ADULT CHILDREN OF ALCOHOLICS AT WORK:

A MULTIDIMENSIONAL INVESTIGATION

OF PERFECTIONISM

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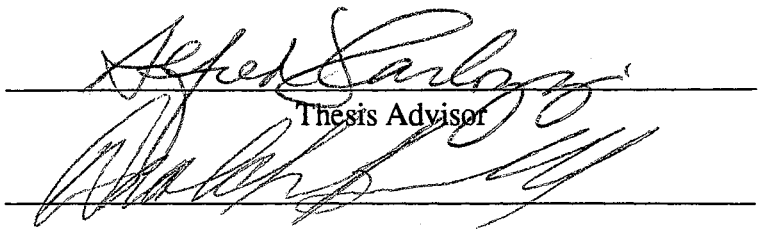

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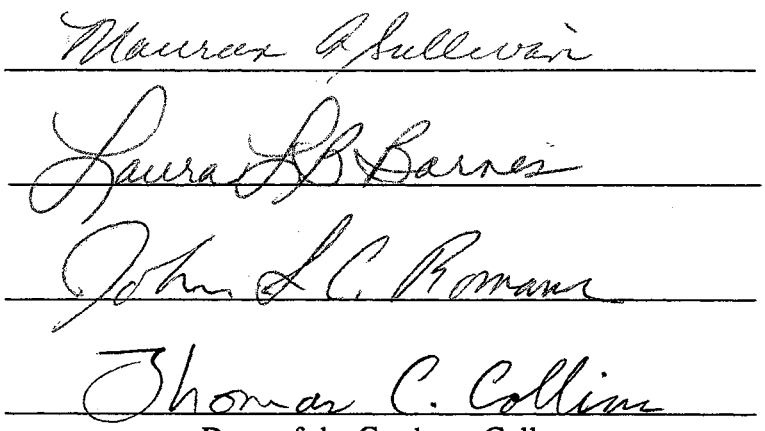

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CHAPTER I

INTRODUCTION

According to current literature (Bean-Bayog & Stimmel, 1987; Brown, 1988; Cermak, 1989; Cermak & Rosenfeld, 1987; Corazzini, Williams, & Harris, 1987; Downing & Walker, 1987; Hinz, 1990; Landers & Hollingdale, 1988; Mathews & Halbrook, 1990; Robinson, 1989), there are over 28 million adults in the United States today who are children of alcoholics. It has been repeatedly claimed (Bean-Bayog & Stimmell 1987; Bepko, 1985; Berlin, Davis, & Orenstein, 1988; Bradshaw, 1988; Brown, 1988; Cermak, 1988, 1989; Krois, 1987; Marlin, 1987; Milman, Bennett, & Hanson, 1985; Robinson, 1989; Woititz, 1983) that children from these families (COAs) develop serious physical, emotional, mental, and spiritual difficulties as a result of their parent's drinking. Adult children of alcoholics (ACOAs) have emerged as a new client population deemed in need of treatment intervention by trained professionals (Roush & DeBlassie, 1989).

Although much has been written about the impact of familial alcoholism on the subsequent interpersonal relationships of ACOAs, very little attention has been given to how ACOAs replicate the patterns they develop in their families and their personal lives in the workplace (Goldberg, 1986; Hall, 1991; Mathews & Halbrook, 1990; Wilson-Schaef & Fassel, 1988). In fact, a 1995 review of the literature revealed few articles and only one empirical study investigating the implications of ACOA issues in the workplace. Estimates place the figure for people affected directly or indirectly by dysfunctional patterns at 25% of the workforce (Hall, 1991). Watkins, Rogers, and Morrow (1989) cited statistics in which the Kemper group reported that over one-third of those seen for family problems during a nine year period by their Personnel Assistance Program were ACOAs. The New England Telephone Company reported that 31% of its Employee

Assistance Program (EAP) general counseling cases in 1985 were ACOAs. By 1986, this company reported that 44% of the cases handled by their EAP program involved ACOAs (Goldberg, 1986). It is stated in a 1985 study of top corporate executives by the Alcoholism Council of Greater New York that 37% of the 62 alcoholic executives were ACOAs. A review was conducted for the Children of Alcoholics Foundation of 100 randomly selected case records from a variety of Employee Assistance Programs in which it was claimed that at least 28% of the employees were children of alcoholics (Watkins et al., 1989).

Despite the above statistics, Woititz (1987) reports that ACOAs are among the most productive and valuable employees. They are found in high management positions as well as in unskilled jobs. "They are dedicated, conscientious, capable, loyal and will do everything in their power to please" (pg. vii). According to Goldberg (1986), only a minority of ACOAs are washouts on the job. Many more are the success stories of the workplace. Woititz (1987) states that when companies begin to address the issues of the ACOA in the workplace, they begin to address the $190.7 billion lost in 1980 according to the Research Triangle Institute for Alcohol, Drug Abuse, and Mental Health Administration - money lost through poor job performance, lost sales, on-the-job accidents, absences from work, medical costs, and the costs of hiring and training new personnel. As Woititz (1987) asserts:

> The value of the COA in the workplace gets clearer and clearer. Recognition of the signs of COA issues as they surface, and responding quickly and appropriately to them will, in both the long and short run, result in maintaining superior workers and greatly reduce the losses due to burnout, physical problems, substance abuse, and impulsive job changes. It is in the economic best interest of companies to be responsive. (p. 110)

Many similarities exist between ACOAs and those children who grew up with other compulsive behaviors. The patterns are not exclusive, so the benefits of workplace awareness carry even greater significance (Woititz, 1987).

Principles for recovery from having been raised by an alcoholic parent(s) have been adopted as central to ACOA recovery programs that are now very much a part of the popular culture. The interest generated has resulted in separate sections in bookstores devoted to the literature of ACOAs, codependency, and dysfunctional families; a professional industry devoted to conducting workshops and self-help seminars for this population; a new generation of self-help support groups such as Al-Anon ACOA groups and Co-Dependents Anonymous (CODA); in-patient and out-patient treatment programs; national conventions where Employee Assistance Program professionals, wellness program specialists, treatment providers, and human resource personnel gather to keep abreast of this rapidly developing field (Mathews & Halbrook, 1990). Nation-wide organizations have sprung up such as The National Association for Children of Alcoholics which operates as an information clearinghouse, produces a quarterly newsletter, and sponsors regional and national conferences annually. The Children of Alcoholics Foundation, Inc. and the National Association for Native American Children of Alcoholics publishes pamphlets, bibliographies, and other information aimed at preventive and remedial intervention services for this population. Projects designed to help children of alcoholics have been co-sponsored by aggregates such as the U.S. Department of Education, Exxon Corporation, and the Metropolitan Life Foundation (The National Association for Children of Alcoholics [NACoA], 1989). As Mathews and Halbrook (1990) argue, "Celebrities, politicians, and other public figures have added substantially to the visibility and acceptance of ACOAs as an important cultural phenomenon demanding the attention of not only the helping professions but researchers,

writers, business management, and educators as well" (p.262). In fact, the President of the United States of America, Bill Clinton, is a self-admitted stepchild of an alcoholic.

Despite the paucity of research, there is, however, much information on ACOA issues, primarily found in "recovery movement" literature. Before beginning a review of this literature, the researcher cautions that the language of the recovery movement has gained so much popular acceptance in America that the terms "ACOA" and "codependent" have became buzzwords. However, there is no clear definition of "alcoholic" (Clinebell, 1988; Denzin, 1987; Ludwig, 1988, Metzger, 1988), consequently, there can be no clear definition of who is a child of an alcoholic. Additionally, "codependent" is a term originally used in the field of alcoholism to denote spouses of alcoholics who inadvertently collude with the alcoholic in maintaining addictive drinking (May, 1988). This word has been redefined in the popular press in such a way that it bears only minimal resemblance to the original definition. With these caveats in mind, an overview of the recovery movement literature is presented.

It is commonly held that codependency characterizes the relational style of alcoholic families. It is assumed that every ACOA is a codependent (Wilson-Schaef & Fassel, 1988). In fact, Wilson-Schaef and Fassel (1988) state that:

> In terms of our system concern, it is imperative to recognize that the co-dependent and the addict are simultaneously different and the same. One calls forth and supports the other. If people quit playing the co-dependent role, addictions could not survive, for addicts must have the collusion of co-dependents to maintain their closed addictive system. (p. 73)

Codependency is described as a primary "disease," experienced by every member of the family. It affects individuals, families, communities, businesses, and perhaps whole societies (Heryla & Haberman, 1991). Much of the limited literature on workplace issues addresses concerns related to codependent/dysfunctional workers. ACOAs and

codependents are very similar with the exception that codependents do not necessarily have an alcoholic parent. A central tenant of the general ACOA literature is that growing up in an alcoholic family results in many negative effects on the adult children. These include authority conflicts, high anxiety, low self-esteem, unclear boundaries of interpersonal responsibility, high needs for control, compulsive behavior, stress related medical disorders, and high needs for approval and affirmation. According to the popular literature, ACOAs represent one of the highest risk groups for developing substance abuse problems themselves or marrying someone who is a substance abuser. It is argued in the ACOA literature that many ACOAs appear to be compulsive and have trouble in setting limits or defining personal goals. It is claimed that they often deal with life in an all-or-nothing manner, alternating between periods of irresponsible and overresponsible behavior. This makes it especially difficult for these adults to identify career objectives and set academic goals (Heryla & Haberman, 1991).

Contrary to popular belief, not all ACOAS are alike. They do not comprise a homogeneous group (Heryla & Haberman, 1991). The position that all ACOAs are dysfunctional is offered in the relative absence of empirical evidence (Burk & Sher, 1988; Fulton & Yates, 1990; Krois, 1987; Plescia-Pikus, Long-Sutter, & Wilson, 1988). In addition, proponents of this view seem to have paid little attention to those children who cope adaptively with parental alcoholism and who eventually function as well-adjusted adults (Burk & Sher, 1988).

Although there is an emphasis on the problems of ACOAs, there also exists a group of researchers focused on identifying "psychologically resilient" or "invulnerable" children and associated protective factors (Hinz, 1990). Werner (1986) identified COAs who were functioning well at age 18 and examined factors that differentiated them from COAs who were experiencing problems. He found that protective variables included a positive temperament for the child, adequate intelligence, good expressive skills, an

internal locus of control, a desire for achievement, being responsible and empathic, good self-esteem, and a belief in the efficacy of their efforts to help themselves. These characteristics seemed to interact with caretaker variables to determine resiliency. One of the most consistent observations concerns the superior academic achievement of many "invulnerable" children (Burk & Sher, 1988; El-Guebaly & Offord, 1977; Hinz, 1990; Stark, 1987). It has been hypothesized that excelling in school is a way to relieve the pressures of living with alcoholic parents (Burk & Sher, 1988; Hinz, 1990; Stark, 1987). Others argue that while high academic achievement may be a positive coping mechanism for children, it is often associated with decreased psychological functioning in adulthood. High achievers may become "workaholics" and thus create and maintain emotional distance from themselves and others (Black, 1981; Burk & Sher, 1988; Hinz, 1990).

Not all COAs are affected equally due to many variables which influence their experiences. Examples of moderator variables believed to have an effect on adult psychopathology include developmental level of the child when problem drinking begins, gender of the child, gender of the alcoholic parent(s), functional level of the alcoholic parent(s), drinking patterns, relationships with siblings or other relatives, marital conflict, degree of family violence, duration of the time of exposure, and the degree of maintenance of family rituals in spite of familial alcoholism (Bennett, Wolin, Reiss, & Teitelbaum, 1987; Berkowitz & Perkins, 1988; Burk & Sher, 1988; Giglio & Kaufman, 1990; Krois, 1987).

Researchers have completed studies comparing ACOAs not in treatment with non-ACOAs on a variety of variables. Many have found no significant differences between the two groups (Chambliss & Hassinger, 1990; Churchill, Broida, & Nicholson, 1988; Havey & Boswell, 1991; Seefeldt & Lyon, 1990; Wilson & Blocher, 1990). It has been proposed that the negative characteristics ascribed to ACOAs are both overstated

and more representative of anyone growing up in a stressful environment (Burk & Sher, 1988; Chambliss & Hassinger, 1990; Havey & Boswell, 1991; Seefeldt & Lyon, 1990).

In the literature, there is a bias toward reporting high rates of psychopathology among ACOAs while ignoring those who are functioning well (Burk & Sher, 1988). Most of the literature is based on clinical impressions of ACOAs in treatment since this is the subpopulation of ACOAs with whom clinicians have contact. It is on this subpopulation that much of the popular literature is based. There has been very little empirical research on ACOA psychopathology (Chambliss & Hassinger, 1990; Hibbard, 1989). Also, numerous methodological shortcomings have been cited with regard to studies that have been conducted (Bennett, Wolin, & Reiss, 1988; Burk & Sher, 1988; Giglio & Kaufman, 1990). Of even greater scarcity is research into how ACOA issues are played out in the workplace (Mathews & Halbrook, 1990).

In order to empirically investigate ways in which issues claimed to be characteristic of ACOA's may be manifested at work, it is necessary to measure characteristics that are representative of the hypothesized intrapsychic and interpersonal components believed to be common among the ACOA population. It is the researcher's belief that certain personality and behavioral components found to be descriptive of perfectionistic persons provide such a measure. Following is an overview of the literature on perfectionism culminating with a discussion of ways in which personality components of both populations are believed to be related.

Perfectionism and the ACOA

Adler suggested that striving for perfection is an innate and intrinsic necessity for human development (Hewitt, Mittelstaedt, & Flett, 1990; Pirot, 1986). Normal individuals strive for perfection, but they set goals which are realistic and can be modified. Neurotic perfectionists, on the other hand, set goals which are unrealistically high and require superiority in all aspects of their behavior. They need to attain their

goals for their own enhancement or protection of their fragile self-esteem (Hewitt et al., 1990; Pirot, 1986). These are self-critical individuals whose standards are beyond reason, who strain toward impossible goals and measure their worth entirely in terms of productivity and accomplishment (Burns, 1980; Halgin & Leahy, 1989; Sorotzkin, 1985). They tend to view the world in a polarized fashion and have an overly active system of self-commands or "the tyranny of the shoulds." They typically have disturbed interpersonal relationships related to anticipation of rejection when they inevitably fall short of their standards as well as hypersensitivity to criticism. This interpersonal style commonly frustrates and alienates others (Halgin & Leahy, 1989; Sorotzkin, 1985). They become extremely vulnerable to emotional turmoil and impaired productivity. They feel that any action that is less that perfect makes them appear inadequate to others and they do not feel worthy of love and affection (Halgin & Leahy, 1989). Perfectionism has been linked to various negative outcomes including characterological feelings of failure, depression, guilt, procrastination, low self-esteem, indecisiveness, performance anxiety, social anxiety, and shame (Halgin & Leahy, 1989; Hewitt & Flett, 1991b).

Individual differences in perfectionism are usually discussed in the literature mainly in relation to self-standards and self-reinforcement behaviors. Extant conceptualizations of this construct focus exclusively on self-directed cognitions (Flett, Hewitt, Blankstein, & O'Brien, 1991; Hewitt & Flett, 1991b). Although perfectionism for the self is an essential component of the construct, Hewitt and Flett (1991b) contend that perfectionism also has interpersonal aspects which are important in adjustment difficulties. These authors postulate that the perfectionism construct consists of three dimensions; self-oriented perfectionism (SOP), other-oriented perfectionism (OOP), and socially prescribed perfectionism (SPP). SOP is the tendency to have perfectionistic standards for the self. It includes a salient motivational component reflected primarily by striving to attain perfection in one's endeavors as well as striving to avoid failures.

According to Hewitt and Flett (1991b) SOP should be related to similar forms of self-directed behavior such as level of aspiration and self-blame. OOP is the tendency to have perfectionistic standards for significant others. It is associated with hostility, lack of trust, and other-directed blame. It should be related to interpersonal frustrations such as cynicism, loneliness, and marital or family problems (Hewitt & Flett, 1991b). SPP is the perception that other people have unrealistically perfectionistic standards for the self and it is difficult, if not impossible, to attain these standards. Because standards are perceived as being excessive and uncontrollable, failure experiences and emotional states, such as anger, anxiety, and depression should be common. These negative emotions could result from a perceived inability to please others. Because persons with high levels of SPP are concerned with meeting other's standards, they should exhibit a strong fear of negative evaluation and place great importance on obtaining the attention but avoiding the disapproval of others (Hewitt & Flett, 1991b).

According to Halgin and Leahy (1989), perfectionism has its roots in developmental experiences. It is suggested that the perfectionism of some individuals evolves from interactions with perfectionistic parents whose self-esteem is contingent upon the success of their children. These individuals strive to be flawless in order to obtain parental love and acceptance. Other hypothesized family environments which contribute to the development of perfectionism are those of strong parental criticism and/or inconsistent approval (Halgin & Leahy, 1989).

Ramsey (1988) states that perfectionism is a component of the alcoholic personality. It is a defense designed to compensate for the alcoholic's perceived failures and defectiveness. It is an attempt to deny one's humanness, inadequacies, and frailties by trying to appear better than everyone else. It serves to delay inevitable feelings of inadequacy and incompetence. The frustration inherent in trying to be perfect leads to a sense of failure and self-resentment that gets manifested through rage. Rage manifests

itself in hostility or bitterness toward others. Although the hostility and bitterness is a defense to protect oneself from further experiences of shame, it becomes disconnected from its original source and becomes a generalized reaction towards almost anyone.

According to Hibbard (1987), most ACOAs hold a deep sense of shame concerning the alcoholic parent, and to varying degrees, are identified with this. The mechanism that is unique to COAs' development is identification with the alcoholic who is a source of shame and embarrassment.

Woititz (1987) conducted a survey of ACOAs in the workplace. She claimed that a feeling of inadequacy was the most predominate feeling these individuals reported on the job. The second most predominate feeling reported was anger. Perfectionism and lack of control were among the top seven feelings experienced. She describes ACOA supervisors as perfectionists who demand compliance from subordinates. Wilson-Schaef and Fassell (1988) state that frequent characteristics of ACOAs at work are perfectionism, workaholism, strong needs for control, and high needs for attention, encouragement, and approval. These authors describe ACOA bosses as driving taskmasters who do not delegate authority easily. ACOA and codependent employees have been described as perfectionistic and controlling with a high need for approval (Cauthorne-Lindstrom & Hrabe, 1990; Hall, 1991; Sorrentino, 1991).

As documented previously, Ramsey (1988) theorizes that perfectionism is a defense against feelings of inadequacy and shame in alcoholics. Hibbard (1987) states that ACOAs identify with the alcoholic parent's shame. Consequently, the researcher postulates that self-oriented perfectionism is basically a defense against feelings of inadequacy as described in the ACOA literature. Socially prescribed perfectionism should be related to the hypothesized ACOAs' strong need for approval and affirmation from others. Their inability to achieve perfection, resulting in not getting the recognition and approval they feel they deserve, possibly results in feelings of anger. Other-oriented

perfectionism appears to be related to the claimed need of ACOAs to be in control, be demanding of co-workers, and failure to delegate responsibility. The failure to achieve perfection possibly manifests itself in hostility and bitterness towards co-workers and subordinates. In other words, it could be a projection of the ACOAs feelings of inadequacy on significant others. As stated previously, Flett et al. (1991b) found other-oriented perfectionism to be related to hostility and other-directed blame. It is a postulate of the researcher that the perfectionism construct addresses the feelings of inadequacy, anger, and lack of recognition reported by Woititz (1987) and the on-the-job behaviors reported by the authors previously mentioned of ACOAs and codependents. That is, the feelings most reported by ACOAs in the workplace could all be related to an inner sense of shame that manifests itself through perfectionism.

