Dissertation prospectus:

Personality assessment of male alcoholics and their spouses: Control issues in alcoholism and codependency

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RUNNING HEAD: ALCOHOLISM AND CODEPENDENCY

Abstract

This study will examine psychological factors related to issues of control, as measured by the Shapiro Control Inventory (Shapiro, 1990). Subjects will be male alcoholics and their spouses, recently engaged in treatment together at an alcoholism treatment center. Observations about the personality features and treatment needs of the two groups will be made, addressing their similar and different therapeutic problems and needs in regard to control issues.

In addition to outlining the treatment needs of the two groups (both separately as well as conjointly), the similarities and differences between the groups will be used to examine the defining aspects of codependency, a hotly debated term recently. Suggestions will be made for use and application of the term codependency.

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Introduction and literature review

The debate about whether there is a profile of the "alcoholic personality" rages on as it has for over 40 years. Especially in the past two decades, researchers in the field of psychological assessment and testing have amassed a mind-numbing mountain of data that attempt to show one or several prototypical personality profile(s) of the average alcoholic. Much of this work has been done using the MMPI, although other quantitative personality scales have also been used. Among these others are the Millon Clinical Multiaxial Inventory (MCMI), 16PF, Beck Depression Inventory, and more than a half dozen instruments less well known.

Much of this body of data has focused on attempts to diagnose or typify the alcoholic. Researchers using the MacAndrews (MAC) scale of the MMPI, as well as other alcohol screening measures, have tried to increase predictive and/or diagnostic validity and reliability in screening for alcoholism. Researchers using some of the other measures listed above seem to have concentrated on demonstrating that the alcoholic is a predictable personality type. Although there are trends in the

plethora of data, more often than not the issues are clouded rather than clarified by these studies. The search for a unitary "alcoholic personality," whether hypothesized to be precedent to or an outcome of alcoholism, has generally proven disappointing to those who have pursued this end. As for the pursuit of predictive and diagnostic accuracy, the results of that quest have likewise been mixed at best.

It is our premise that one reason for the failure of the large number of attempts to find a unitary profile, or even a valid predictive screening measure, is the global nature of the measures used. From the range of possible human problems covered by a general personality inventory, there are certain of the measure's factors that seem to repeatedly load higher for many alcoholics. However, these loadings are not predictable, nor do they seem to indicate anything other than that the person in question is from a clinical population. This is the case with the MMPI. The 2-8-7-4 profile that has been sought and sometimes found among alcoholics is frequently found in other clinical populations.

We do not intend to typify or diagnose those addicted to the drug alcohol. Instead we turn to the common clinical observation of those who treat alcoholism, that alcoholics

have issues of control; that is, losing control over things they can have some control of, and trying to control things that they realistically cannot. Our aim is to confirm and further delineate the intricacies and ramifications of these observations. In doing so, we will contribute data that will add to the understanding of the treatment needs and psychosocial difficulties of those who present themselves for treatment of alcoholism, as well as those closest to them, also often in need of therapy. Our purposes include describing issues that many alcoholics have in common, and differentiating the issues of alcoholics from the issues of those who present for treatment due to difficulties unrelated to substance abuse. We hope to provide information that is useful to clinicians planning and providing treatment for their alcoholic clients.

A second goal is to examine the similarities and differences between the issues of the alcoholic and those of the non-alcoholic partner. In doing so we will be able to examine the merits and meaning of the term codependency. Most who treat alcoholics agree that those closest to the alcoholic also need therapy, but the term codependency has been used in many different ways to mean many different things. At times it seems as if some providers claim that if one is not alcoholic, then

one must be codependent. We will attempt to clarify whether spouses of alcoholics have issues related to control, and if so, describe what form they take.

Many therapists of alcoholics report that their clients have "issues with control." What does that mean? In order to contribute to treatment guidelines that are generally useful with alcoholic populations, we must systematically study the phenomena of alcoholics' perceptions, attitudes, and attributions about the role of control in their lives.

The first of the Twelve Steps of Alcoholics Anonymous (1976) states the necessity for the alcoholic to admit complete powerlessness over alcohol. Yet it is not only alcohol over which the alcoholic has lost control. A bit of pointed humor sometimes heard in A.A. circles is, "I used to think I had a problem with alcohol; then I realized I had a problem with life." Indeed, there are many areas over which the alcoholic loses some or all control, and there are many forms that loss of control can take.

Several psychological constructs that relate to various aspects of control have been formulated, such as self-efficacy (Bandura, 1977); learned helplessness (Seligman, 1975; Abramson, Seligman & Teasdale, 1978); and internal/external locus of

control (Rotter, 1966). All of these attitudes, behavioral sets, or attributional styles has a bearing on the issues that an alcoholic brings to treatment.

