50 +	Bachelors +
32	Youngest	25-49	Bachelors +
27	Middle	25-49	Masters
33	Middle	5	High School +
37	Youngest	20-24	Bachelors +
31	Youngest	25-49	Masters
27	Youngest	25-49	Bachelors +

* Reported in thousands of dollars.

Demographic Data of Caucasian Female Adults from Non-Alcoholic Families

AGE	SIBLING ORDER	INCOME*	EDUCATION
29	Oldest	25-49	Bachelors +
32	Middle	25-49	Bachelors +
47	Oldest	20-24	Bachelors +
47	Middle	50 +	Masters
31	Oldest	25-49	Bachelors +
31	Middle	5	Masters
55	Youngest	50 +	High School +
40	Youngest	25-49	Masters
50	Youngest	25-49	High School +
55	Oldest	25-49	Masters
44	Middle	50 +	Bachelors +
46	Middle	25-49	Bachelors +
35	Oldest	25-49	Bachelors
27	Middle	10-14	High School +
40	Youngest	25-49	Bachelors +
38	Middle	50 +	Bachelors
55	Oldest	25-49	Masters
55	Middle	25-49	Masters

* Reported in thousands of dollars.

VITA

Patricia Lea King

Candidate for the Degree of

Doctor of Education

Thesis: LOCUS OF CONTROL AMONG FEMALE CHILDREN OF ALCOHOLICS: A TREATMENT APPROACH

Major Field: Counseling and Student Personnel

Specialization: Counseling and Development

Biographical:

Personal Data: Born in Sallisaw, Oklahoma, November 3, 1953, the daughter of Hazelgene McLellan King and the late Thomas William King.

Education: Graduated from Sallisaw High School, in May, 1972; received Bachelor of Science Degree in Special Education from Central State University, in May, 1976; received Master of Science Degree from The University of Oklahoma Health Sciences Center in December, 1980; completed requirements for the Doctor of Education Degree at Oklahoma State University in May, 1989.

Professional Experience: Teacher, Deaf Education, Mid-Del Public Schools, August 1976, to June 1978; Parent Advisor, Oklahoma State Department of Education, January 1977, to May 1979; Teacher, Deaf Education, Harrah Public Schools, August 1978, to October 1983; Counselor, Harrah Public Schools, October 1983, to June 1984; Counselor, Stillwater Middle School, August 1984, to July 1987, Counselor, Stillwater Domestic Violence, Inc., October 1986, to September 1987; Counselor, Putnam City North High School, August 1987, to July 1988; Instructor, El Reno Junior College, August 1988 to present.