Statement of the Problem

There is a vast lack of empirical investigation concerning the ways in which claimed ACOA characteristics may be manifested in the workplace. Assertions made about the workplace behavior of ACOAs are based on the popular literature. Numerous discrepancies exist between claims made in this literature and the findings of the majority of empirical research. This study was designed to empirically investigate the relationship between ACOA status (ACOA or non-ACOA) and self-oriented perfectionism (SOP), other-oriented perfectionism (OOP), and socially prescribed perfectionism (SPP). Second, the relationship between occupational classification (manager or non-manager) and SOP, OOP, and SPP was investigated. Third, an investigation was conducted in order to determine if there was an interaction between groups (ACOA managers, ACOA non-managers, non-ACOA managers, non-ACOA non-managers) on the perfectionism dimensions. Finally, among the ACOA population, the relationships of the demographic variables of interest to this study and the perfectionism measures were investigated. The problem of the study was addressed by asking the following questions:

1. Does the degree of SOP, OOP, and SPP among ACOAs differ from the degree of SOP, OOP, and SPP among non-ACOAs?

2. Does the degree of SOP, OOP, and SPP among managers differ from the degree of SOP, OOP, and SPP among non-managers?

3. Is there an interaction between ACOA status and occupational classification in the degree of SOP, OOP, and SPP among individuals participating in the study?

4. Among ACOAs, are there significant relationships between parental educational level in the family-of-origin and the three dimensions of perfectionism?

5. Among ACOAs, are there significant relationships between the gender of the ACOA and the three dimensions of perfectionism?

6. Among ACOAs, are there significant relationships between the gender of the alcoholic parent(s) and the three dimensions of perfectionism?

7. Among ACOAs, are there significant relationships between the age of the ACOA when parental problem drinking began and the three dimensions of perfectionism?

Definition of Terms

Adult Child of an Alcoholic: This will be operationally defined as the score obtained on the Children of Alcoholics Screening Test (Jones, 1983a). A score of 6 or more indicates a child of an alcoholic whereas as score of 2 to 5 indicates children of problem drinkers or possible alcoholics. For the purposes of this study, a score of 6 or above will indicate ACOA status. It is conceptually defined as those adults who perceive that one or both of their parents have, or has had, an alcohol abuse problem.

Non-Adult Child of an Alcoholic: This will be operationally defined as the score obtained on the Children of Alcoholics Screening Test. For the purposes of this study, a score below 6 will indicate non-ACOA status. It conceptually defined as those adults

who do not perceive that one or both of their parents have, or has had, an alcohol abuse problem.

Self-Oriented Perfectionism: This will be operationally defined as the score obtained on the SOP subscale of the Multidimensional Perfectionism Scale (Flett, Hewitt, Blankstein, & O'Brien, 1991). It is conceptually defined as the tendency to have perfectionistic standards for the self. SOP includes a motivational component that consists of the active striving for the perfect self.

Other-Oriented Perfectionism: This will be operationally defined as the score obtained on the OOP subscale of the Multidimensional Perfectionism Scale. It is conceptually defined as the tendency to have perfectionistic standards for significant others. It is associated with hostility and other-directed blame.

Socially Prescribed Perfectionism: This will be operationally defined as the score on the SPP subscale of the Multidimensional Perfectionism Scale. It is conceptually defined as the perception that other people have unrealistically perfectionistic standards for the self and it is difficult, if not impossible, to attain these standards of perfection.

Management Personnel: This will be operationally defined as those individuals who answer "yes" to item 3 of the Demographic Information Sheet developed for this study. It is conceptually defined as those individuals who have a position of authority and responsibility over other employees in their workplace.

Non-management Personnel: This will be operationally defined as those individuals who answer "no" to item 3 of the Demographic Information Sheet. It is conceptually defined as those individuals who do not have authority and responsibility over other employees in their workplace.

Parental Educational Level in the Family of Origin: This will be operationally defined as the highest grade completed in school by the ACOAs' parents.

Statement of the Hypotheses

Based on a review of the literature related to the research questions, the following null hypotheses are formulated:

1) The degree of self-oriented perfectionism (SOP), other-oriented perfectionism (OOP), and socially-prescribed perfectionism (SPP) among ACOAs does not differ significantly from the degree of SOP, OOP, and SPP among non-ACOAs.

2) The degree of SOP, OOP, and SPP among managers does not differ significantly from the degree of SOP, OOP, and SPP among non-managers.

3) There is not a significant interaction between groups (ACOA, non-ACOA, manager, non-manager) and the degree of SOP, OOP, and SPP among individuals participating in this study.

4) Among ACOAs, there are no significant relationships between parental educational level and the three dimensions of perfectionism.

5) Among ACOAs, there are no significant relationships between the gender of the ACOA and the three dimensions of perfectionism.

6) Among ACOAs, there are no significant relationships between the gender of the alcoholic parent(s) and the three dimensions of perfectionism.

7) Among ACOAs, there are no significant relationships between the age of the ACOA when parental problem drinking began and the three dimensions of perfectionism.

Significance of the Study

Given the lack of empirical research into ACOAs who are functioning well, the lack of investigation into ACOA issues at work, and the conflicting findings among research that has been conducted, it is evident that many questions remain unanswered. The large numbers of ACOAs in the American population coupled with the extreme paucity of research in this area makes it evident that increased knowledge about the issues ACOAs may bring to the workplace will benefit not only individual ACOAs but

individuals from other dysfunctional families, their co-workers, the companies that employ them, and society as a whole.

Assumptions of the Study

Certain assumptions were made in this study. First, it was assumed that the instruments used would accurately measure the variables of interest. It was further assumed that there would be no major violations of the assumptions underlying multivariate analysis of variance. These include: the underlying populations, from which subjects for each group were drawn, are normally distributed; the variances of the different groups are equal or homogeneous; errors are uncorrelated; and the interrelationship between self-oriented, other-oriented, and socially prescribed perfectionism is linear within each cell. Finally, the assumptions underlying correlational analysis were assumed to have been upheld. These include linearity of relationship; homoschedastisity; normality of error; and independence among subjects. All assumptions were evaluated and found to be upheld.

Limitations of the Study

There were certain limitations to this study which should be noted. Since the subjects were derived from a large corporation in the Southwest, they may not be representative of all corporate employees in other sections of the United States. An acknowledged limitation is the inability to generalize past the population from which the sample was extracted. Another limitation is that all participation in the study was voluntary. It is unknown whether the attitudes of persons not participating in the study differ significantly from the attitudes of persons participating. A further limitation is that information was gained through self-report questionnaires. Self-report instruments rely on the respondents' awareness of self. This could be especially problematic in the ACOA population since denial is a commonly noted personality defense among members of an alcoholic family system. Self-report instruments are also subject to faking and response

sets, however, they are standard forms of data collection in the study of human personality functioning.

Summary and Overview of Remaining Chapters

Chapter I introduced the reader to the area of Adult Children of Alcoholics, emphasizing the role of perfectionism as related to hypothesized issues ACOAs bring to the workplace. A statement of the problem was presented along with research questions and hypotheses. Several key terms were defined. Chapter II consists of a review of related literature. In Chapter III subject selection and description, procedures, instrumentation, methods, and analysis of data are described. The findings are reported in Chapter IV. A summary of the study as well as conclusions and recommendations for further research are presented in Chapter V.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The literature on adult children of alcoholics is diverse. This chapter consists of a review of the pertinent literature including theories, clinical impressions, and empirical findings. Subject matter is organized into a number of sections. In the first section, the theoretical foundations upon which current ACOA literature is based are reviewed. The next major section consists of a review of claims made in the literature concerning personality characteristics thought to be descriptive of ACOAs which are founded on clinical impressions. In addition, empirical research which has been conducted in order to investigate these claims is reviewed. Specific subsections reflect major areas of interest to which attention has been devoted by clinicians and researchers. In the third section, a special focus is placed upon ACOAs in the workplace. The last major section consists of a review of the literature on perfectionism with a special emphasis given to the interrelationships between personality characteristics of perfectionists and those characteristics believed to be common among ACOAs.

Before beginning a review of the literature, it is important to note that many claims made in the popular press concerning ACOAs are unsubstantiated and/or contradicted by empirical research. In addition, there is much controversy about alcoholism. This field of study is full of paradoxes and contradictions. The terms "alcoholism" and "alcoholic" are virtually a Pandora's box. In fact, there is not even a clear consensus on a definition of either term (Clinebell, 1988; Denzin, 1987; Ludwig, 1988; Metzger, 1988). Consequently, classifying one as an adult child of an alcoholic is too often arbitrary.

Theoretical Antecedents

The theoretical underpinnings upon which current ACOA literature is based fall into three schools of thought: family systems theory, developmental psychology, and object relations theory.

Family Systems Model

This model looks at individual family members as playing a part in the whole system. The family has basic needs. In an alcoholic family, children adopt certain roles in order to fulfill these needs. Depending on the particular role, each child behaves in specific ways, plays specific functions in family interactions, and develops particular strengths and weaknesses that influence their potential for adult functioning. These roles are called the hero, the scapegoat, the lost child, and the mascot (Bepko, 1985).

The hero is typically the oldest child. They become overfunctioners and often assume parental responsibility at an early age. The child's behavior is compliant and directed at providing a sense of structure and order for the family. Heroes are highly self-reliant and dependable. They frequently function as a surrogate parent to both younger siblings and the nonalcoholic parent. In later life, they experience chronic feelings of guilt and inadequacy. They approach most life situations by attempting to organize and control and have difficulty in their ability to relax, have fun, and take life less than seriously.

The scapegoat functions to deflect the attention of the family away from the critical issues of alcoholism and marital discord. This child withdraws from the parental subsystem and behaves badly. She or he acts out to get attention. The scapegoat is irresponsible whereas the hero is overresponsible.

The lost child adapts to the chaotic situation by staying out of everyone's way. In the face of constant crisis, contradiction, and inconsistency, this child passively accepts all situations with a degree of detachment. She or he is a loner who helps the family by

making no demands. They receive no attention, nurturing, or support. They experience themselves as worthless and confused. They are underresponsible and never develop a sense of self. These children typically never actualize their intellectual or emotional potential.

The mascot is usually comical and entertains and distracts the family. Because of their ability to hold an audience, they feel some sense of control in what is a confusing and frightening world. Since they act childishly to maintain their role, they develop few serviceable or mature coping skills and are often limited by immature behaviors and attitudes. The mascot and scapegoat may both serve as the family placater. They react directly to the emotional dimension of the family interactions and try to take care of everyone's feelings. They try to make all situations better. It should be noted that no child's behavior fits any role perfectly and a child's role may shift over time depending on the progression of alcoholism and life events (Bepko, 1985; Corazzini, Williams, and Harris, 1987; Krois, 1987).

The roles of children in alcoholic families are complimentary and point to the underlying distortion of self-experience in the family. Members do not experience themselves as distinct and valued human beings but as functions whose sense of self emerges in response to the demands, inadequacies, and inconsistent behavior of someone else.

Ackerman (1987) shuns the concept of the roles and suggests that clusters of behavior exist in which ACOAs possess varying degrees of characteristics that cross over several ACOA typologies. Contrary to popular belief, differences exist among ACOAs. They are not a homogeneous group. They experience dissimilar types and degrees of problems (Bernard & Spoentgen, 1986).

No empirical verification of the hypothesized family roles was found in the literature review. Only one study (Hibbard, 1989) was found in which family roles were

investigated by comparing birth order of ACOAs with various measures of psychopathology. There were no significant correlations with any of the indices of pathology.

Developmental Psychology

This model looks at ACOAs in terms of the developmental stages postulated by Erikson. It is believed that the younger the child when the alcoholic disturbance begins, the more severe will be the resulting effects. The nature of childhood experiences, coping strategies, and ways of understanding and relating to parental alcoholism depend upon the children's ages at the onset of parental drinking problems (Robinson, 1989).

According to Robinson (1989), parental drinking begins to affect children in infancy. Infants must successfully resolve the conflict of trust versus mistrust. In alcoholic families, infant trust is challenged from the first day of life since the parents are too consumed with alcoholism to provide adequate support and nurturance. The inconsistency, neglect, and abuse of many alcoholic homes give children a sense of mistrust, insecurity, and separation anxiety. These feelings build across the lifespan and are transformed into problems with intimacy, insecure relationships, and fear of abandonment in adulthood. The inability to trust extends to one's self, opinions, and confidence.

Children then move into the stage of autonomy versus shame and doubt. Children who develop a sense of autonomy have parents who are patient and supportive. Shame and doubt and problems with control arise in COAs when they witness parents who scold and criticize them for making poor choices and mistakes or deny them opportunities to make choices and develop self-control. Children who are not allowed to exercise autonomy begin to develop codependency. They develop self-doubt about their abilities to manage their own lives. As adults, they have difficulty making decisions and carry issues around control and negative attitudes toward authority into their adult personalities.

The third stage of development is initiative versus guilt. In this stage, children internalize right from wrong and adhere to the rules of society. Reality testing is a critical issue since children at this stage think magically and cannot think logically. Reality testing in alcoholic homes is complicated by the fact that children are often told that what they saw didn't really happen or wasn't as bad as they perceived it to be. As a result, they become confused and often overuse their fantasy world as an escape. Rules of right and wrong change daily so children never understand what the rule for the day is. Since children are very egocentric at this stage, they feel guilty because they believe their parent drinks because of something they did. As an adult, they may become overly responsible for others and put others needs before their own. They have trouble distinguishing what is normal and feel to blame for their parent's drinking.

School age children negotiate the developmental state of industry versus inferiority. In most alcoholic homes, failure and disapproval are common. Consequently, children may believe that the results of their work are not worthwhile and they themselves have low self-worth. In adulthood, these people have difficulty following through on a project or, at the other extreme, get stuck in this stage and spend the rest of their lives trying to prove to themselves and to others that they are competent and worthwhile.

During adolescence, individuals must struggle with the stage of identity versus role confusion. They must answer the questions "Who am I?" "Where am I going?" "What will I do with my life?" They must find a fit between who they are and what society wants them to be. This fit is impossible for COAs who have been unsuccessful at the previous stages (Berlin, Davis, & Orenstein, 1988; Brown, 1988; Robinson, 1989). The adolescent attempts to integrate the values and the culture inside the family with those outside the family. He or she attempts to master many of the existing emotional ambiguities and wide inconsistencies through the cognitive move into formal operations. This cognitive level encompasses the ability to merge contradictory or polar opposites

and integrate complex ideas and information about the self and the environment. The defense mechanism of denial in the alcoholic system interferes with the progression to formal operations. Denial limits the range of what can be recognized, explored, and integrated. Impairments in early childhood developmental tasks interrupt the path of normal development so severely that the preadolescent is not emotionally prepared to negotiate the adolescent tasks of identification and separation. The developmental groundwork required to successfully negotiate these tasks is either missing, full of deficits, or dominated by defensive accommodations necessary to sustain early attachment or the limited adjustment that has been achieved. While difficulties occur in the earlier stages, often a crisis does not occur until the onset of adolescence. Unresolved issues from previous stages of development interfere with the identity crisis and lead to role confusion and a negative self-concept. It is in this stage that many ACOAs are stuck (Brown, 1988; Robinson, 1989).

Proponents of development theory have outlined many negative effects on children of growing up with an alcoholic parent during different developmental stages. While these propositions may be valid for a number of children, other writers (Burk & Sher, 1988; Berkowitz & Perkins, 1988; El-Guebaly & Offord, 1977; Fulton & Yates, 1990; Plescia-Pikus, Long-Suter, & Wilson, 1988; Wolin & Wolin, 1993) have proposed that many COAs develop strengths and resiliencies as a result of growing up in an adverse home environment.

It is the researcher's opinion that the age of the child when parental problem drinking begins may indeed have a differential effect on the personality functioning of ACOAs. However, little research has been completed investigating this claim. No empirical research was found investigating ways in which the developmental level of the COA when parental problem drinking begins may affect the achievement level and/or work behavior of adults from alcoholic families.

Object Relations Theory

This model is also based on developmental stages. It is an approach that has its origin in psychoanalytic theory. From the object-relations perspective, an infant does not view others as individuals with a separate identity but as objects for gratifying needs. According to Hibbard (1987), ACOAs display characterological difficulties resulting from developmental deficits and anomalies in the ego and superego structuralization and pathology of the self and object relational representations, usually condensed with poorly resolved oedipal issues. These developmental difficulties are the basis of characterological adaptation patterns which ACOAs present. Hibbard (1987) argues that there is nothing uniquely discernible and no newly discovered nosological entity in the ACOA population. What is unique to the pathologies of ACOAs is the genetic basis for them and the etiologic roles which parental alcoholism played. There seem to be certain characteristic and recurring kinds of pathogenic mechanisms in alcoholic homes which lead to developmental anomalies and deficits. What is unique to ACOA pathologies are these mechanisms triggered by or intertwined with parental alcoholism. The pathogenic mechanisms in ACOA pathology are related to the absence of developmentally appropriate parenting.

A recurring mechanism in alcoholic homes is that parental alcoholism breeds an atmosphere which encourages the polarization of the instincts, rather than the blending and neutralization of these instincts. In other words, due to inappropriate parenting, the child is unable to integrate their parents' inconsistent behaviors into a whole object consisting of both good and bad personality attributes. Instead, the developing self "splits" self-object representations into the all good object and the all bad object (Kohut & Wolf, 1978). This phenomena is commonly termed "splitting" which refers to an individual's tendency to alternately overidealize and devalue others. Instinctually polarized defenses strain self and object constancy which is the most common form of

pathology in this population. These defensively polarized drive derivatives and the self and object relations they determine are at the heart of ACOA pathogenicity. They define the core of codependency.

Secondly, parental alcoholism renders one or both parents unavailable or distorted for various introjective, identificational, or mirroring functions. Examples are the child's needs for a parental image to idealize or a young girl's needs to either have her oedipal strivings appropriately received and mirrored by the father, or to find a significant identificatory passive-feminine model in the mother.

Third, there are compensatory mechanisms which may be triggered within the family system to restore homeostatic balance. The nonalcoholic parent may compensate for the humiliation of being married to an alcoholic by narcissistically using the children to his or her own benefit. On the other hand, the homeostatic forces may triangulate the child either through a series of myths and secrets or through an oedipal competition with the same-sexed parent for the opposite-sexed parent's affection and loyalty. In one form or another, alcoholic family systems develop compensatory mechanisms which developmentally affect the child's personality structure.

Fourth, alcoholism usually involves a fair degree trauma such as neglect or family violence. These various forms of trauma are destructuralizing.

Fifth, most ACOAs hold a deep sense of shame, embedded in the self and object representations at various developmental levels. The mechanism that is unique to these children's development is identification with the source of shame, with the alcoholic, who is a source of shame and embarrassment. Hibbard (1987) states that there is no single telltale pathognomonic trait of ACOAs, but rather a set of recurrent pathogenic mechanisms which have combined with other factors to produce the pathology. Consequently, each ACOA must be treated as a unique individual.

Empirical studies have shown no consistent validation of the assertion that ACOAs display a greater incidence of personality disorders than non-ACOAs. There is a marked lack of research investigating ACOA issues from an object-relations perspective. Hibbard (1989) did complete one study in which he found more object relational pathology among ACOAs, however, the subject sample was small. The author stated that more research is needed in this area.

Clinical Impressions and Empirical Studies

The majority of ACOA literature is based on clinical impressions. Clinical studies indicate that there are long-term negative consequences produced as a result of growing up in a family in which there is an alcoholic parent, however, little empirical research has been conducted to substantiate this assertion (Fulton & Yates, 1990; Plescia-Pikus, Long-Suter, & Wilson, 1988). Although there are a limited number of empirical studies, it should be noted that numerous methodological shortcomings have been cited with regard to studies that have been conducted. These include the lack of controls, absence of studies comparing ACOAs to adults from other dysfunctional families, the lack of blind data collection, poorly defined criteria for alcoholism, restricted range of tests used for assessment, oversimplified reasoning about causes and effects, use of small and often unrepresentative samples, failing to statistically control for Type I errors, failing to control for parental psychopathology, and lack of longitudinal studies and selective sampling with a pathology bias for those already in treatment (Bennett, Wolin, & Reiss, 1988; Burk & Sher, 1988; Giglio & Kaufman, 1990; Havey & Boswell, 1991).