The Shapiro Control Inventory (Shapiro, 1990) is a ~~brief~~ self report rating scale that is yields scores relating to the following: the species of control; the agent and object of control; the domain of control; and the mode of control. Species of control include what can be described variously as actual control, perceived control, illusion of control, lack of control, loss of control (after having had it), competence, self efficacy, need for control, etc. Agent and object of control addresses who (or what) is in or out of control of whom (or what). Domains of control describe the area under or out of control (body/somatic, cognitive, interpersonal, occupational). Shapiro's modes of control include four general classes of coping strategies relative to control: Positive active; positive yielding; negative active; and negative yielding. The measure appears to have fairly good reliability and validity, and the pre-publication manual includes some normative data.

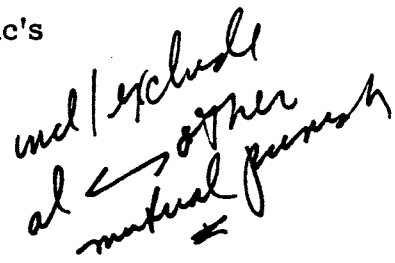
Our comparisons of the results of alcoholics and their spouses on the Shapiro Control Inventory (SCI) will allow us to examine the issues brought to therapy by the spouse of the

SCI allows you to look @ control issues + how they don't work

alcoholic, thus providing data useful for examination of the meaning of the term codependency. Some authors claim that codependency is a primary clinical entity, with a predictable set of symptoms that are progressive, similar to chemical addiction (Cermak, 1986). Those who claim that codependency is a unitary disorder assert that it is similar to chemical addictions in other ways also, such as defense mechanisms, compulsive behavior, and effects on interpersonal relationships.

Others refute this view, stating that the term codependency is used is such diverse and sometimes vague ways as to render it useless. The latter group claim that problems diagnosable as affective disorders, character pathology, and anxiety disorders have been subsumed under the rubric of codependency. Such a broad range of clinical problems, they argue, are clouded by being lumped together. Since clarification is an aim of diagnosis, the term as used is counter-productive.

We will operationalize the term codependency as follows. A codependent, for the purposes of our research, is a spouse of an alcoholic, or an intimate partner of an alcoholic who has remained in relationship to the alcoholic for a considerable period of time despite the adverse effects of the alcoholic's drinking-related behavior.



Our general research question is: What are the similarities and differences between male alcoholics and their spouses in personality factors related to issues of control? Sub-questions include: What are the personality characteristics of alcoholics related to issues of control? What are the personality characteristics of spouses of alcoholics related to issues of control? How are the two similar and/or different relative to control issues? How are alcoholics and/or codependents different from and/or similar to non-alcoholic, non-codependent persons?

Methodology

Subjects

Subjects will be selected for the following groups:

GROUP 1	Male alcoholics (Alc.)	Wives (Co.)
CONTROL GROUP (in marital therapy)	Husbands (Con-M)	Wives (Con-F)

Alcoholic Ss will be male clients (female alcoholics, especially those in treatment, are too few to sample adequately) who are in treatment at a chemical dependency treatment program (site as yet to be determined), and the group 1 wives will be

their spouses. The Ss will be asked to volunteer to participate in a study of recovery treatment. The alcoholics will be selected only if no other drugs are used regularly, and will be given the SCI, plus an interview for demographic information and other data after 7 to 10 days of abstinence, and with the treatment center's appraisal that the S is no longer toxic. The wife will be tested and interviewed at the same time as (but separately from) her alcoholic husband, to avoid confounding through discussion between Ss from the different groups. The couples in marital therapy, it is hoped, will be gathered from the general mental health or family counseling service of the same treatment center or a similar one in the same locale, in order to keep demographic variables between group 1 and control group Ss roughly equivalent. The control group Ss will be screened and accepted if no substance abuse problems are noted in the screening interview. Ss during screening will be asked about their spouse's substance use as well as their own, to minimize the denial of substance problems that may exist among these Ss.

Research of this type may uncover information of critical clinical importance to the subj, and a mutually acceptable form of release of information will be negotiated with the host agency. The aim

of obtaining uncensored information for the research will be balanced with the ethical and legal obligations to protect clients who are Ss. Basically, permission will be obtained in some measure allowing the researcher to share clinically vital information with the treatment staff according to mutually agreed upon guidelines between the researcher and the host agency.

Measures

As stated above, the primary measures will be the SCI and an interview. The interview will cover demographic information, substance use data for the S and their spouse (as a cross-check of data obtained from the spouse about their own use), and data about the S's perception of important issues they must deal with while in treatment. A measure of "faking good" or "faking bad" (social desirability or attempts to look clinically more severe) will be used as well (as yet to be determined), as the SCI does not have validity scales like those on the MMPI.

Statistics & Power Analysis

Data will be analyzed by analysis of variance. More data on the SCI are needed to run a power test, so that the N needed for an acceptable effect size can be determined.

Summary and questions

The proposed study will yield data on specifically focused personality-related measures related to control. Some questions yet to be answered include the following. The selected measure seems appropriate, but is it the best one available? ANOVA seems like the appropriate statistic, but is another procedure more relevant to the type of data being collected and the question being asked? What are the specific hypotheses? Should pre-treatment and post-treatment measures on the SCI be taken to assess change due to therapy?

References

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