Life in an Alcoholic Family

Life in an alcoholic family has been described as inconsistent, unpredictable, arbitrary, and chaotic (Krois, 1987; Mathews & Halbrook, 1990). Parental mood swings are unpredictable and expectations are inconsistent. Robinson (1989) believes that children of alcoholics (COAs) have to interact with at least three different parents: the

drinking alcoholic parent, the sober alcoholic parent, and the nonalcoholic parent. When both parents are alcoholic, COAs must figure out how to get along with multiple personalities. In some ways, this is comparable to living with parents who are schizophrenic. Children often find themselves "walking on eggshells" by trying to second-guess parents in order to do what they want (Robinson, 1989; Schumrum & Hartman, 1988). The focus of the family is on the alcoholism. Children are often ignored, neglected, disciplined inconsistently, scapegoated, and given few concrete limits and guidelines for behavior. Arguments, illogical and repetitious thinking, domestic violence, and incest are common (Brown, 1988; Robinson, 1989; Schumrum & Hartman, 1988). The family often isolates itself from other members of the community due to the shame felt about the alcoholism in the family. Children are fearful of bringing friends home because the alcoholic parent might embarrass them and also to protect the "family secret." That is, the alcoholism becomes a major family secret which is usually denied inside the family and is certainly denied outside. This secret becomes a governing principle around which the family organizes itself. This secret governs its adaptations, coping strategies, and shared beliefs that maintain the structure and hold the family members together (Brown, 1988).

According to Milman (1985), COAs encounter many difficulties that most children of nonalcoholic families do not. Child abuse and neglect, spouse abuse, emotional unavailability of parents, and sexual abuse are some of the issues many COAs face in their families-of-origin.

Codependency

The concept of codependency has gained wide spread popularity in the recovery movement. It is advertised as a national epidemic resulting in millions of book sales, support groups, and treatment programs. In the popular press, codependency is defined to include anyone affected by someone else's behavior and obsessed with controlling it.

According to this definition, it has been asserted that 96 percent of all Americans suffer from codependency (Kaminer, 1992).

Codependency originally referred to the problems of women married to alcoholics. This researcher asserts that the term "codependency" has been misdefined and misused by many popular writers. For the purpose of this research, codependence is defined as the unwitting collusion of persons involved with alcoholics in supporting addictive drinking (May, 1988). With this caveat in mind, following is a discussion of assertions based on clinical impressions regarding codependency in the alcoholic family.

According to Krois (1987), codependency characterizes the relational style of alcoholic families. Codependents give other people power over their own sense of self-worth. If the other person(s) fails to live up to one's expectations, one suffers a loss of self-esteem. Codependents live according to unspoken rules which validate and legitimate the belief that their sense of self-worth stems from the behavior of those close to them. They try to control other people's lives in order to make their lives more secure. This process gives others a great deal of power over them. A sense of self-worth is built through making choices based on one's needs and feelings. Codependents make their choices on the basis of what they perceive to be someone else's needs. In order to feel good about themselves, they direct their energy towards making others happy. Consequently, when childrens' self-esteem is based on making the alcoholic parent happy, they are unsuccessful and left with a feeling of disappointment and failure (Krois, 1987). Cermak (1989) asserts that this relational style continues in adulthood. Not everyone wants to have power over another's self-esteem. Those who do usually possess a narcissistic need to be considered special. Chemical dependents and persons with personality or impulse disorders usually have this need. Consequently, a complimentary situation exists. The codependent and the dependent can find mutual gratification without ever having to express their needs overtly. Cermak (1986) and Woititz (1983)

postulate that ACOAs have a 50% higher chance of marrying an alcoholic than the general population for this reason.

According to Cermak (1989), growing up in an alcoholic family subjects persons to stress that is outside the range of normal human experience. "Outside of residence in a concentration camp, there are very few sustained human experiences that make one the recipient of as much stress as does being a close family member of an alcoholic" (Bean-Bayog & Stimmel, 1987, p. 24). Cermak (1989) states that, due to this environment of sustained, intense stress, Post-Traumatic Stress Disorder (PTSD) develops. He postulates that the characteristics of ACOAs are best seen as a combination of codependence and PTSD. In fact, Cermak (1986), has argued that codependence is actually a personality disorder.

Some verification of the assertion that COAs experience a high degree of stress in their families-of-origin has been provided by empirical research. Havey and Boswell (1991), in a study of 442 undergraduate students, found that ACOA students rated the stress experienced in their homes higher than did the non-ACOAs. Bradley and Schneider (1990) conducted a study of 39 college ACOAs and 28 non-ACOA students. In agreement with Havey and Boswell (1991), these researchers also found that the ACOA students reported more stress related to parental alcoholism than the non-ACOA subjects.

Intimacy, Interpersonal Trust, and Control

According to Krois (1987), a characteristic of alcoholic families is that of not expressing feelings. Emotions are repressed and distorted or expressed in an angry, judgmental manner. Denial is a central issue, with both parents pretending that things are different than they really are. There is a marked lack of emotional interaction. Frequently, everyone in the family is afraid that the others will find out how they really feel (Krois, 1970).

According to Bradshaw (1988), COAs learn to defend themselves with ego defenses. They repress their feelings, deny what's going on, displace their rage onto their possessions, create illusions of love and connectedness, idealize and minimize, and dissociate so that they no longer feel anything at all resulting in psychic numbness. Bradshaw (1988) states that this is the basis of compulsions and addictions. As adults, COAs have difficulty in being aware of and expressing feelings and have issues around control, trust, and intimacy (Bradshaw, 1988; Brown, 1988; Brown & Beletsis, 1986; Cermak, 1989; Cermak & Brown, 1982; Downing & Walker, 1987; Krois, 1987).

Ricelli (1987) states that a salient issue of ACOAs is in the heavily conflicted area of intimacy. He found that the most highly noted characteristic of ACOAs was that they have difficulty with intimate relationships. In describing the ACOA groups they led, several authors (Brown & Beletsis, 1986; Cermak & Brown, 1982; Corazzini, Williams, & Harris, 1987; Delaney, Phillips, & Chandler, 1989; Downing & Walker, 1987; Riccelli, 1987; Roush & DeBlassie, 1989; Schwartzberg & Schwartzberg, 1990) found issues around self-disclosure, trust, and control to be predominant.

In an effort to investigate the assertion that ACOAs have difficulty with intimate relationships due to issues around self-disclosure, interpersonal trust, and control (Brown & Beletsis, 1986; Cermak & Brown, 1982; Corazzini, Williams, & Harris, 1987; Ricelli, 1987), Bradley and Schneider (1990), conducted a study in which they compared 39 college ACOAs with 28 non-ACOA peers on measures of trust, self-disclosure, and need for control. The relationship between the sex of the alcoholic parent, the distress experienced as a function of the parents' alcoholism, and personality functioning was also evaluated. The Children of Alcoholics Life-Events Schedule was chosen to measure the stressful experiences of subjects who lived in homes with an alcoholic parent. Interpersonal trust was measured by the Interpersonal Trust Scale. Self-disclosure was measured with three subscales of the Jourard Self-Disclosure Questionnaire. Control was

measured with the Control subscale of the Minnesota Multiphasic Personality Inventory (MMPI). Subject's drinking patterns were assessed with a set of nine questions. Using one-way ANOVAs, the authors found that the ACOA students reported more stressful experiences than did the non-ACOA controls. They also found the ACOAs to be significantly higher in their need for control. No significant differences between groups were found on the interpersonal trust and self-disclosure measures. To evaluate the effects of gender of the alcoholic parent, 2 x 2 ANOVAs were conducted. There was a significant main effect for paternal alcoholism on the control scale. There was a small, but significant main effect for maternal alcoholism on the interpersonal trust measure. A small, but significant negative correlation between level of stress in the alcoholic home and interpersonal trust was found. Problem drinking among the ACOA subjects was found to be associated with the stress measure rather than the report of parental alcoholism. The authors concluded that parental alcoholism has some influence on the personality functioning of young adults. However, these effects are not as clear-cut as the literature suggests. The results of this study suggest that gender of the alcoholic parent may be an important moderator variable.

Wilson and Blocher (1990) completed an empirical study in which they compared personality characteristics of 20 ACOA and 21 non-ACOA university students as measured on the 12 scales of the Personal Orientation Inventory (POI). The POI is purportedly an indicator of psychological well-being. The Children of Alcoholics Screening Test (CAST) was used to distinguish ACOAs from non-ACOAs. The significance of differences between the mean scores for the two groups was assessed with t-tests at the .05 level. In contrast with the assertion that ACOAs experience difficulty identifying feelings, expressing feelings spontaneously, and developing intimate relationships and self-worth, these researchers found no significant differences between the ACOAs and the non-ACOAs in any of these functioning areas. In fact, no significant

differences were found on any of the 12 POI scales. The researchers concluded that the problems ACOAs experience are also prevalent among adult children from other types of dysfunctional homes. Wilson and Blocher (1990) state that "the results of this study cast doubts as to whether researchers can consider parental alcoholism alone, without consideration of various intervening variables, and find a pattern of personality characteristics in the offspring that is distinguishable from that of the offspring of nonalcoholics" (pg. 173). Other factors, such as the age of the child at the onset of parental alcoholism or the existence of abuse, may make a difference in the effects of parental alcoholism.

In summary, the assertion made in the popular literature that ACOAs experience significant difficulties with intimacy, interpersonal trust, and control has not been substantiated by empirical research. Instead, results of studies that have been conducted indicate that, overall, ACOAs are not different from non-ACOAs in any of these functioning areas. When differences were found, they appear to be related to moderator variables such as gender of the alcoholic parent and degree of stress in the home environment.

Dysfunctional Personality Characteristics of ACOAs

It is asserted in the popular literature that alcoholic families are characterized by sustained environments of inconsistency, fear, chaos, abandonment, denial, and potential or real violence. As a result of growing up in such an environment, an impaired adult is predicted to emerge with a multiplicity of complex psychological problems (Fulton & Yates, 1990).

Various writers (Bean-Bayog & Stimmel, 1987; Brown, 1988; Cermak, 1988, 1989; Downing & Walker, 1987; Marlin, 1987; Metzger, 1988; Wholey, 1988) have described many negative characteristics found among children of alcoholics. These include authority conflicts and unfulfilled dependency needs, intense defiance,

aggressiveness, high anxiety, low self-esteem, denial of perceptions, needs, and experience, and a high incidence of fighting with peers and trouble in school. Bean-Bayog and Stimmel (1987) postulate that COAs have a greater likelihood of behavioral disorders and difficulties in regulating their moods. These authors claim that significant disturbances in the use of the senses, emotional disturbance, attention deficit disorders, eating disorders, and conduct disorders are found frequently. According to Bean-Bayog and Stimmel (1987), fearfulness, inappropriate emotional expression, and self-dissatisfaction are pronounced. These authors also state that psychosomatic complaints and stress related medical disorders are common. It is stated (Bean-Bayog & Stimmel, 1987; Brown, 1988) that ACOAs show restricted emotional spontaneity, denial of personal needs, unclear boundaries of interpersonal responsibility, difficulty trusting, and fear of abandonment.

Results of empirical studies which have been conducted in order to investigate claims made about ACOAs in the popular literature are conflicting. Berkowitz & Perkins (1988) studied differences in eight personality characteristics of a nonclinical sample of self identified ACOAs and their peers from nonalcoholic homes in a survey of 860 university students. An extensive questionnaire was distributed to the subjects. The questionnaires included measures of impulsiveness, self-depreciation, lack of tension, independence/autonomy, need for social support, directiveness, sociability, and other-directedness. The researchers also investigated gender differences in personality characteristics of ACOAs, and differences in the impact of parental alcoholism depending on which parent was alcoholic. The results indicated that ACOAs were similar to peers on most characteristics, however, ACOAs reported more self-depreciation. They also found that self-depreciation was greater for women than men and that women with an alcoholic father were more likely to report self-depreciation than women with an alcoholic mother. Male ACOAs were found to score higher on independence-autonomy

than male non-ACOAs. The findings of this study suggest that gender of both the ACOA and the alcoholic parent may produce differential effects on adult personality characteristics. The authors point out that their results point to the resilient character of many COAs in coping with parental alcoholism. That is, COAs may experience both adaptive and dysfunctional consequences of parental alcoholism. According to Berkowitz and Perkins (1988) "the different roles adopted by COAs in response to family disorganization and confusion may encourage some children to acquire a greater degree of responsibility and to exercise greater decision-making than that generally found in children from nonalcoholic families" (pg. 209). The authors concluded that their study points to the resiliency of COAs as well as identifying potential negative effects of parental alcoholism.

Alcoholism and Character Disorders

It is commonly held that ACOAs represent one of the highest risk groups for developing substance abuse problems themselves or marrying someone who is a substance abuser (Bean-Bayog & Stimmel, 1987; Brown, 1988; Cermak, 1986; Woititz, 1983). In addition, it is claimed that ACOAs are more likely to display characterlogical difficulties than non-ACOAs (Bean-Bayog & Stimmel, 1987; Brown, 1988; Cermak, 1986; Hibbard, 1987).

In their review of the literature, Burk and Sher (1988) state that the intergenerational transmission of alcoholism is a well-established outcome with a large proportion of COAs likely to abuse alcohol as adults. According to these authors, it is clear that COAs may manifest a wide variety of psychopathology. However, the reviewers state that there are COAs who are psychologically healthy in spite of their parents' pathology. The results of empirical studies tend to support the findings of Burk and Sher (1988). In addition, several moderator variables have been identified that appear to moderate the negative effects of parental alcoholism on children.

Fulton & Yates (1990) were interested in determining if ACOAs defined a specific treatment group among adults in inpatient treatment for substance abuse. They hypothesized that, if the ACOA concept is valid, ACOA substance abusers should display more personality and psychiatric psychopathology and a more severe substance abuse pattern than the non-ACOA substance abusers. They interviewed 217 subjects comparing ACOAs to non-ACOAs on a variety of demographic, personality, psychiatric illness, and substance abuse phenomenology measures. They found that 40.6% of the subjects reported at least one parent with alcoholism. After employing a Chi Square with Yates' correction analysis on categorical variables and t-tests on continuous variables, they did not find any significant differences between subjects for the severity of their own alcoholism. Also, there were no significant differences between the two groups for drugs chronically used, prevalence of antisocial personality disorder, or other major psychiatric disorders. There were no significant differences between the two groups on Axis 1 diagnoses or any of the 11 DSM-III personality disorder types. Limitations of the study included the inability to estimate the increased relative risk of substance abuse and/or psychiatric illness among ACOAs that are not in treatment and the possible confounding effect of alcohol and drug abuse consequences on study measures since years of significant substance abuse may contaminate personality and psychiatric illness measures by "washing out" premorbid differences between the groups. The authors concluded that ACOAs do account for a substantial percentage of adults in substance abuse treatment, however, no other distinguishing differences were found between ACOA and non-ACOA substance abusers. A very salient caution to the reader is that using the concept of COA and ACOA outside of substance abuse treatment groups may be problematic. Such a designation implies a psychological and/or interpersonal deficit for anyone with an alcoholic parent. This all-inclusive designation fails to consider the variability of

environmental trauma in alcoholic homes and the ability of many to develop normally despite early adversity.

A divergent finding was reported by Hibbard (1989) who completed a correlational study in which he compared 15 university student ACOAs and 15 non-ACOAs matched for gender and age on measures of characterological pathology and level of object relational development in order to assess whether ACOAs were more personality disordered than non-ACOAs. For inclusion as an ACOA, a subject's parent had to have experienced alcoholism onset prior to the subject's twelfth birthday. Parental alcoholism was diagnosed by administering the subjects the Family Tree Questionnaire for Assessing Family History of Drinking Problems. In addition to a demographic questionnaire, instruments used were a modified form of the Millon Clinical Multiaxial Inventory (MCMI) and two Rorschach measures which were combined to form a measure of object relational pathology. Correlations between birth order and indices of pathology were examined. No significant correlations were found. Intactness of the parent's marriage and pathology was not correlated. The eight Basic Personality (BP) scales and three Pathological Personality (PP) scales of the MCMI were used in this study to determine if ACOAs are more personality disordered than non-ACOAs. Each subject's two high-point BP scale scores were averaged to form a measure of moderate-level personality pathology. Each subject's single high-point PP scale score was computed as a measure of severe-level personality pathology. Significantly higher levels of personality pathology were found among the ACOAs on both measures. ACOA males were higher on the Histrionic and Hypomanic scales. ACOA females were higher on the Dsythymic scale. Main effects for group differences revealed ACOAs to be higher on the Negativistic and Cycloid scales but lower on the Compulsive scale. Males appeared to make a more externalized, expansive adaptation and females a more internalized, inhibited adaptation to familial alcoholism. In addition, significantly greater object

relational pathology was registered by the ACOA group on the multivariate Rorschach measure. A limitation of this study is the small sample size. The author states that replications and cross validation with other instruments are needed as well as studies including control offspring of other chronic psychiatric diagnoses.

In order to investigate the intergenerational transmission of alcoholism in families, Bennett, Wolin, Reiss, and Teitelbaum (1987) completed a study in which they asserted that there are certain protective factors which influence the transmission of alcoholism to offspring. In order to test their hypothesis, they interviewed 68 couples from 30 alcoholic families-of-origin. Their findings indicated that ACOAs who do not repeat their parent's self-destructive behavior marry strong spouses from healthy families. In addition, they found that a key difference between ACOAs who repeat their parent's drinking patterns and those who do not is the achievement of psychological independence from their parents.

Locus of Control and Self-Esteem

Mills (1991) was interested in investigating control orientation in children of alcoholics and alcoholics who were in residential treatment for the first time as compared to alcoholics who had received prior residential treatment. It was hypothesized that alcoholic participants would demonstrate an internal locus of control while COA participants would demonstrate an external locus of control. Subjects consisted of 14 male alcoholics in treatment for the first time, seven males who had received treatment previously, and eight adolescent male COAs in outpatient counseling. All subjects were administered the Rotter Internal-External Control Scale. The average score in Rotter's normative sample of 575 male elementary psychology students was 8.1. The mean score for the alcoholic subjects in this study was 9.9. A t-test was calculated to compare those in treatment for the first time with those who had received previous inpatient treatment. While not statistically significant, those in treatment for the first time tended to be more

externally oriented. The mean score for COAs in this study was 9.1. The results of this investigation did not support the original hypothesis concerning alcoholic subjects but did support the original hypothesis for COA subjects. That is, the COAs participating in this study did exhibit a more external orientation than those subjects in Rotter's normative sample. Results of this study are greatly limited due to the small number of subjects in the study and the use of scores for males only. Finally, although the author compared mean scores obtained in this study with those obtained by Rotter, no formal analysis of the data was performed in order to test for statistical significance.

In opposition to the proposition of external locus of control among ACOAs, Churchill, Broida, & Nicholson (1988) examined the differences in locus of control and self-esteem for ACOAs and non-ACOAs by testing 497 students in introductory psychology classes. ACOAs and non-ACOAs were identified by answers on the Children of Alcoholics Screening Test (CAST), locus of control by the Rotter Internal/External Locus of Control Scale, and self-esteem by answers on the Jackson Personality Inventory self-esteem rating scale. Separate Mann-Whitney U tests showed no significant gender-related differences in age, self-esteem, locus of control, or CAST score, consequently, gender was ignored as a variable in all subsequent analyses. Spearman rho correlations showed a significant relationship between locus of control and self-esteem and between age and locus of control. Subjects with an external locus of control tended to be younger and to have lower self-esteem. Scores on the CAST were not correlated significantly with age or either of the personality variables. No significant differences were found between the ACOA and the non-ACOA subjects on either of the personality variables. The results of this study suggest that personality characteristics of ACOAs are not the direct result of being raised in an alcoholic home. Such results call into question the hypothesis that being the child of an alcoholic results in certain behavior patterns and personality functioning particular to this population alone.

This researcher proposes that the external locus of control orientation found among adolescent COAs in the Mills (1991) study could be due to the age of the subjects rather than being children of alcoholics.

Thirteen Characteristics Believed To Be Descriptive of ACOAs

Janet Woititz, a prolific writer in the ACOA literature, described 13 characteristics that ACOAs commonly display. These are:

1. ACOAs guess at what normal is.
2. ACOAs have difficulty following a project through from beginning to end.
3. ACOAs lie when it would be just as easy to tell the truth.
4. ACOAs judge themselves without mercy.
5. ACOAs have difficulty having fun.
6. ACOAs take themselves very seriously.
7. ACOAs have difficulty with intimate relationships.
8. ACOAs over-react to changes over which they have no control.
9. ACOAs constantly seek approval and affirmation.
10. ACOAs feel that they are different from other people.
11. ACOAs are either super responsible or super irresponsible.
12. ACOAs are extremely loyal, even in the face of evidence that loyalty is underserved.
13. ACOAs are impulsive. They tend to lock themselves in a course of action without giving serious consideration to alternative behaviors or possible consequences. This impulsivity leads to confusion, self-loathing, and loss of control over their environment. In addition, they spend an excessive amount of energy cleaning up the mess. (Woititz, 1983, p. 24-50)

The characteristics outlined by Woititz (1983) have not been substantiated by empirical research. Chambliss & Hassinger (1990) developed an instrument, the Adult Children of Alcoholics Characteristics Test (ACOAT), designed to measure identification with the 13 characteristics outlined by Woititz. They administered the ACOAT to 103 introductory psychology university students in order to see if a non-clinical sample of ACOAs would identify with these characteristics more than non-ACOAs. Of their sample, nine subjects identified themselves as ACOAs. It was found that items on this instrument did not discriminate ACOAs from non-ACOAs regardless of whether ACOA status was determined by the recollection of parental alcohol use or ACOA self labeling. The authors state that this finding raises important questions about the accuracy of the common portrayal of ACOAs in the clinical literature. However, an alternative explanation is that the ACOAT may lack adequate sensitivity to distinguish between a non-clinical sample of ACOAs and non-ACOAs. A revised ACOAT was administered. A positive relationship was found between paternal alcoholism and endorsement of items designed to measure identification with Woititz's characteristics. No correlation was found with maternal alcoholism. Major limitations of this study include the small ACOA sample size and the questionable validity of the ACOAT.

In a similar vein, Seefeldt & Lyon (1990) attempted to validate 12 of the 13 characteristics delineated by Woititz. The only unexamined characteristic was "ACOAs have difficulty with intimate relationships." Their study attempted to assess differences between non-treatment ACOAs, treatment ACOAs, and non-ACOAs. In addition, the authors attempted to discover which of Woititz's characteristics predict membership into these three groups. The subjects were 147 undergraduate students. Their status as to the various groups under examination was assessed using an instrument developed by the authors. Empirical scales were selected which appeared to measure the 12 characteristics outlined by Woititz. These instruments included the Personality Research Form (PRF),

the Responsibility and Social Adroitness scales of the Jackson Personality Inventory (JPI), and the Imposter Phenomenon Scale (IPS). T-tests for independent samples on raw scores from the PRF, JPI, and IPS were computed to determine if ACOAs were different from non-ACOAs on any of the 12 characteristics. A subgroup of students identified themselves as having participated in treatment groups for ACOAs; consequently, ANOVAs for independent samples were performed on these same scores for non-ACOAs, non-treatment ACOAs, and treatment ACOAs. A discriminate function analysis was performed using scores from the various scales as predictors of membership in each of the three groups. There were no significant differences found on any of the twelve characteristics among the various groups. Differences between ACOAs and non-ACOAs were also examined for males and females separately. These analyses produced only one significant difference. That is, female non-ACOAs scored significantly higher than the female ACOAs on the Social Recognition scale of the PRF which was chosen to measure the characteristic "ACOAs constantly seek approval and affirmation." This difference is in the opposite direction of that predicted by Woititz. Results of this study indicated that ACOAs who had sought treatment were undifferentiable from non-ACOAs and from ACOAs who had never sought treatment. A step-wise discriminate function analysis revealed that a large number of false positives were produced in which non-ACOAs were predicted as members of one of the ACOA groups. The total percentage of cases correctly classified was only 39.5%. The authors concluded that the traits believed to be characteristic of ACOAs were not more prevalent among this group than they were among non-ACOAs. They suggest that a serious reconsideration of the group referred to as "ACOA" must be undertaken. The description of the category "ACOA" is not as clear-cut as Woititz described.

Havey & Boswell (1991) also attempted to verify Woititz's characteristics in a non-clinical population of 442 undergraduate students. They hypothesized that factors

other than ACOA status, particularly degree of stress in the home, accounted for the development of certain psychological and/or emotional disorders in adults. Subjects were administered a questionnaire developed by the authors. Eighteen items were based on the 13 characteristics posited by Woititz. The effects of parental alcoholism and perceived level of stress during childhood on the subjects' perceptions of the applicability of the 13 characteristics were tested. In addition to classifying the subjects as ACOA or non-ACOA, they were classified into three groups based upon the level of perceived stress in their childhood homes. A parental alcoholism effect was found for only one of the characteristics; "I seek approval and affirmation from others," however, it was in the opposite direction of the one posited by Woititz. This finding agrees with that of Seefeldt and Lyon (1990) in which their female ACOA sample also reported less identification with this characteristic. Havey and Boswell (1991) did find that ACOAs rated the degree of stress experienced in their homes higher than did the non-ACOAs. In addition, there were main effects for stress found for five statements. An interaction effect was found for the statement "I am loyal to family and friends, even to people who don't deserve it", however, this effect appeared to be primarily due to a greater agreement with this statement by subjects classified as medium childhood stress. The authors concluded that the degree of perceived stress, rather than ACOA status, appeared to be the key variable in the subjects identification with five of Woititz's characteristics. The authors state that their results do not support the generalizability of Woititz's model to a non-clinical, college sample, but rather supports the body of research which suggests the resiliency of some COAs.

Achievement Among ACOAs

Stark (1987) states that ACOAs often look for external solutions to feel good about themselves. They may become superachievers in order to meet this need. According to El-Guebaly and Offord (1977), some ACOAs appear to compensate for

home troubles by high achievement in school. It has been maintained (Wilson & Blocher, 1990) that female ACOAs succeed remarkably well as far as outsiders can tell. They are likely to be well educated and doing well in their careers. Many ACOAs overcompensate for their difficulty in expressing feelings and establishing relationships by seeking positions of high performance work situations in order to prove themselves (Woititz & Wegscheider, cited in NIAAA, 1984). In contrast, Schumrum and Hartman (1988) found, as a result of their experience in working with ACOAs in an urban university counseling center, that these individuals exhibited personality traits that parallel the constructs put forward as components of chronic career indecision. In the population studied, many of the clients described job histories that consisted of a string of unrelated entry level positions over a number of years. The authors believe that chronic career indecision is related to the personality constructs of trait anxiety, identity confusion, and an external locus of control. They are convinced that the best subjective way to make a differential diagnosis between developmental and chronic career indecision is to ask clients to describe their experience of growing up in their families-of-origin. They claimed that ACOAs who were chronically career undecided told similar stories. In order to cope with their home environment, they withdrew to their room and engaged in solitary creative activities. This sounds strikingly similar to the description of a "lost child."

Other researchers have investigated the controversy surrounding the dichotomy between those clinicians who describe ACOAs as high-achieving and those who describe ACOAs as under-achievers. Plescia-Pikus, Long-Suter, and Wilson (1988) designed a study in which they hypothesized that well-being among ACOAs would be lower than non-ACOAs, ACOAs would be higher on achievement measures than non-ACOAs, and ACOAs would show a higher stress reaction than non-ACOAs for their most significant life stress. In order to test their hypotheses, they compared 44 ACOAs with 92 non-ACOAs. A demographic questionnaire, the Achievement via Conformance,

Achievement via Independence, and Sense of Well-being scales of the California Psychological Inventory (CPI) were administered to subjects. Factor B for intelligence from the Sixteen Personality Factor Questionnaire (16PF) as well as two different adaptations of the Impact Event Scale (IES) were also administered. Results indicated that the ACOA subjects were over-all lower in well-being and achievement via conformance than the controls. In a secondary analysis it was found that high well-being ACOAs scored higher on both measures of achievement than did the controls. In an over-all comparison, no significant difference was found between the two groups on the IES. However, in the secondary analysis, low well-being ACOAs were found to score higher on both stress intrusion and stress avoidance than non-ACOAs. High well-being ACOAs were significantly higher in both achievement via conformance and achievement via independence than low well-being controls. The high well-being ACOAs were also lower in stress intrusion. Controls with high well-being scored significantly higher on all five variables than ACOAs with low well-being. For achievement via conformance, low well-being ACOAs scored significantly lower than low well-being controls and higher than controls for stress avoidance. There was a sampling limitation to this study in that most persons who were approached agreed to participate in the research, however, a small number of individuals appeared to be uncomfortable with the subject matter and others openly refused to participate and expressed hostility. For a portion of the subjects the survey seemed to be very threatening. The researchers speculate that reasons for this include the requirement that subjects acknowledge information being denied, suppressed, or repressed. Different results might have been found if these subjects had not self-eliminated themselves from the research. Another limitation of this study is that the sampling was limited to a university population.

Despite the above limitations, a very salient finding of this study is that, although the over-all well being scores for ACOAs were lower than the non-ACOAs, those

ACOAs with high well-being scored higher on both achievement scales than did the rest of the subjects in the study. It could be that children with certain types of personality traits develop early autonomy, coping skills, and high self-esteem in spite of their negative environment. Because of this negative environment, they may tend to overcompensate via achievement. ACOAs with high well-being were not different from controls with high well-being on any of the measures. This finding bolsters the argument that they may have learned healthy coping skills even within a dysfunctional family. On the other hand, certain personality traits of other ACOAs may yield to the alcoholic environment. The results of this study support the findings of El-Guebaly and Offord (1977) who reported that ACOAs whose fathers were alcoholic but who found emotional satisfaction in their relationships with their mothers appeared to compensate for home troubles by high achievement in school.

Wolin and Wolin (1993), assert that the professions of psychiatry and psychology, as well as the self-help movement, have done a lot to alarm children from troubled families of their vulnerability but not nearly enough to inform them of their resilience. Although survivors of dysfunctional families do not escape the past totally unharmed, these authors assert that children of disturbed or incompetent parents learn to watch out for themselves and grow strong in the process. They identify seven resiliencies that helps one to rise above adversity. The resiliencies are insight, independence, relationships, initiative, creativity, humor, and morality. The resiliencies tend to cluster by personality type. Individuals with different personality characteristics tend to develop different resiliencies.

Wolin and Wolin (1993) report that in the initiative resiliency, demonstrating competence runs through the early memories of the resilient survivors they have interviewed. The authors report that "by exploring and molding the environment to their will, resilient children consolidate confidence for themselves" (p. 143). Other attributes

found in ACOAs who were free of drinking problems and leading satisfying lives were finding and building on their own strengths and deliberately and methodically improving on their parent's life-styles.

Adult Children of Alcoholics At Work

There is a marked scarcity of literature discussing career concerns of ACOAs or ways in which personality characteristics may be manifested at work. Also, little has been written about workplace behaviors believed to be common among other codependents. Since it is frequently held that every ACOA is codependent (Krois, 1987; Cermak, 1986, 1989) and that many similarities exist between ACOAs and those adults who grew up with other compulsive behaviors (Woititz, 1987), the terms "ACOA" and "Codependent" will be used interchangeably in the following review of the literature that does exist.

ACOAs As Workers

Hibbard (1987) states that occupational dissatisfaction is high among ACOAs. According to Wilson-Schaef & Fassel (1988) ACOAs have special difficulties in the workplace. In their book The Addictive Organization, these authors state that frequent characteristics of ACOAs are perfectionism, workaholism, strong need for control, and high needs for attention, encouragement, and approval. Mathews & Halbrook (1990) speculate that ACOAs constantly seek approval and affirmation from supervisors and co-workers. They say that it is no wonder Woititz (1987) found lack of recognition and feelings of inadequacy among the predominate feelings experienced on the job. This search for approval and affirmation is what Wilson-Schaef & Fassel (1988) call "impression management" and what Woititz (1987) labels the "imposter phenomenon." Mathews & Halbrook (1990) warn the reader that, due to the paucity of empirical research, their conclusions must be viewed speculatively as they are drawn primarily from clinical reports.

ACOAs As Managers

One of the narratives included in Home Away From Home (Woititz, 1987) was that of an EAP manager who described ACOAs as "awful" supervisors. He said they are demanding and do not delegate authority. They can not be pleased. Their victims are their subordinates who feel abused, confused, and ready to give up. Woititz (1987) describes ACOA supervisors as perfectionists who demand compliance from their subordinates. This leads to management styles which tend to perpetuate the alcoholic family system. Subordinates become codependent. Wilson-Schaef & Fassell (1988) describe ACOA managers as tough bosses who are difficult to work for and are driving taskmasters. Because of their high need for control, they do not delegate easily. Because of their need to be liked, they give mixed messages to employees. They have high expectations of themselves and their subordinates. Their problem is rarely with the job. It is almost always with the personnel. In addition, these authors state that a top executive or key employee has a great deal of influence and power on the whole climate of a company. Entire systems can take on the personality of the executive and be influenced by his or her behavior.

Sorrentino (1991) describes codependent managers whose constant need to be in control results in an autocratic leadership style. Managers with codependent tendencies have the compulsion to solve the problems of subordinates and to constantly seek approval for their actions. Their overzealousness for perfectionism may be viewed by the manager's department head as good, however, it may frustrate the employees because nothing can be good enough. Burnout, job dissatisfaction, staff turnover, absenteeism, and unsatisfactory performance may reflect the progression of codependency.

According to Hall (1991), the managerial role provides precisely the kind of power position that makes it possible for codependents to perpetuate the role of caretaker. Such behavior can be very damaging to the organization. It can turn the company into

another dysfunctional family. Many dysfunctional managers avoid conflict by becoming workaholics. Many companies seem to admire this trait because they know they will get their money's worth from the employee. However, workaholics are almost always unable to delegate responsibility. Staff know that s/he is never satisfied with their efforts. These managers take more interest in meddling in staffers' territory than in accomplishing substantive goals. If a dysfunctional manager were to change completely, s/he would have to adopt a new management style. Currently, there is no management development model for dealing with dysfunctional managers. Helping these managers presents a new and different problem for organizations (Hall, 1991).

Cauthorne-Lindstrom & Hrabe (1990) describe characteristics of codependency which include rigidity and perfectionism, need to control, and dependence on others for approval. They believe that codependent managers may vacillate between permissiveness and excessive control due to their struggle with the opposing impulses of control and pleasing others. Codependent managers who have a need to keep on the good side of the staff may destroy the organization's efforts to implement changes or new ideas. Staff loyalty to the organization will not exist if the manager is role-modeling ways to circumvent organizational desires and needs. These authors state that organizations are likely to have mostly enabling and hero types in the codependent manager group because they are seen as able to do the job. However, their staff may express a high degree of dissatisfaction or be underdeveloped.

The only empirical research found in the literature discussing the implications of ACOA issues for the worker is Woititz's (1987) Home Away From Home. Her study consisted of an experimental group of 248 ACOAs and a control group of 117 non-ACOAs. Included in the experimental group were those subjects who reported a parent or grandparent as alcoholic. The control group reported no alcoholism in their family. The hypothesis was that "individuals who grow up with alcoholism and those who do not

feel differently about themselves in the workplace" (p. 111). She administered a questionnaire to each subject. The questionnaire asked sex of the subject, age, address, profession, job description and salary range, bad feeling most often on job, and what family role was played. She did not say how she picked her sample; just that "it is important to discover if the data collected from a larger, random sample is consistent with the attitudes and feelings expressed by the clinical population" (p. 111). In her results, she said nothing about family roles. Woititz (1987) claimed that ACOAs are represented in all job categories, however, the numbers are skewed toward occupations that are considered stressful. She stated that 30% of the ACOAs in the experimental group reported feelings of inadequacy as their most predominant feeling on the job. The second most predominant feeling was anger. Lack of control and perfectionism were among the top seven feelings experienced. Thirty-five percent of the non-ACOAs in the control group did not report any bad feelings as opposed to 100% of the experimental group. Of those control subjects who reported a bad feeling, stress was reported most often. Only 3% of the control subjects reported feelings of inadequacy and none reported anger. Woititz (1987) also described a characteristic of ACOAs as wanting to be liked by everyone. Home Away From Home contains several testimonials in which the issues of perfectionism, need for control, and need for approval and affirmation are recurring themes.

Perfectionism and the ACOA

Perfectionism In The Workplace

Although many perfectionists are hardworking, meticulous, and thorough, their drive to excel is, at best, self-defeating (Raudsepp, 1990). It has been found that striving for perfection often decreases productivity, lowers potential earnings, impairs health, botches personal relationships at work, and results in unhealthy mood swings. Perfectionism distorts judgement and is destructive to decision making (Raudsepp, 1990).

Although employers are looking for productivity and quality in their employees, the perfectionist typically tries to go several steps beyond "the extra mile," straining unremittingly toward impossible goals. He or she takes on too much work and sets unrealistic deadlines. They may work long and hard to produce one perfect report, for example, while other work piles up. Perfectionists miss important opportunities at work and fail to make vital decisions because they are too concerned with details and believe that there is only one correct solution to a problem. Until they have found it, they resist any course of action or commitment. They hesitate to take risks or offer new ideas for fear of appearing foolish. According to Raudsepp (1990), perfectionists relate poorly to people. In addition to setting unrealistic standards for themselves, they also expect superlative performance from others. As bosses they are stern, impatient taskmasters, hypercritical and aloof and their subordinates seldom meet their exacting standards. They rarely praise subordinates or give them any recognition. With colleagues, they tend to be picky, argumentative, uncooperative, and inflexible. They rarely alter their way of doing things to accommodate others and stubbornly resist any kind of advice or constructive criticism. They are frequently lonely people who react defensively to criticism and always anticipate rejection or humiliation. Since they overreact to even a hint of criticism, they often bring about the disapproval and rejection they fear. Since they cannot reach their impossible standards, their lives are marked by chronic disappointments, low self-esteem, feelings of inadequacy, and feelings of being overwhelmed. The perfectionists behavior hurts themselves, their co-workers, and the company as a whole (Raudsepp, 1990).

Lau (1990) states that relentlessly striving for perfection can be counterproductive to the individual and the company. Lau described one study in which 3,500 corporate executives were surveyed and found that perfectionism can rob people of their energy and creative potential. The personal lure underlying perfectionism is always getting to feel

competent, in control, and being able to meet one's highest expectations of oneself. The external payoff is earning the reputation of being reliable, accurate, and thorough. Perfectionists will not attempt anything new. They will not attempt alternative methods, take risks, experiment with new ideas or seek change (Lau, 1990).

Interrelationships Between Perfectionism Dimensions and Hypothesized Characteristics of the ACOA

Historically, individual differences in perfectionism have been discussed for many years, however, only recently has there been any attempt to study this construct in an empirical fashion. As a result of recent investigations, several important findings have emerged. It has became apparent that perfectionism is associated with a host of adjustment difficulties (Hewitt, Flett, & Blankstein, 1991). Perfectionism has been linked with alcoholism, eating disorders, chronic pain, depression, obsessive-compulsive tendencies, impulsivity, suicidal behavior, narcissism, Type A behavior, irrational beliefs, and various personality disorders (Flett, Hewitt, Blankstein, & Dynin, in press; Flett, Hewitt, Blankstein, & Koledin, 1991; Hewitt & Flett 1993, in press; Hewitt et al., 1991; Hewitt, Flett, & Turnbull, 1992; Hewitt, Flett, & Turnbull-Donovan, 1992).

A group of researchers have completed numerous empirical studies in order to investigate the perfectionism construct. As a result of the findings of these studies, the investigators contend that perfectionism is a multidimensional construct. Although perfectionism includes an intrapsychic component, it also consists of interpersonal aspects that are important in adjustment difficulties (Flett, Blankstein, Hewitt, & Koledin, 1992; Flett, Hewitt, Blankstein & Koledin, 1991; Flett et al., in press; Flett, Hewitt, Blankstein, & O'Brien, 1991; Flett, Hewitt, & Dyck, 1986; Hewitt & Flett, 1990; Hewitt & Flett, 1991a, 1991b; Hewitt & Flett, 1993, in press; Hewitt et al., 1991; Hewitt, Flett, & Endler, in press; Hewitt & Genest, 1990; Hewitt, Flett, & Turnbull, 1992; Hewitt, Flett, & Turnbull-Donovan, 1992; Hewitt, Mittelstaedt, & Flett, 1990).

Self-oriented perfectionism (SOP) involves self-directed behaviors such as setting exacting standards for oneself and stringently evaluating and censuring one's own behavior. Recurrent and persistent dissatisfaction with themselves leaves perfectionists feeling unrelenting distress which expresses itself in varying forms such as depression, performance anxiety, social anxiety, procrastination, and study ineffectiveness (Halgin & Leahy, 1989; Hewitt & Flett, 1991b). Individuals with perfectionistic standards and motives for themselves endorse an irrational belief that it is very important to be thoroughly competent and achieving in all respects. They typically have a low frustration tolerance stemming from the belief that it is catastrophic when things are not exactly like they want it to be (Flett, Hewitt, Blankstein, & Koledin, 1991). Flett et al. (in press) found that there is a significant association between SOP and Type A achievement strivings. Type A behavior is characterized by competitiveness, aggressiveness/hostility, speed, and impatience. These descriptions of the self-oriented perfectionist are remarkably similar to those descriptions of ACOAs who are hypothetically characterized by low self-esteem, depression, feelings of inadequacy, stress related medical disorders, and compulsive achieving.

Another dimension of perfectionism involves beliefs and expectations toward others. The other-oriented perfectionist has unrealistic standards for significant others, places importance on other people being perfect, and stringently evaluates others' performance. Other-oriented perfectionism should lead to other-directed blame, lack of trust, and feelings of hostility towards others. It is related to interpersonal frustrations such as cynicism and loneliness and to marital and/or family problems. Other-oriented perfectionism may also be associated with desirable attributes such as leadership ability and facilitating others' motivation (Hewitt & Flett, 1991b). Flett, Hewitt, Blankstein, and Dynin (in press) completed two studies designed to investigate the relationships between dimensions of perfectionism as measured by the Multidimensional Perfectionism Scale

and various measures of Type A behavior. Analyses of the data from study one revealed that OOP was associated with impatience and irritability for males whereas results of study two indicated that OOP was correlated with components of Type A behavior such as competitiveness and hostility in both males and females. The authors state that Type A individuals possibly generate much conflict and hostility in their lives by having overly high expectations of others. "This extrapunitive behavior may lead to difficult interpersonal relationships and may underscore recent indications that Type A individuals are characterized by more dysfunctional relationships and an inappropriate tendency to control others in social situations" (p. 13). Hewitt, Flett, and Turnbull (1992) conducted a study in which they examined the association between perfectionism dimensions and personality disorders using the personality disorder subscales of the Minnesota Multiphasic Personality Inventory. It was found that OOP was correlated with narcissism at the .001 level of significance. The characteristics of the other-oriented perfectionist appear to parallel those ACOAs who are described as angry individuals who are demanding of others and fail to delegate authority.

Socially prescribed perfectionism involves perceptions of one's need to attain the standards and expectations prescribed by significant others. The essence of SPP is the belief that others have unrealistic standards for one's behavior and that others will be satisfied only when these standards are attained. The standards imposed by significant others are perceived as being excessive and uncontrollable. SPP is a social-cognitive variable that involves an external locus of control and a sense of hopelessness about the inability to please others. It involves failure experiences and negative emotional states such as anger, anxiety, and depression. Socially prescribed perfectionists tend to exhibit a great fear of negative evaluation and strong needs for approval from significant others (Hewitt & Flett, 1991a; 1991b; Hewitt, Flett, & Turnbull-Donovan, 1992). Flett, Hewitt, Blankstein & Koledin (1991) found SPP to be significantly correlated with high self-

expectations, demand for approval, dependency, blame proneness, and anxious overconcern as measured by the Irrational Beliefs Test. In a sample of 41 male and 46 female in-patients and out-patients of the Brockville Psychiatric Hospital, Hewitt Flett, and Turnbull-Donovan (1992) found that SPP was related significantly to increased levels of suicide potential as measured by the MMPI Threat Suicide Scale. These findings are in accordance with other findings which show that levels of SPP are elevated in patients with psychiatric diagnoses such as major depressive disorder and borderline personality disorder. In another study, SPP was found to be associated with high levels of achievement, impatience, and competitiveness (Flett et al., in press). Hewitt, Flett, and Turnbull (1992) found SPP to be correlated positively with the paranoid, schizotypal, and antisocial subscales of clusters 1 and 2 and with all cluster 3 subscales (avoidant, compulsive, dependent, passive aggressive) of the MMPI personality scales. The strongest correlation (.55, $p < .001$) was found between SPP the paranoid subscale. There was a correlation of .39 ($p < .001$) with the dependent subscale. These findings provide support that individuals high in SPP have a marked need for affection and social approval. In a sample of 103 university undergraduates, Flett, Hewitt, Blankstein, & O'Brien (1991) found SPP to significantly associated with depression and low self-esteem. SPP has been found to be related to a poor problem solving orientation, impulsivity, and procrastination (Flett et al., 1992; Hewitt and Flett, in press). An overview of the characteristics found to be involved in SPP reveal an amazing congruence with the descriptions of depression, impulsivity, strong needs for approval and affirmation from others, anxiety, and low self-esteem espoused as representative of ACOAs.

Chapter Summary

Presented in this chapter was a review of the literature pertinent to this study. The clinical literature cited in this chapter indicates that there are many negative consequences

of being reared in an alcoholic family. Other literature presents a divergent view in that ACOAs are described as being resilient with many strengths developed as a result of their upbringing. The literature suggests that adult children of alcoholics demonstrate both negative and positive behaviors at work. Empirical studies are few with many conflicting findings. Research concerning perfectionism was reviewed with a special emphasis on the interrelationships between the personality characteristics of perfectionists and those characteristics believed to be descriptive of ACOAs. In addition, the parallels between perfectionistic behavior in the workplace and behaviors believed to be typical of ACOAs at work was discussed.

CHAPTER III

METHODOLOGY

The methods and procedures utilized in the study are presented in this chapter. The chapter is divided into the following sections; subjects and procedure instrumentation, design, and analysis of data.

Subjects and Procedure

The participant pool consisted of all employees of one plant of a large manufacturing corporation in the southwestern United States. The total number of employees was 1213. Altogether 147 persons participated: 96 males and 50 females. One person did not report gender (see Table 1). Forty-four identified adult children of alcoholics (ACOAs) and 103 non-ACOAs participated in the study. Sixty-eight of the participants were managers and 74 were not, with five persons not reporting occupational classification (see Table 1). Among the ACOA participants, 34 had problem drinking fathers, three had problem drinking mothers, and seven persons reported that both of their parents were problem drinkers (see Table 1). Participants' ages ranged from 16 to 63 years with a mean age of 37.8 years. Two persons did not report age. Ages of the ACOA participants at the onset of parental problem drinking ranged from infancy to 20 years with a mean age of 5.3 years. Four persons did not report age at the onset of parental problem drinking (see Table 2). The educational level of the participants' parents ranged from less than high school to completion of a graduate or professional degree with a mean educational level of 2.2 (means reflect coding; see Table 3). A description of each group is presented below.

Adult Children of Alcoholic Managers

The sample of ACOA managers consisted of six females and 12 males. Participants' ages ranged from 20 to 51 years with a mean age of 39.6 years. Age of the participants when parental problem drinking began ranged from infancy to 12 years with a mean age of 5.23 years (see Table 2). The educational level of participants' parents ranged from less than high school to completion of a graduate or professional degree with the mean educational level of the fathers 2.22 and of the mothers 2.28 (see Table 3).

Adult Children of Alcoholic Non-Managers

The sample of ACOA non-Managers was composed of nine females and 16 males. The sample ranged in age from 16 to 52 years with a mean age of 32.1 years. Age of the participants when parental problem drinking became a problem ranged from infancy to 20 years with a mean age of 5.32 (see Table 2). Educational level of the parents ranged from less than high school to completion of a graduate or professional degree with the mean paternal educational level of 1.94 and the mean maternal educational level of 2.08 (see Table 3).

Non-Adult Children of Alcoholic Managers

The sample of non-ACOA managers consisted of 15 females and 34 males with one person not reporting gender. Ages ranged from 22 to 63 years with a mean age of 39.5 years (see Table 2). Again, parental educational level ranged from less than high school to completion of a graduate or professional degree with a mean paternal educational level of 2.22 and a mean maternal educational level of 1.98 (see Table 3).

Non-Adult Children of Alcoholic Non-Managers

The sample of non-ACOA non-managers was composed of 20 females and 29 males. Participants' ages ranged from 20 to 40 years with a mean age of 38.3 years (see Table 2). Parental educational level ranged from less than high school to completion of a

graduate or professional degree. The mean educational level of the fathers was 2.16 and the mothers was 2.10 (see Table 3).

The researcher initially mailed a research packet to the home address of all members (1213) of the participant pool. Enclosed in each packet was a letter from the researcher explaining the nature of the study and instructions for completing the research protocol, an information sheet explaining the nature of the study and ensuring confidentiality and anonymity, an informed consent form, the Demographic Information Sheet, the Children of Alcoholics Screening Test, and the Multidimensional Perfectionism Scale.

As per instructions on the informed consent form, employees were asked to sign and date the consent form, returning it separately from the research packet. They were asked to keep the information sheet. After signing consent forms, participants completed the remaining sections of the research packet. The Demographic Information Sheet was presented first followed by the research instruments presented in a counterbalanced order. Participants were asked to return the packets within two weeks.

One hundred and twelve persons (9%) returned completed packets via mail to Oklahoma State University Mailing Services in postage prepaid, self-addressed envelopes which were forwarded to the researcher. Four weeks after the first mailing, a second research packet was mailed to 500 randomly selected persons among the 1101 non-respondents. Again, they were asked to return the packets within two weeks. Thirty-five persons returned completed packets. This equals a response rate of 7% for the 500 persons who received second packets and an overall response rate of 3% for the initial 1101 non-respondents. Although the response rates for the first and second mailings were relatively consistent (9% and 7% respectively), the total response rate (9% and 3%) was only 12%.

The nature of this study resulted in several specific sampling difficulties which should be considered. First, the participant population was composed of corporate employees. Although every effort was made to assure persons that their responses would be anonymous and confidential, an apprehensiveness seemed to exist related to the employees' job security. In fact, the researcher received several telephone calls from potential participants inquiring as to how their name was obtained. Consequently, this factor appeared to negatively influence the response rate.

Another sampling difficulty encountered was the sensitive nature of the focus of the study. The researcher proposes that admission of alcoholism is a phenomenon generally found to be a delicate subject among most Americans. In addition, it is claimed (Brown, 1988; Robinson, 1989) that denial is a salient component of alcoholic family systems. This factor, interacting with concerns about job security, most likely contributed to the low response rate.

Table 1

Demographic Information by Group

Demographic Information	Subjects		
	ACOAs n=44	Non-ACOAs n=103	Total N=147
Gender			
Male	29	67	96
Female	15	35	50
Occupational Classification			
Manager	18	50	68
Non-Manager	25	49	74
Parent With Drinking Problem			
Father	34		
Mother	3		
Both	7		

Note. Totals reflect the fact that not all subjects completed all items. ACOAs = Adult children of alcoholics.

Table 2

Means, Standard Deviations, and Ranges for Ages of Subjects and Ages of ACOAs When Parental Problem Drinking Began

Group	Mean	SD	Range	n
Age in Years				
ACOA Managers	39.6	7.6	20-51	18
ACOA Non-Managers	32.1	10.2	16-52	25
Non-ACOA Managers	39.5	9.7	22-63	49
Non-ACOA Non-Managers	38.3	11.8	20-40	48
Age of ACOA when parental problem drinking began				
Managers	5.2	4.3	0-12	18
Non-Managers	5.3	4.8	0-20	22

Note. ACOAs = Adult children of alcoholics.

Table 3

Means, Standard Deviations, and Ranges for Educational Level of Subjects' Parents

Group	Mean	SD	Range	n
Fathers				
ACOA Managers	2.2	1.4	1-5	18
ACOA Non-Managers	2.0	1.0	1-5	25
Non-ACOA Managers	2.2	1.2	1-5	50
Non-ACOA Non-Managers	2.2	1.0	1-5	49
Mothers				
ACOA Managers	2.3	1.3	1-5	18
ACOA Non-Managers	2.1	1.1	1-5	25
Non-ACOA Managers	2.0	.8	1-5	50
Non-ACOA Non-Managers	2.1	1.0	1-5	49

Note. Educational level was coded as follows: 1 = Less than high school, 2 = High school or GED, 3 = Two year college or vocational degree, 4 = Four year college degree 5 = Graduate or professional degree. ACOA = Adult child of an alcoholic.

Instrumentation

Each subject completed a research protocol consisting of the following: A Demographic Information Sheet (DIS), the Children of Alcoholics Screening Test (CAST), and the Multidimensional Perfectionism Scale (MPS). With the exception of the Demographic Information Sheet which was presented first, the instruments were counterbalanced in order of presentation.

Demographic Information Sheet

A Demographic Information Sheet was utilized in this study in order to provide a descriptive profile of the subjects in the sample. The DIS consisted of questions designed to gather general demographic information as well as information concerning the variables of interest to this study. General characteristics representing the profile included: age, gender of subject, parental educational level in the family-of-origin, and subject occupational status. Subjects were asked if they believe they have, or have had, an alcoholic parent. If they answered in the affirmative, they were asked the gender of the alcoholic parent(s) and their age at the onset of parental problem drinking.

Children of Alcoholics Screening Test

The Children of Alcoholics Screening Test (CAST) is a 30-item self report inventory developed by Jones (1983a). The primary goal of the CAST is to aid in the identification of "at risk" children of alcoholics in schools and clinics so that children of alcoholics (COAs) can receive appropriate preventive and/or remedial intervention services (Jones, 1983a).

In constructing the CAST, Jones (1983a) formulated items derived from real-life experiences that were shared with him by children of clinically diagnosed alcoholics who were in treatment at a Chicago based family alcoholism treatment center. Additional items were constructed from published case studies on COAs. This resulted in 30 items designed to measure children's attitudes, feelings, perceptions, and experiences related to

their parents' drinking behavior. All items were judged to be face valid by both alcoholism counselors and adult children of alcoholics (Jones, 1983a).

Reliability. To assess the reliability of the CAST, a Spearman-Brown split-half (odd vs. even) reliability coefficient was computed with three samples. The first sample consisted 82 latency-age and adolescent children of alcoholics. The second sample consisted of 133 latency-age and adolescent COAs. The subjects for the two samples were randomly selected from a Chicago school system. The resulting reliability coefficient was .98 (Jones, 1982). The Spearman-Brown (odd-even, split-half) formula was calculated with a sample of 81 adults residing in Chicago. The resulting coefficient was .98. Although the CAST possesses adequate internal consistency, there are no studies reported in the test manual assessing the reliability of this instrument over time.

Validity. Jones (1982) used the method of contrasting groups in two studies designed to demonstrate the validity of the CAST. In the first study, the author anonymously administered the CAST to 82 latency-age and adolescent children of clinically-diagnosed alcoholics, 15 self-reported COAs, and 118 randomly selected control group children. An analysis of variance showed that the clinically diagnosed and self-reported COAs scored significantly higher ($p < .0001$) on the CAST compared to the controls. Chi-square analyses showed that all 30 CAST items significantly discriminated COAs from control children. The two COA groups did not reliably differ in their total CAST scores, consequently, the author grouped these subjects into an overall children of alcoholics group. The 118 control group subjects were scored as a one and the 97 COAs were scored as a two. Correlating these group scores with the total CAST scores yielded a validity coefficient of .78 ($p < .0001$). Jones (1982) found that a cutoff score of six or more "yes" answers reliably identified COAs. The author found that 100% of the COA group scored six or above on the CAST as compared to 23% of the control group. As a result of this study, Jones (1982) suggested that a CAST score of 0 indicates no parental

alcoholism while a score of 1 might suggest parental problem drinking. Scores of 2 to 5 indicate parental problem drinking or, possibly, alcoholic drinking. A score of 6 or more indicates parental alcoholism.

In the second study, Jones (1983b) administered the CAST to 81 adults. Five subjects reported that one or more of their parents had received treatment for alcoholism. These adults formed the ACOA group. The author compared the ACOA group scores with scores of the control group which was comprised of the other 76 adults who reported no parental alcoholism treatment. He found that the ACOA group scored significantly higher ($t = 2.5$, $p < .01$) than the controls. The 81 subjects also reported how much alcohol they observed their parents consume in a typical week and how many days a week their parents usually drank. Jones (1983b) found significant positive correlations ($r = .63$, $p < .01$) between the subjects' total CAST score and the total number of alcoholic drinks their parents consumed in a typical week. A significant positive correlation ($r = .42$, $p < .01$) was also found between the subjects' total CAST scores and the total number of days that both parents were observed consuming alcohol in an average week (Jones, 1983b).

Multidimensional Perfectionism Scale

The Multidimensional Perfectionism Scale (MPS) was developed by Hewitt and Flett (1991b). Previous measures of perfectionism focused exclusively on self-directed cognitions. Hewitt and Flett (1991b) contended that the perfectionism construct also has interpersonal aspects which are important in adjustment difficulties. As a result of their contention, they developed the MPS which is designed to measure self-oriented perfectionism (unrealistic standards and perfectionistic motivation for the self), other-oriented perfectionism (unrealistic standards and perfectionistic motivation for others), and socially prescribed perfectionism (the belief that significant others expect oneself to be perfect). The primary difference among these dimensions is not the behavior pattern

per se, but the object to whom the perfectionistic behavior is directed (Hewitt & Flett, 1991b; Hewitt, Flett, Turnbull-Donovan, & Mikail, 1991).

The authors used the construct validation approach in constructing the MPS. Descriptive passages reflecting the three perfectionism dimensions were derived from case descriptions and theoretical discussions. These descriptions were presented to a graduate student and three undergraduate students at York University, North York, Ontario, Canada. These students were asked to generate items that could be rated for agreement. This process resulted in 162 items which were corrected for clarity. Duplicate items were deleted and some items were rephrased in order to be reverse keyed. This resulted in a total of 122 potential items that could be rated for agreement on a 7-point scale. Psychology students at York University (52 men and 104 women) were administered the items with instructions to rate them on the 7-point Likert scale. Subjects also completed the Marlowe-Crowne Social Desirability Scale as a control for the response bias of social desirability. An item was selected if it had a mean score between 2.5 and 5.5, a correlation of less than .40 with its respective subscale, a correlation of less than .25 with the other subscales, and a correlation of less than .25 with social desirability. These criteria resulted in the 45-item MPS with three subscales of 15 items each designed to measure the three dimensions of perfectionism. Means and standard deviations for each subscale were computed (SOP $\underline{M}$ = 65.27, SD = 14.01; OOP $\underline{M}$ = 53.38, SD = 12.55; SPP $\underline{M}$ = 48.17, SD = 12.88). Higher scores reflect greater levels of perfectionism. The only gender difference was in OOP with men scoring higher than women ($\underline{t}$ = 2.57, $\underline{p}$ < .01). Item-to-subscale total correlations were computed on each item and ranged between .51 and .73 for self-oriented items, .46 and .64 for other-oriented items, and .45 and .71 for socially-prescribed items. The coefficient alphas were .86 for SOP, .82 for OOP, and .87 for SPP. Intercorrelations among the MPS subscales ranged between .25 and .40 indicating some degree of overlap. Additional analyses

showed that SOP was not correlated with social desirability. Although small, significant negative correlations were found between social desirability and OOP ($r = -.25$, $p < .05$) and SPP ($r = -.39$, $p < .01$). Results of this study indicate that the perfectionism dimensions have adequate internal consistency and that the subscales are relatively distinct (Hewitt & Flett, 1991b).

Reliability. Reliability of the MPS was assessed with a non-clinical sample of 104 York University students (33 men and 71 women) who completed the MPS and personality and psychopathology measures. Thirty-four randomly selected subjects completed the MPS at Time 1 and 3 months later at Time 2. Test-retest reliabilities were .88 for SOP, .85 for OOP, and .75 for SPP (Hewitt & Flett, 1991b). In order to demonstrate test-retest reliability of the MPS in a clinical sample, Hewitt, Flett, Turnbull-Donovan and Mikail (1991) conducted a study in which they administered the MPS to a sample of 49 psychiatric outpatients (19 men and 30 women) of the Brockville Psychiatric Hospital, Brockville, Ontario, Canada. Subjects completed the MPS initially then were retested three months later. The respective correlations were .69, .66, and .60 for SOP, OOP, and SPP. These results corroborated previous findings that levels of perfectionism are relatively stable in both a clinical and non-clinical sample.

Validity. In order to assess the validity of the different dimensions of perfectionism, factor-analytic techniques were employed in a study of 1,106 university students (399 men and 707 women) from York University and 263 psychiatric patients (121 men and 142 women) from the Brockville Psychiatric Hospital. In addition, validity of the three dimensions was assessed by determining the degree to which others could rate the level of perfectionism in target individuals. The MPS was administered to the subjects. A subset of 25 target subjects from a fourth-year psychology class completed the MPS. They were then asked to have someone they knew well fill out the MPS. Instructions were altered for the significant others by asking them to complete the MPS as

they believed the subject would. Clinician ratings were obtained for a subset of 21 psychiatric outpatients. Three clinical psychologists and one psychometrist were given rating forms and detailed descriptions of the perfectionism dimensions. They were asked to rate their own therapy patients on the dimensions; then they were asked to administer the MPS to those patients. Ratings were done on an 11-point scale to enable fine discriminations. In the student sample, there were no gender differences in mean scores on the three subscales. Alpha coefficients were calculated resulting in .89 for SOP; .79 for OOP; and .86 for SPP. A principal-components factor analysis was performed on item responses. A subsequent scree test confirmed that three factors should be retained, accounting for 36% of the variance. The first factor included all 15 SOP items with factor loadings ranging between .45 and .66. The second factor included all 15 SPP items with loadings ranging between .39 and .63. The third factor was made up of 13 OOP items with loadings ranging between .38 and .63. The other two items for the OOP subscale had factor loadings of .24 and .32 on the third factor but had slightly higher loadings on the second factor. In the subscale means for the psychiatric sample, men had higher OOP scores than women ($t = 3.02$, $p < .01$). No other gender differences were found. Alpha coefficients were .88 for SOP, .74 for OOP, and .81 for SPP. Factor-analysis of this data again revealed that the factors accounted for 34% of the variance. Following rotation, 14 of the 15 SOP items loaded highest on the first factor (.36 to .77), with the remaining item loading highest on the third factor. Fourteen items of the SPP subscale loaded highest on the second factor (.32 to .63), with one item loading higher on the third factor. Ten OOP items loaded highest on the third factor (.33 to .60). The remaining OOP items loaded on the first and third factors. In order to determine whether the factor structure was similar for the two samples, a test of the factor structure's replicability was performed by computing the coefficient of congruence. The coefficients

were .94 for SOP, .93 for SPP, and .82 for OOP which indicates that the factor structure was highly similar across the two samples.

Correlations were calculated between the student targets and the MPS scores supplied by the observers. The respective correlations were SOP $r = .35$, $p < .05$; OOP $r = .47$, $p < .01$; and SPP $r = .49$, $p < .01$. Significant correlations were not obtained when correlations were computed between the measures not tapping the same dimension. Further analyses revealed that the correlations between clinician ratings and MPS scales were significant for SOP ($r = .61$, $p < .01$), OOP ($r = .43$, $p < .05$) and SPP ($r = .52$, $p < .01$). Again, significant correlations were not obtained between measures not tapping the same dimension.

In addition to providing normative data, results of this study showed that there are few gender differences in mean levels of perfectionism, with the exception of OOP being higher in men with severe adjustment problems. Also, this study showed that the subscales have an adequate degree of internal consistency. More important, the results provided support for the hypothesized dimensionality of the MPS. The MPS was found to have three underlying factors in both clinical and nonclinical samples. The results involving observer ratings confirmed that levels of SOP, OOP, and SPP are observable to others indicating that perfectionism is salient in interpersonal contexts (Hewitt & Flett, 1991b).

Convergent and discriminant validity of the MPS were assessed by administering numerous measures related to self and socially related behavior to three samples of students at York University. Sample 1 consisted of 104 students (33 men and 71 women) who completed the following personality measures: the MPS, Attitudes Toward Self Scale, Self and Other-Blame Scale, Fear of Negative Evaluation Scale, Irrational Beliefs Test, Locus of Control Scale, Symptom Checklist 90-Revised, and a measure of Academic Standards. Sample 2 consisted of 93 students (29 men and 64 women) who

completed the MPS and The Narcissistic Personality Inventory. Sample 3 consisted of 45 female students who completed the MPS, The Authoritarianism Scale, and The General Population Dominance Scale. It was found that SOP was correlated significantly with self-related measures such as high self-standards, self-criticism, and self-blame. SOP was not found to be correlated with demand for approval of others, fear of negative evaluation, locus of control, authoritarianism, dominance, or other-directed blame. These results support the discriminate validity of this subscale. The SOP subscale was not correlated significantly with measures of minimum or ideal self-standards, however, a gender difference was found in that SOP and minimum self-standards were correlated for women but not for men. SOP was correlated significantly with self-importance of performance and self-importance of goal attainment. There were no significant correlations between the self-measures and OOP or SPP. Positive correlations were found between OOP and other-blame, authoritarianism, and dominance. There were significant correlations between OOP and high standards and self-criticism. SPP was correlated significantly with measures of demand for approval from others, fear of negative evaluation, and locus of control. Although SPP was associated significantly with self-criticism, overgeneralization of failure, self-blame, and other-blame, it was not correlated significantly with high self-standards, authoritarianism, or dominance. Significant correlations were also found between SPP and minimum social standards, ideal social standards, and the social importance of goal attainment. This subscale was not correlated with any of the self-standard or self-importance measures. SOP and OOP were found to be correlated with narcissism. SOP was correlated with overall narcissism, authority, and entitlement. Significant correlations were also found between OOP and overall narcissism, authority, exploitativeness, and entitlement. SPP was not correlated with any of the narcissism measures. The correlations between SOP and the SCL-90 showed that all of the symptom scales were correlated significantly. OOP was correlated

significantly only with the phobic anxiety and paranoia subscales. A gender difference was found, with OOP in men correlating with obsessive-compulsiveness, interpersonal sensitivity, anxiety, hostility, phobic anxiety, and paranoia. There were no significant correlations between OOP and SCL-90 measures for women. The SPP subscale was correlated moderately with all of the SCL-90 subscales (Hewitt & Flett, 1991b).

Hewitt and Flett (1991b) provided further evidence of the validity of the MPS in a study of 91 undergraduate students (34 men and 57 women). The authors hypothesized that SOP should be related to guilt and disappointment and that SPP should be related to anger. A further goal of this study was to assess the role of response biases in perfectionism. The subjects completed the MPS, the Multidimensional Anger Inventory (MAI), the Problem Situation Questionnaire (PSQ), the Burns Perfectionism Scale (BPS), and a measure of impression management; the Other-Deception Questionnaire (ODQ). Significant correlations were obtained between SOP and guilt, disappointment, and anger. SPP was correlated with anger, shame, and guilt. OOP was not correlated significantly with any of the emotion measures. Women tended to show slightly higher correlations between SPP and regret, disappointment, and guilt, however, these correlations were not significant. The BPS correlated most strongly with SOP, however, it was also correlated with OOP and SPP. The only correlation approaching significance between the ODQ and the MPS was the SPP subscale; however, greater SPP was associated with less impression management. Thus, the three dimensions of perfectionism do not appear to be strongly influenced by response bias. Evidence of concurrent validity was obtained in that all three subscales of the MPS were significantly correlated with the BPS. As predicted, the largest correlation was with the SOP subscale.

Hewitt and Flett (1991b) completed an additional study designed to test the hypothesis that perfectionism is correlated significantly with certain personality disorders in psychiatric patients. A second goal of this study was to examine how individual

differences in perfectionism relate to Axis I disorders of the Diagnostic and Statistical Manual of Mental Disorders (Third Edition, Revised (DSM-III-R; American Psychiatric Association, 1987). Subjects were 77 adult psychiatric patients (39 men and 39 women) from the Brockville Hospital. This subject pool included 31 inpatients and 46 outpatients. Subjects were administered the MPS and the Millon Clinical Multiaxial Inventory (MCMI) in random order. There were no significant correlations between SOP any of the MCMI subscales for the total sample. Although direct tests found that there were no gender differences in the strength of the correlations, it was found that SOP was correlated positively with paranoia for men ($r = .40$, $p < .05$) and negatively with the schizotypal subscale for women ($r = -.34$, $p < .05$). There was a marginally significant correlation ($p < .10$) between SOP and dependency for men. OOP was correlated positively with the histrionic, narcissistic, and antisocial subscales and negatively correlated with the schizotypal subscale. As to gender differences, OOP was not correlated with any basic personality patterns for men. For women, however, OOP correlated positively with the "dramatic cluster" disorders and was negatively correlated with the schizoid, avoidant, and schizotypal subscales. SPP correlated positively with the schizoid, avoidant, passive-aggressive, schizotypal, and borderline subscales but correlated negatively with the compulsive pattern. There were no gender differences found for these correlations. SOP correlated significantly with somatoform symptoms, hypomania, and alcohol abuse. Men demonstrated positive correlations between SOP and alcohol and drug abuse. Among women, greater SOP was associated with greater hypomanic symptoms and reduced psychotic thinking. OOP was significantly correlated with hypomania and drug abuse. There were no gender differences. SPP was correlated positively with all of the clinical symptom syndromes with the exception of drug abuse and psychotic delusions. The largest correlations were obtained with dysthymia, anxiety, and psychotic depression. A gender difference was evident in that women showed a

significant positive correlation between SPP and alcohol abuse whereas men showed a nonsignificant correlation. Hewitt and Flett (1991) state that these findings clearly demonstrate that the interpersonal dimensions of perfectionism are important in severe psychopathology.

After developing the MPS and conducting reliability and validity studies in a nonclinical sample, Hewitt, Flett, Turnbull-Donovan, and Mikail (1991) completed additional research in order to establish normative data for clinical subjects as well as demonstrating concurrent validity of the MPS subscales in a clinical population.

Several samples were used in the first research project in order to establish normative data. The first sample was comprised of 387 patients (194 men and 193 women) from the Brockville Psychiatric Hospital (223 outpatients and 164 inpatients). Two other samples used to establish normative data included 34 male spouse abusers, 399 chronic pain patients (213 men and 186 women), and 199 subjects (100 men and 99 women) recruited from a large urban city and surrounding rural area. All subjects were administered the MPS along with other personality measures. The means and standard deviations obtained did not differ as a function of inpatient versus outpatient status, however, there were gender differences in the psychiatric patient group. Men had higher OOP scores whereas women had higher SPP scores. Men from the community sample were also higher on OOP than were women. No gender differences were found in the chronic pain patients. Overall, it appeared that higher levels of SPP are associated with more severe forms of psychopathology. The highest SPP scores were reported by inpatients. The means obtained for SOP and OOP did not differ substantially across the various groups.

The second study was undertaken to establish concurrent validity. The subjects were 60 psychiatric patients (35 men and 25 women) from the Brockville Psychiatric Hospital. There were 36 outpatients and 24 inpatients. The most frequent diagnoses,

made according to the DSM-III-R, were schizophrenia, alcoholism, depression, and adjustment disorders. All subjects completed the MPS, Burns Perfectionism Scale (BPS), Attitude Toward Self Scale (ATSS), Frost Multidimensional Perfectionism Scale (FMPS), Marlowe-Crowne Social Desirability Scale (MCSDS), and the Balanced Inventory of Desirable Responding (BIDR). Correlations were calculated between the MPS subscales and the other measures. Using the Bonferroni procedure, only correlations with $p < .001$ were considered significant. The findings revealed that SOP was related to various measures of self-related behavior in the total sample. Significant correlations were obtained between SOP and the ATSS measures of high self-standards, self-criticism, overgeneralization, and perseveration. It was also correlated with the BPS and the Concern Over Mistakes, Personal Standards, and Parental Expectations on the FMPS. For the total sample, OOP was correlated with only the Personal Standards subscale of the FMPS, however, there was a positive correlation between OOP and the BPS for men and the Parental Expectations subscale of the FMPS for women. Overall, SPP was correlated with the FMPS Parental Expectations and Parental Criticism subscales. SPP was also significantly correlated with the remaining Self-Punitive measures with the exception of the Organization subscale of the FMPS. As for response biases, none of the MPS subscales were correlated with Impression Management or Social Desirability. Gender differences were also assessed with only three correlations differing significantly. SOP and ATSS Self-Criticism was greater for women than men as was SOP and ATSS Overgeneralization. Finally, the correlation between SPP and FMPS Parental Expectations was greater for women than men (Hewitt, Flett, Turnbull-Donovan, & Mikail, 1991).

Design

This study was correlational in nature. The independent variables were adult children of alcoholic status (ACOA or non-ACOA), and occupational classification

(manager or non-manager). The dependent variables were self-oriented, other-oriented, and socially prescribed perfectionism. This resulted in a multivariate 2 x 2 factorial design. Among the ACOA sample, relationships among the demographic variables of interest to this study (parental educational level in the family-of-origin, gender of the ACOA, gender of the alcoholic parent(s), and age of the ACOA when parental problem drinking began) and the dependent measures were investigated.

Analysis of Data

Since the literature suggests that there are possible relationships between being an adult child of an alcoholic (ACOA) and various behavioral correlates, a 2 x 2 multivariate analysis of variance (MANOVA) was conducted in order to determine if any differences existed between groups on any linear combination of the dependent variables. The independent variables were adult children of alcoholic status (ACOA or non-ACOA) and occupational classification (Manager or non-Manager). The dependent variables were Self-Oriented Perfectionism (SOP); defined as the tendency to have perfectionistic standards for the self; Other-Oriented Perfectionism (OOP); defined as the tendency to have perfectionistic standards for significant others; and Socially Prescribed Perfectionism (SPP), defined as the perception that other people have unrealistically perfectionistic standards for the self. When a research participant did not complete an item on the dependent measure, the midpoint of the scale for that item was substituted for missing data. In order to correct for unequal n's, the method of unweighted means was utilized. This method is recommended for proportional factorial designs in which sample size reflects differences in the size of the underlying populations. This method allows the researcher to provide an unbiased estimate of the combined mean (Stevens, 1986). The data matrix contained four cells with three scores per subject.

For the ACOA sample, the relationships among variables of interest to this study (parental educational level, gender of the ACOA, gender of the alcohol parent(s), age of

the ACOA when parental problem drinking began) were evaluated via correlation coefficients and Hotelling's T^2. A .05 level of statistical significance was utilized for all analyses.

CHAPTER IV

RESULTS

Introduction

This chapter presents a discussion of individual and preliminary analyses used to test the seven null hypotheses. Procedures employed to test adherence to the assumptions underlying MANOVA (independence of observations, normality of the dependent measures, homogeneity of the variance-covariance matrices) are described. This chapter concludes with a summary of the results of the main analyses.

Preliminary Analyses

Admission of Parental Alcoholism

In order to assess the research participant's recognition of parental alcoholism, a Biserial correlation coefficient was computed between the scores obtained by subjects on the Children of Alcoholics Screening Test (CAST) and answers to question five (Do you believe you have, or have had, a parent with a drinking problem?) on the Demographic Information Sheet (DIS). The analysis indicated that the ACOA participants did recognize that their parent(s) had a drinking problem, $r = .887$, $p < .000$.

Consistency of Admission of Parental Alcoholism

In order to assess the consistency of the subject's admission of a parental drinking problem, a Phi coefficient was computed between answers to question one on the CAST (Have you ever thought that one of your parents had a drinking problem?) and answers to question five on the DIS. The analysis indicated that the subjects were consistent in their admission of parental alcoholism, $r = .936$, $p < .000$.

Independence of Observations

Research packets were individually mailed to the home address of each member of the subject pool. According to Glass and Hopkins (cited in Stevens, 1986), whenever the treatment is individually administered, observations are independent. Although it was impossible to determine if any participants discussed their answers with other respondents, it is reasonable to conclude that this assumption was upheld.

Normality of the Dependent Measures

Probability plots were examined for each dependent variable. All distributions were normally distributed. According to Stevens (1986), multivariate normality is likely to be detected by examining the univariate normality of the observations on each dependent variable. Therefore, it is reasonable to conclude that this assumption was upheld.

Analysis of Homogeneity

In order to test the assumption of homogeneity of variance-covariance matrices, Box's M test was conducted. The analysis indicated that the assumption of homogeneity between groups on self-oriented, other-oriented, and socially-prescribed perfectionism, the dependent variables, should not be rejected. Box's $M = 26.34$, $p < .124$.

Analysis of Sphericity

Bartlett's Test of Sphericity was conducted in order to examine the correlation matrix of the dependent variables. This analysis is used to determine whether the dependent variables are significantly correlated. The analysis indicated that the intercorrelation among the dependent variables was significant. Bartlett's Test of Sphericity = 92.69, $p < .000$.

Main Analyses

Hypothesis One

The first null hypothesis postulated that the degree of self-oriented perfectionism (SOP), other-oriented perfectionism (OOP), and socially-prescribed perfectionism (SPP)

among ACOAs would not differ significantly from the degree of SOP, OOP, and SPP among non-ACOAs.

A 2 X 2 multivariate analysis of variance (MANOVA) was used to analyze the effect of group differences (ACOA, non-ACOA) on the three dimensions of perfectionism. The results indicated that there were no significant differences between groups F (3, 136) = .622, $p < .60$; therefore, the null hypothesis was not rejected (see Tables 4 and 5).

Hypothesis Two

Hypothesis Two speculated that there would not be any significant differences on any dimension of perfectionism between managers and non-managers.

As predicted, results of the MANOVA indicated that there were no significant differences between groups on any perfectionism measure, F (3, 136) = 1.174, $p < .322$; therefore, the null hypothesis was not rejected (see Tables 4 and 5).

Table 4

Multivariate Tests of Significance for Differences Between Groups on Level of Perfectionism

Source of Variation	Test Name	Value	F	df	p
ACOA Status	Pillai's	.01354	.62234	3, 136	.602
	Hotelling's trace	.01373	.62234	3, 136	.602
	Wilks' Lambda	.98646	.62234	3, 136	.602
Occupational Classification	Pillai's	.02524	1.17391	3, 136	.327
	Hotelling's trace	.02590	1.17391	3, 136	.322
	Wilks' Lambda	.97476	1.17391	3, 136	.322
ACOA X Occupation	Pillai's	.00692	.31585	3, 136	.814
	Hotelling's trace	.00697	.31585	3, 136	.814
	Wilks' Lambda	.99308	.31585	3, 136	.814

Note. ACOA = Adult child of an alcoholic.

Table 5

Cell and Marginal Means by Groups

	Variable						
	SOP		OOP		SPP		
Group	Mean	SD	Mean	SD	Mean	SD	n
Cell Means							
ACOA Mgr.	73.722	14.154	63.778	9.124	55.833	14.337	18
ACOA Non-Mgr.	69.760	19.062	59.40	11.587	53.84	17.269	25
Non-ACOA Mgr.	70.860	13.701	62.340	10.095	51.720	12.189	50
Non-ACOA Non-Mgr.	72.510	16.163	59.735	11.706	52.082	11.471	49
Marginal Means							
ACOAs	71.409	16.906	60.886	10.853	54.318	15.946	44
Non-ACOAs	72.049	14.916	61.126	10.918	51.563	11.780	103
Managers	71.618	13.774	62.721	9.801	52.809	12.812	68
Non-Mgrs.	71.581	17.116	59.622	11.587	52.676	13.611	74

Note. Totals reflect the fact that not all participants completed all items. The midpoint of the scale for that item was substituted for missing data. ACOAs = Adult children of alcoholics. Mgr. = Manager.

Hypothesis Three

The third null hypothesis stated that there would not be a significant interaction between groups (ACOA, non-ACOA, manager, non-manager) and the degree of self-oriented, other-oriented, and socially-prescribed perfectionism among individuals participating in this study.

Results of the MANOVA indicated that there was not a significant interaction between groups, $F(3, 136) = .316$, $p < .814$; therefore, the null hypothesis was not rejected (see Tables 4 and 5).

Hypothesis Four

The fourth hypothesis speculated that, among ACOAs, there would not be any significant relationships between parental educational level in the family-of-origin and the three dimensions of perfectionism.

Spearman correlation coefficients were computed in order to test this hypothesis. Results of this analysis indicated that there were no significant relationships between parental educational level and the perfectionism measures, therefore, the null hypothesis was not rejected (see Table 6).

Hypothesis Five

The fifth hypothesis stated that there would be no significant relationships between the gender of the ACOA and the perfectionism dimensions.

This hypothesis was investigated two ways. First, Hotelling's T^2 was computed in order to determine if there was any difference between groups (male, female) on the perfectionism measures. Results of this analysis indicated that there were no significant differences between groups $F, (3, 40) = .291$, $p < .832$ (see Tables 7 and 8).

Table 6

Spearman Correlation Coefficients for Parental Educational Level and Perfectionism Dimensions

	Dependent Variables		
Group	SOP	OOP	SPP
Father's Educational Level	.09	.11	- .01
Mother's Educational Level	.02	.06	- .06

Note. SOP = Self-oriented perfectionism, OOP = Other-oriented perfectionism, SPP = Socially prescribed perfectionism. Educational level was coded as follows: 1 = less than high school, 2 = high school or GED, 3 = two year college or vocational degree, 4 = four year college degree, 5 = graduate or professional degree.

Table 7

Multivariate Tests of Significance for Gender of the ACOA and Level of Perfectionism

Test Name	Value	F	df	p
Phillai's	.02137	.29117	3,40	.832
Hotellings trace	.02184	.29117	3,40	.832
Wilk's Lambda	.97863	.29117	3,40	.832

Note. ACOA = Adult child of an alcoholic.

Table 8

Means and Standard Deviations For Gender of the ACOA and Level of Perfectionism

Group	Variable	Mean	SD	n
Male				
	SOP	70.00	17.03	29
	OOP	60.69	12.28	
	SPP	53.03	16.03	
Female				
	SOP	74.13	16.91	15
	OOP	61.27	7.77	
	SPP	56.80	16.03	

Note. SOP = Self-oriented perfectionism, OOP = Other-oriented perfectionism, SPP = Socially prescribed perfectionism. ACOA = Adult child of an alcoholic.

Second, a strength of association test (point biserial coefficients) was computed. Results failed to yield any significant coefficients, therefore, the null hypothesis was not rejected, SOP $r = -.12$, $p < .45$; OOP $r = -.03$, $p < .87$; SPP $r = -.11$, $p < .46$, therefore, the null hypothesis was not rejected.

Hypothesis Six

The sixth null hypothesis postulated that there would be no significant relationships between gender of the alcoholic parent(s) and the three dimensions of perfectionism.

This hypothesis was unable to be tested due to inadequate sample size. Therefore, only means and standard deviations for each group are reported (see Table 9).

Hypothesis Seven

The seventh hypothesis stated that there would not be any significant relationships between the age of the ACOA when parental drinking began and the three perfectionism dimensions.

Pearson Product Moment correlation coefficients were computed in order to investigate this hypothesis. As predicted, no significant relationships were found, SOP $r = -.114$, $p < .483$; OOP $r = -.147$, $p < .364$; SPP $r = -.182$, $p < .262$; therefore, the null hypothesis was not rejected (see Table 10).

Table 9

Means and Standard Deviations for Gender of the Alcoholic Parent(s) and Perfectionism Dimensions.

Group	Variable	Mean	SD	n
Fathers				
	SOP	70.53	16.90	34
	OOP	61.32	9.98	
	SPP	54.32	15.71	
Mothers				
	SOP	68.00	15.39	3
	OOP	61.33	8.02	
	SPP	53.67	2.52	
Both				
	SOP	76.29	19.17	7
	OOP	60.29	15.40	
	SPP	57.14	20.36	

Note. SOP = Self-oriented perfectionism, OOP = Other-oriented perfectionism, SPP = Socially prescribed perfectionism.

Table 10

Pearson Correlation Matrix for Age of the ACOA When Parental Problem Drinking Began and Perfectionism Dimensions

	Independent Variable	Dependent Variables		
Variables	Age	SOP	OOP	SPP
Age	1.00			
SOP	-.11	1.00		
OOP	-.15	.56**	1.00	
SPP	-.18	.54**	.46**	1.00

two-tailed. *$p < .002$. **$p < .000$

Note. SOP = Self-oriented perfectionism, OOP = Other-oriented perfectionism, SPP = Socially prescribed perfectionism.

Summary

The multivariate analysis of variance indicated that there were no significant differences between groups on Self-Oriented Perfectionism, Other-Oriented Perfectionism, and Socially Prescribed Perfectionism.

Spearman correlation coefficients were computed in order to assess possible relationships between educational level of the ACOAs' parents and the three perfectionism measures. No significant relationships were found.

Hotelling's T^2 and point biserial correlation coefficients were computed in order to examine possible relationships between the perfectionism measures and the gender of the ACOA. No significant relationships were found.

Pearson Product Moment correlations were run in order to assess relationships between the three dimensions of perfectionism and age of the ACOA when parental problem drinking began. No significant relationships were found.

Finally, possible significant relationships between gender of the alcoholic parent(s) and the perfectionism dimensions were unable to be investigated due to inadequate sample size.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to address certain inconsistencies in the literature concerning hypothesized effects on adult working people of being raised in an alcoholic family, and, to add our knowledge of this scarcely researched population. Specifically, the focus of this study was to investigate whether adult children of alcoholics (ACOAs) are more likely to display characteristics of perfectionism that distinguishes them from other employees in a work setting. Second, relationships between occupational classification (managers and non-managers) and three dimensions of perfectionism were examined. Finally, among the ACOA population, certain moderator variables (parental educational level in the family-of-origin, gender of the ACOA, gender of the alcoholic parent, age of the ACOA when parental problem drinking began) postulated to affect adult personality were investigated.

One hundred and forty-seven persons participated in the study: 96 males and 50 females. Forty-four ACOAs and 103 non-ACOAs participated. Sixty-eight of the participants were managers and 74 were not. Altogether, there were 18 ACOA managers, 25 ACOA non-managers, 49 non-ACOA managers, and 49 non-ACOAs who were not managers. The sample was drawn from employees at one plant of a large manufacturing corporation in the southwestern United States. All participants were volunteers.

Each participant completed a research protocol consisting of a Demographic Information Sheet (DIS), the Children of Alcoholics Screening Test (CAST), and the Multidimensional Perfectionism Scale (MPS). Scores from these instruments were used to analyze the data. To that end, scores on the Multidimensional Perfectionism Scale

were used to measure the dependent variables: self-oriented perfectionism (SOP), other-oriented perfectionism (OOP), and socially prescribed perfectionism (SPP). The independent variables were measured as follows: scores on the CAST measured ACOA status and answers on the DIS measured occupational classification and the demographic variables of interest to this study.

Seven research hypotheses were generated. The results of the analyses are presented below.

Hypothesis One

Hypothesis one postulated that the degree of self-oriented, other-oriented, and socially prescribed perfectionism would not significantly differ between ACOAs and non-ACOAs. Multivariate analysis of variance (MANOVA) yielded results that failed to reject the null hypothesis [F (3, 136) = .622, p <.60].

Hypothesis Two

Hypothesis two speculated that there would not be any significant differences between managers and non-managers on the perfectionism dimensions. Results of the MANOVA failed to reject this hypothesis [F (3, 136) = 1.174, p <.322].

Hypothesis Three

Hypothesis three stated that there would not be a significant interaction between groups on the perfectionism measures. Results of the MANOVA failed to reject this hypothesis [F (3, 136) = .316, p < .814].

Hypothesis Four

The fourth hypothesis speculated that, among the ACOA participants, there would not be any significant relationships between the parental educational level in the family-of-origin and the three dimensions of perfectionism. Results of Spearman correlation coefficients revealed no significant relationships, therefore, this hypothesis was not rejected.

Hypothesis Five

Hypothesis five postulated that there would not be any significant relationships between gender of the ACOA and the perfectionism measures. Results of Hotelling's T^2 was not significant [F (3,40) = .291, p <.832]. Point biserial coefficients were also computed. There were no significant correlations, consequently, this hypothesis was not rejected.

Hypothesis Six

The sixth null hypothesis stated that there would not be any significant relationships between gender of the alcoholic parent(s) (father, mother, both) and the perfectionism dimensions. This hypothesis was unable to be tested due to inadequate sample size.

Hypothesis Seven

The seventh hypothesis speculated that there would be no significant relationships between age of the ACOA when parental problem drinking began and self-oriented, other-oriented, and socially prescribed perfectionism. Results of Pearson Product Moment correlations failed to reject this hypothesis.

Conclusions

This section addresses implications, speculations, and possible explanations related to the research findings. Moreover, this section will discuss known or suspected weaknesses of this study.

Adult Children of Alcoholic Status and Perfectionism

The results of this study do not support distinct differences between ACOAs and non-ACOAs on any perfectionism dimension despite claims made in the popular literature that ACOAs are characterized by low self-esteem, feelings of inadequacy, high needs for control, perfectionism, depression, anxiety, and high needs for approval and affirmation. However, when considering these findings, it is important to

remember that the majority of this literature is based on ACOAs seeking psychological treatment. These assertions have not been substantiated by empirical research. Also, there has been far less attention paid to those ACOAs who are functioning well (Burk & Sher, 1988). It is possible that these characteristics are common among clinical samples and occur less frequently among persons who do not seek psychological services.

A closely related explanation for the lack of differences found in this study is that classifying ACOAs or their parents as a homogeneous population fails to take into account the fact that all problem drinkers are not alike and that there are differences in the ways persons in different families react to the drinking member. In other words, as stated by Fulton and Yates (1990), environmental trauma in alcoholic homes and the disruption of familial relationships inside alcoholic family systems may be quite variable. It seems reasonable that the effects on children growing up in these families may also be quite variable. Classifying all ACOAs as alike may result in an "averaging out" effect which would conceal possible differences that may exist within the ACOA population itself.

Another important point to consider is that there was a sampling limitation in that all participation in this research was voluntary. It has been documented that alcoholism is denied both inside and outside of the family (Brown, 1988). Plescia-Pikus, Long-Suter, and Wilson (1988) noted that some individuals approached to participate in their study found the subject of parental alcoholism to be very threatening. It is feasible that a portion of those persons who declined to participate in this study are denying parental alcoholism and/or find it a very sensitive subject. In other words, these sampling limitations could have affected the research findings.

A final speculation concerning the lack of differences between groups is that the MPS may not be a good measure of ACOA behaviors in the workplace. Other than the Children of Alcoholics Screening Test, the researcher found no published instruments designed specifically to measure ACOA characteristics; either in or outside of the

workplace. Consequently, it was necessary to choose an instrument that appeared to measure workplace behaviors claimed in the popular literature to be common among the ACOA population. It could be that the failure to find significant differences between ACOAs and non-ACOAs lies in the assessment of these hypothesized differences.

Occupational Classification and Perfectionism

The hypothesis that there would be no difference in the dimensions of perfectionism among managers and non-managers was supported. Before beginning a discussion of this finding, it is important to reiterate the rationale for including this factor in the research design.

Several authors, in their review of the literature (Burk & Sher, 1988; El-Guebaly & Offord, 1977; Stark, 1987), have noted that high achievement in school is a consistent finding among those ACOAs who are functioning well. Other authors have argued (Black, 1981; Hinz, 1990) that high scholastic achievement results in decreased psychological functioning in adulthood which is manifested by workaholism. It is claimed (Burns, 1980; Halgin & Leahy, 1989) that perfectionists measure their worth entirely in terms of productivity and accomplishment which leads to feelings of failure and inadequacy. Wilson-Schaef & Fassel (1988) and Wotitz (1987) states that ACOAs have special difficulties in the workplace such as feelings of inadequacy, workaholism, perfectionism, and high needs for control. Hall (1991) states that the managerial role provides the kind of power position that makes it possible for codependents to perpetuate the role of caretaker. In fact, Wilson-Schaef & Fassel (1988) state that the entire organization can take on the personality of the executive. Self-oriented and other-oriented perfectionism has been found to correlate with Type A achievement striving and leadership ability (Hewitt & Flett, 1991b). It seems logical to assume that managerial personnel are high achievers. This raises several questions. Could it be that managers tend to be more perfectionistic than non-managers regardless of ACOA status? Could

managers be more vulnerable to psychological difficulties than non-managers? Is high achievement among ACOAs an example of resilient persons who have coped adaptively with parental alcoholism or is high achievement merely a way avoiding psychological issues such as fragile self-esteem and difficulties with intimacy? Do managerial personnel carry personal issues into the workplace that affect the entire organization? As can be seen, these and other important questions are raised. Given the conflicting claims made in the literature and the paucity of empirical research, it seemed important to examine occupational classification as related to managers in general and ACOA managers in particular.

Again, one possible reason for the failure to detect significant differences between managers and non-mangers could be instrumentation. The MPS was designed to measure intra and interpsychic components of perfectionism rather than work behaviors per se. It could be that an instrument designed for use particularly in the workplace would have resulted in different findings.

Another explanation is also related to the voluntary nature of subject participation. It is conceivable that subjects who are characterized by high levels of perfectionism found the research questionnaires threatening and declined to participate in the study. However, this finding may not be the result of instrumentation or sampling limitation. It may indeed be reasonable to conclude that the findings reflect no real differences on any perfectionism dimension between managers and non-managers. If this is true, it is also reasonable to conclude that high achievement does not necessarily reflect a pathological coping style among management personnel. Rather, it may reflect a psychologically healthy self-image and a belief in one's abilities to influence life in a positive way.

Interaction Between ACOA Status, Occupational Classification, and Perfectionism

Another predicted finding concerns the failure to detect a significant interaction between groups on the perfectionism dimensions. This finding more specifically addresses the questions raised in the preceding section, and raises additional ones as well.

If high achievement among ACOAs is a pathological coping mechanism among these individuals, then why were no significant differences found between ACOA managers and the other research groups on the perfectionism measures? Or, is high achievement really a healthy adaptation to parental alcoholism? If claims made in the popular literature concerning ACOA psychopathologies are accurate, why were no distinguishing characteristics found among the ACOA subjects? If the assertions made about ACOA workers in general and ACOA managers in particular are valid, how does one account for the lack of differentiation among the research participants? One explanation is that ACOAs do not comprise a homogeneous group. It is possible that differences could have been found if only ACOAs seeking assistance in their company's EAP program had been sampled. Once more, sampling difficulties could have affected the research findings. Only 18 ACOA managers participated in the study. What does this mean? Are those ACOA managers who declined to participate in the study different in some systematic way from those who chose to participate? Also, the ACOA non-manager group was approximately one-half the size of the non-ACOA non-managers (25 versus 49). Although group size may reflect real differences in the size of the underlying populations, future research should be designed to include a larger sample of the ACOA population.

Despite the limitations of this study and possible explanations for the lack of significant differences between those ACOAs and non-ACOAs sampled, results do call into question the claim that ACOAs are a distinct population characterized by distinct pathologies which are carried over into the workplace. If, in fact, there are no unique

differences, results of this study present a major challenge to the assertions made in the popular literature.

Moderator Variables Affecting ACOA Personality Functioning

An interesting finding concerns the failure to detect any relationships between certain moderator variables believed to affect the adult personality functioning of persons reared in an alcoholic home environment.

One weakness of the research on ACOAs is the failure to control for differing home environments. Although it seems reasonable that the educational level achieved by the ACOAs' parents would influence some aspects of the home environment, educational level alone does not address factors such as family violence, emotional and sexual abuse, or the quality of relationships among family members. Possibly, differences would have been detected among the ACOA subjects if other methods were used which would accurately measure salient family characteristics such as those outlined above.

It should also be remembered that this study was carried out with a non-clinical, employed sample of the ACOA population. This not only excludes those ACOAs who may be so dysfunctional that they cannot hold a job, but their parents as well. It is probable that some ACOAs were raised in home environments characterized by low parental educational level, unemployment, and poverty. If it is true that differences in alcoholic home environments produce differential effects on adult personality functioning, then some of those ACOAs raised in these families may also be unemployed. That is, the lack of a significant relationship is this study does not necessarily indicate that parental educational level is unrelated to ACOA personality functioning.

Another moderator variable that has been hypothesized to affect adult personality functioning is that of the gender of the ACOA. Results of this study failed to find any gender-related differences on any of the perfectionism dimensions. This finding is not surprising since few gender differences have been found in the research that has been

conducted. However, it should be remembered that some investigators (Berkowitz & Perkins, 1988; Seefeldt & Lyon, 1990) did find gender differences on specific personality variables. Therefore, one possible explanation for the lack of significant differences among the ACOAs participating in this study is that the MPS may not measure ACOA characteristics that are influenced by gender.

Another explanation is that gender effects may be complex. For example, the gender of the ACOA in interaction with certain caretaker variables may produce differential effects on adult personality functioning. At any rate, there is a need for future research designed to investigate the complexity of gender issues among the ACOA population.

A closely related variable to the above is gender of the alcoholic parent(s). It will be remembered that Bradley and Schneider (1990) found that the ACOA subjects in their study were higher in their need for control if their fathers were alcoholic and were less interpersonal trusting if their mothers were alcoholic than the non-ACOA subjects. Berkowitz and Perkins (1988) found that female ACOAs reported more self-depreciation than their male counterparts; especially if their mothers were alcoholic. The fact that this moderator variable was unable to be investigated in this study due to inadequate sample size again emphasizes the need for carefully designed research in the area of gender issues.

The final moderator variable investigated in this study was the age of the ACOA when parental problem drinking began. Although proponents of the developmental psychology model postulate that the younger the child when the alcoholic disturbance begins, the more severe will be the resulting effects (Robinson, 1989), no significant relationships between this variable and the perfectionism dimensions were found.

It is interesting that, although not significant, all correlation coefficients were negative. In other words, if the above assertion is true, children who were young when

parental problem drinking began should exhibit more dysfunctional personality characteristics than children who were older when the disturbance began. This would be reflected by negative correlation coefficients. Why then, were no significant relationships found?

An important factor to consider when evaluating the results of this study is restriction of range. That is, this research was designed to sample the population of non-clinical, employed ACOAs while ignoring those who may be so seriously affected by parental alcoholism that they would seek treatment. In agreement with the findings of certain researchers (Berkowitz & Perkins, 1988; El-Guebaly & Offord, 1977; Plescia-Pikus, Long-Suter, & Wilson, 1988; Wolin & Wolin, 1993) it is certainly possible that the ACOAs sampled in this study had developed resiliencies as a result of their alcoholic home environment. This raises several questions. If the sample had included those ACOAs seeking psychological services and/or unemployed ACOAs, would significant relationships have been found? Alcoholism is frequently viewed as a progressive disease (Alcoholics Anonymous, 1976). If problem drinking occurs early in the life of alcoholic nuclear families, does this indicate later severe family dysfunction resulting in serious detrimental effects on adult children? As one can see, may intriguing questions remain unanswered. This is fertile ground for future research.

In summary, this research should be viewed as exploratory in nature. Its primary purpose has been to provide a starting point for the empirical investigation of assertions made in the popular literature concerning the influence of alcoholic family systems on the workplace behaviors of adults from these families.

Recommendations

There remains a deficit of research in the area of ACOA issues in general and a complete lack of scientific studies which were designed expressly to investigate

employed ACOAs within the work setting (Woodside, 1992). Although alluded to in the previous section, recommendations for future research will be listed here.

1. Future studies designed to specifically investigate workplace behaviors and career concerns among non-clinical samples of ACOAs should be carried out. As stated by Woodside (1992), reports of ACOAs' employment status have been extrapolated from the general body of research on adult children of alcoholics and related back to the workplace. The findings of this study suggest that such generalizations may be erroneous.

2. Since this study was conducted on a sample of corporate employees, additional studies sampling ACOAs from a variety of job settings should be carried out.

3. Since only non-clinical, employed ACOAs were sampled in this study, future research is recommended that would include persons from a more heterogeneous ACOA population. That is, studies should be conducted which include clinical and non-clinical, employed and unemployed samples of the ACOA population.

4. Since this study utilized ACOA employees in the southwestern United States, studies sampling employees from other regions of the United States is recommended.

5. The findings of this study did not reveal any significant relationships between parental educational level in the family-of-origin and the perfectionism dimensions. Future research designed to investigate and control for various indices of family disruption is indicated.

6. Results of this research failed to discover significant relationships between the age of the ACOA when parental problem drinking began and the dependent measures. However, the possibility of restriction of range should not be ignored. It is recommended that future research in this area be undertaken which would encompass both clinical and non-clinical samples of the ACOA population.

7. The findings of this study did not reveal any significant differences between ACOA and non-ACOA employees; at both the management and non-management levels of occupational classification. Since it is proposed that some adult children of alcoholics develop resiliencies as a result of growing up in an alcoholic home environment (Wolin & Wolin, 1993) and that some ACOAs compensate for being reared in a negative environment by high achievement (Plesia-Pikus, Long-Suter, & Wilson, 1988), future research investigating personality characteristics of those ACOAs who are functioning well in their careers should be undertaken.

8. This study revealed no significant relationships between gender of the ACOA and the measures of perfectionism. Also, relationships between gender of the alcoholic parent(s) and the indices of perfectionism was unable to be investigated. Given that some empirical research has found gender-related differences among ACOAs, future research into this complex issue is recommended.

9. Since this study relied solely on self-report data, it is recommended that future research be undertaken utilizing additional sources of information such as work records and supervisor ratings in order to confirm employee self-reports.

10. Given the low response rate obtained in this study, future research utilizing qualitative methods of data collection is indicated. For example, personal interviews could be conducted in order to determine if any distinguishing characteristics exist between nonresponders and responders.

11. As stated previously, the lack of significant findings in this study could be due to inadequate instrumentation. No valid and reliable means of assessing the workplace functioning of adult children of alcoholics is available. Therefore, future research utilizing new and varied means of assessment is recommended.

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APPENDICES

APPENDIX A

COVER LETTER: FIRST MAILING

Oklahoma State University

COLLEGE OF EDUCATION

Applied Behavioral Studies in Education
116 North Murray Hall
Stillwater, Oklahoma 74078
405-744-6040

Dear Research Participant:

This is a research project designed to gather information concerning the differences in personal feelings and characteristics of adults who were and were not raised by a parent(s) who had a drinking problem. This research has been approved by the Institutional Review Board (IRB) of Oklahoma State University. The IRB is a committee composed of at least 15 members whose purpose is to insure that you are not harmed in any way by participation in this research.

I would very much appreciate your help in this research for my doctoral dissertation. Participation is entirely voluntary. However, your decision to take the time to participate will provide valuable information which can be used to promote the personal welfare and job satisfaction of many working Americans such as yourself. Understanding the many demands made upon your time, I have designed this survey so as to minimize the time required to help me with my research. Participation will take approximately 15 minutes.

I want to assure you that your responses will be completely anonymous and confidential. ***No one, not even the researcher or your employer will know your name.*** Since the **CONSENT FORM** will be returned separately from the **RESEARCH QUESTIONNAIRES**, you are guaranteed that your name cannot be attached to your responses. Please do not write your name on any of the **RESEARCH QUESTIONNAIRES**. ***Only the*** **CONSENT FORM**, which you are asked to return separately, requires your signature. The results of this study will be reported as group data, not individual responses.

If you decide to participate, please complete the following steps:

1. Read the information sheet and keep it for your own information.

2. Read the **CONSENT FORM**, sign and date it, and return it in the postage prepaid, self-addressed envelope marked **CONSENT.**

3. Complete the **RESEARCH QUESTIONNAIRES** in the order in which they are arranged and return them in the postage prepaid, self-addressed envelope marked **RESEARCH.**

4. Please return your completed forms by August 29, 1994.

I appreciate and thank you for your help.

Sincerely,

Janet Caldwell, M.S.

APPENDIX B

COVER LETTER: SECOND MAILING

Oklahoma State University

COLLEGE OF EDUCATION

Applied Behavioral Studies in Education
116 North Murray Hall
Stillwater, Oklahoma 74078
405-744-6040

Dear Research Participant:

Recently I mailed you a research packet. Although I have received several responses, I have not yet received yours and would really appreciate your help. ***I want to take this chance to emphasize that your responses are very important regardless of whether or not you were raised by a parent with a drinking problem.***

I know you meant to respond or thought your responses were not relevant to this study and might have misplaced the packet. Consequently, I have enclosed a complete new packet in booklet form for your convenience.

If possible, could you please:

1. Read the information sheet and keep it for your own information.

2. Read the consent form, sign and date it, detach it from your booklet, and return it in the postage prepaid, self-addressed envelope marked CONSENT.

3. Complete the research questionnaires, remove them from your booklet, and return them in the postage prepaid, self-addressed envelope marked RESEARCH. Please do not write your name on any of the questionnaires since your responses remain fully anonymous and confidential.

4. Please return your completed forms by October 10.

I thank you and am very grateful for your help.

Sincerely,

Janet Caldwell

APPENDIX C

DEMOGRAPHIC INFORMATION SHEET

DEMOGRAPHIC INFORMATION SHEET

For the following items, please circle the appropriate response when no blank is provided, and fill in those items for which a blank is provided.

1. Gender: Male Female
2. Age:_____
3. In your current employment position, do you have authority and responsibility over any other company employees?

   Yes No
4. What was the highest grade completed in school by your:

Father?	Mother?
Less than high school	Less than high school
High school or GED	High school or GED
Two year college or vocational degree	Two year college or vocational degree
Four year college degree	Four year college degree
Graduate or professional degree	Graduate or professional degree

5. Do you believe you have, or have had, a parent with a drinking problem?

   Yes No

If you answered "yes" to item five, please answer items six, seven, and eight.

6. Which of your parents was a problem drinker?

   Mother Father Both
7. How old were you when one or both of your parents' drinking became a problem? _____
8. While growing up, did you live with the parent(s) who had a drinking problem?

   All of the time Most of the time

   Some of the time None or almost none of the time

APPENDIX D

CHILDREN OF ALCOHOLICS SCREENING TEST

C. A. S. T.

Please check the answers below that best describe your feelings, behavior, and experiences related to a parent's alcohol use. Take your time and be as accurate as possible. Answer all 30 questions by checking either "Yes" or "No".

Gender: Male _____ Female _____ *Age*: _____

Yes	No	Questions
___	___	1. Have you ever thought that one of your parents had a drinking problem?
___	___	2. Have you ever lost sleep because of a parent's drinking?
___	___	3. Did you ever encourage one of your parents to quit drinking?
___	___	4. Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?
___	___	5. Did you ever argue or fight with a parent when he or she was drinking?
___	___	6. Did you ever threaten to run away from home because of a parent's drinking?
___	___	7. Has a parent ever yelled at or hit you or other family members when drinking?
___	___	8. Have you ever heard your parents fight when one of them was drunk?
___	___	9. Did you ever protect another family member from a parent who was drinking?
___	___	10. Did you ever feel like hiding or emptying a parent's bottle of liquor?
___	___	11. Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
___	___	12. Did you ever wish your parent would stop drinking?
___	___	13. Did you ever feel responsible for and guilty about a parent's drinking?
___	___	14. Did you ever fear that your parents would get divorced due to alcohol misuse?
___	___	15. Have you ever avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?
___	___	16. Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
___	___	17. Did you ever feel that you made a parent drink alcohol?
___	___	18. Have you ever felt that a problem drinking parent did not really love you?
___	___	19. Did you ever resent a parent's drinking?
___	___	20. Have you ever worried about a parent's health because of his or her alcohol use?
___	___	21. Have you ever been blamed for a parent's drinking?
___	___	22. Did you ever think your father was an alcoholic?
___	___	23. Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
___	___	24. Did a parent ever make promises to you that he or she did not keep because of drinking?
___	___	25. Did you ever think your mother was an alcoholic?
___	___	26. Did you ever wish you could talk to someone who could understand and help the alcohol related problems in your family?
___	___	27. Did you ever fight with your brothers and sisters about a parent's drinking?
___	___	28. Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
___	___	29. Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
___	___	30. Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

___ TOTAL NUMBER OF "Yes" ANSWERS

Camelot Unlimited
5 N. Wabash Avenue • Suite 1409 Dept 18CF • Chicago, IL 60602 (312) 938-8861

APPENDIX E

MULTIDIMENSIONAL PERFECTIONISM SCALE

MPS

Listed below are a number of statements concerning personal characteristics and traits. Read each item and decide whether you agree or disagree and to what extent. If you *strongly agree*, circle 7; if you *strongly disagree*, circle 1; if you feel somewhere in between, circle any one of the numbers between 1 and 7. If you feel neutral or undecided the midpoint is 4.

		Disagree						Agree
1.	When I am working on something, I cannot relax until it is perfect.	1	2	3	4	5	6	7
2.	I am not likely to criticize someone for giving up too easily.	1	2	3	4	5	6	7
3.	It is not important that the people I am close to are successful.	1	2	3	4	5	6	7
4.	I seldom criticize my friends for accepting second best.	1	2	3	4	5	6	7
5.	I find it difficult to meet others' expectations of me.	1	2	3	4	5	6	7
6.	One of my goals is to be perfect in everything I do.	1	2	3	4	5	6	7
7.	Everything that others do must be of top-notch quality.	1	2	3	4	5	6	7
8.	I never aim for perfection in my work.	1	2	3	4	5	6	7
9.	Those around me readily accept that I can make mistakes too.	1	2	3	4	5	6	7
10.	It doesn't matter when someone close to me does not do their absolute best.	1	2	3	4	5	6	7
11.	The better I do, the better I am expected to do.	1	2	3	4	5	6	7
12.	I seldom feel the need to be perfect.	1	2	3	4	5	6	7
13.	Anything I do that is less than excellent will be seen as poor work by those around me.	1	2	3	4	5	6	7
14.	I strive to be as perfect as I can be.	1	2	3	4	5	6	7
15.	It is very important that I am perfect in everything I attempt.	1	2	3	4	5	6	7
16.	I have high expectations for the people who are important to me.	1	2	3	4	5	6	7
17.	I strive to be the best at everything I do.	1	2	3	4	5	6	7
18.	The people around me expect me to succeed at everything I do.	1	2	3	4	5	6	7
19.	I do not have very high standards for those around me.	1	2	3	4	5	6	7
20.	I demand nothing less than perfection of myself.	1	2	3	4	5	6	7

MPS

		Disagree						Agree
21.	Others will like me even if I don't excel at everything.	1	2	3	4	5	6	7
22.	I can't be bothered with people who won't strive to better themselves.	1	2	3	4	5	6	7
23.	It makes me uneasy to see an error in my work.	1	2	3	4	5	6	7
24.	I do not expect a lot from my friends.	1	2	3	4	5	6	7
25.	Success means that I must work even harder to please others.	1	2	3	4	5	6	7
26.	If I ask someone to do something, I expect it to be done flawlessly.	1	2	3	4	5	6	7
27.	I cannot stand to see people close to me make mistakes.	1	2	3	4	5	6	7
28.	I am perfectionistic in setting my goals.	1	2	3	4	5	6	7
29.	The people who matter to me should never let me down.	1	2	3	4	5	6	7
30.	Others think I am okay, even when I do not succeed.	1	2	3	4	5	6	7
31.	I feel that people are too demanding of me.	1	2	3	4	5	6	7
32.	I must work to my full potential at all times.	1	2	3	4	5	6	7
33.	Although they may not show it, other people get very upset with me when I slip up.	1	2	3	4	5	6	7
34.	I do not have to be the best at whatever I am doing.	1	2	3	4	5	6	7
35.	My family expects me to be perfect.	1	2	3	4	5	6	7
36.	I do not have very high goals for myself.	1	2	3	4	5	6	7
37.	My parents rarely expected me to excel in all aspects of my life.	1	2	3	4	5	6	7
38.	I respect people who are average.	1	2	3	4	5	6	7
39.	People expect nothing less than perfection from me.	1	2	3	4	5	6	7
40.	I set very high standards for myself.	1	2	3	4	5	6	7
41.	People expect more from me than I am capable of giving.	1	2	3	4	5	6	7
42.	I must always be successful at school or work.	1	2	3	4	5	6	7
43.	It does not matter to me when a close friend does not try their hardest.	1	2	3	4	5	6	7
44.	People around me think I am still competent even if I make a mistake.	1	2	3	4	5	6	7
45.	I seldom expect others to excel at whatever they do.	1	2	3	4	5	6	7

APPENDIX F

INFORMATION SHEET

INFORMATION SHEET

The Department of Applied Behavioral Studies supports the practice of protection for human participants in research. The following information is provided so that you can decide whether you wish to participate in the present study.

The researcher is interested in collecting information about adults who were raised by a parent(s) who has, or has had, a drinking problem. This study is concerned with the differences in personal feelings and characteristics between persons who were and were not raised by parents who had a drinking problem. You will be asked to fill out a short questionnaire that will provide the researcher with some background information about you. You will also be asked to complete a questionnaire that inquires into your feelings, behavior, and experiences related to a parent's alcohol use. Finally, you will be asked to complete a questionnaire consisting of a number of statements concerning personal characteristics and traits.

Participation will take approximately 15 minutes. It is completely voluntary. However, your decision to take the time to complete the study will provide valuable information. You may choose to not participate, or you may begin but then withdraw at any time with no penalty of any sort from either the researcher or your employer. Your responses will be completely anonymous and confidential. **No one, not even the researcher, will know your name.** Please do not write your name on any of the forms or response sheets, except the CONSENT FORM. No attempt will be made to attach your name to responses. The results of this study will be reported as group data, not individual responses. **Please keep this sheet for your own information.** Please sign and date the CONSENT FORM and return it in the postage prepaid, self-addressed envelope marked CONSENT. Please fill out the RESEARCH QUESTIONNAIRES and return them in the postage prepaid, self-addressed envelope marked RESEARCH.

If you should have any questions about this study, please contact Janet Caldwell at (405) 743-2294 or Dr. Al Carlozzi, Department of Applied Behavioral Studies, Oklahoma State University, at (405) 744-6036. If you have any questions about your rights as a research participant, please contact Beth McTernan at the OSU University Research Services (405) 744-5700. To obtain information regarding the results of the study, please contact Janet Caldwell or Dr. Al Carlozzi. Your cooperation and efforts are greatly appreciated.

****

This information sheet is yours to keep. At this time you may choose to continue your participation in this study, or you may stop. Because your name will not be on any of the forms involved in this study, your answers will remain fully anonymous and confidential.

THANK YOU FOR YOUR TIME

YOUR COOPERATION AND EFFORTS ARE GREATLY APPRECIATED

APPENDIX G

CONSENT FORM

CONSENT FORM

The Department of Applied Behavioral Studies supports the practice of protection for human participants in research. The following information is provided so that you can decide whether you wish to participate in this study.

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****

I have read these instructions and understand my rights. I further understand that I may keep the information sheet that outlines my rights as a research participant.

_____ _____

Date Participant's Signature

VITA

Candidate for degree of

Doctor of Philosophy

Thesis: ADULT CHILDREN OF ALCOHOLICS AT WORK: A MULTIDIMENSIONAL INVESTIGATION OF PERFECTIONISM

Major Field: Applied Behavioral Studies

Area of Specialization: Counseling Psychology

Biographical:

Personal Data: Born in Springfield, Missouri on October 16, 1950, the daughter of Joe and Helen Jones.

Education: Graduated from Southwest Missouri State University with a Bachelor of Science degree in Psychology, December, 1974; received a Master of Science degree in Applied Behavioral Studies from Oklahoma State University, July, 1991; completed requirements for the Doctor of Philosophy degree at Oklahoma State University, December, 1995.

Professional Experience: Case Manager, Burrell Community Mental Health Center, Springfield, Missouri, 1982 to 1986; Case Manager, Mental Healthcare Services, Tulsa, Oklahoma, 1987 to 1991; Instructor, Spring, 1992, Teaching Assistant, Fall, 1992 to Fall, 1993, Department of Applied Behavioral Studies in Education, Oklahoma State University; Psychotherapist, 1993 to 1994, Personal Counseling Services, Oklahoma State University; Predoctoral Psychology Intern, Department of Veteran's Affairs Medical Center, Little Rock, Arkansas, September 1994-August, 1995.

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 04-13-94 **IRB#:** ED-94-091

Proposal Title: ADULT CHILDREN OF ALCHOHOLICS AT WORK: A MULTIDIMENSIONAL INVESTIGATION OF PERFECTIONISM

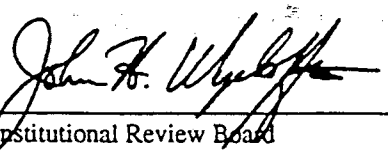
Principal Investigator(s): Al Carlozzi, Janet Caldwell

Reviewed and Processed as: Modification

Approval Status Recommended by Reviewer(s): Approved

ALL APPROVALS MAY BE SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING.
APPROVAL STATUS PERIOD VALID FOR ONE CALENDAR YEAR AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL.
ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

Comments, Modifications/Conditions for Approval or Reasons for Deferral or Disapproval are as follows:

Signature:  Date: July 26, 1994

Chair of Institutional Review Board