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Occupational Behaviors and Quality of Life: A Comparison Study of Individuals Who Self-identify as Adult Children of Alcoholics and Non-Adult Children of Alcoholics

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Abstract

An estimated 43% of adults in the U.S. come from families with a history of alcoholism. They are described as victims of an alcoholic family environment, including polytraumatic experiences which may interfere with normal development and interpersonal functioning. Long-term effects of alcoholism within the family structure are especially reflective in the lives of adult children of alcoholics (ACOAs). This study uses a quantitative, non-experimental survey design to acknowledge and understand whether a relationship exists between occupational behaviors and quality of life, as well as the implications of growing up with an alcoholic parent and/or guardian. Survey instruments used include the Adapted Flanagan Quality of Life Scale (QOLS) and Occupational Behaviors Satisfaction Checklist (OBSC). Results were indicative of an existing relationship between overall quality of life and satisfaction with occupational engagement with differences noted between ACOAs and non-ACOAs. Gaining a better understanding of the relationship between occupational behaviors and quality of life affords occupational therapists and other healthcare providers the ability to supplement mental health treatment to achieve improved quality of life and to establish skills which will foster rich and meaningful occupational engagement.

Key words: Adult children of alcoholics, alcoholism, quality of life, occupational engagement, occupational therapy

Introduction

It is a commonly held belief that alcoholism runs in families and that alcoholism is a family disease with respect to the profound effects it not only has on the alcoholic, but also on the family members living with or in close relation with an alcoholic family member (Black, 1982; Ellis, Zucker, & Fitzgerald, 1997; Goodwin, 1991; Jacob & Johnson, 1997; Windle & Windle, 1996). Based on research that largely began in the early

1970's, the long-term effects of alcoholism within the family structure seem to be especially reflective in the lives of adult children of alcoholics (ACOAs). ACOAs are described as being "victims of an alcoholic family environment"—including polytraumatic experiences which potentially "undermine normal psychosocial development, cause distress and impaired interpersonal functioning" (Heath, 1995; Dinwiddie & Reich, 1991; Drake & Vaillant, 1988; Johnson, Sher, & Rolf, 1991; Sher, 1997).

According to Schoenborn (1991), an estimated 43 percent of adults in the United States have relatives who are alcoholics. Additionally, approximately one in eight Americans is a child of an alcoholic (COA) and one in five college students comes from a background of parental alcohol abuse (Mathew, Wilson, Blazer, & George, 1993; Stratton & Penney, 1992). However, it is important to consider the inaccuracies of reporting of ACOAs in the general population, secondary to denial and shame (Anda, et al, 2002, p. 1001); therefore, by the very nature of growing up in an alcoholic family environment, we can assume a portion of this population remains underreported. Spawning from a surge of biopsychological interest in ACOAs, research studies have been conducted to not only identify and address the unique problems of ACOAs, but also to promote the design and implementation of effective preventive interventions to break the cycle of alcoholism and the negative consequences commonly associated with the disease (Price & Emshoff, 1997; Dies & Burghardt, 1991).

A foundational belief in the fields of occupational science and therapy is that developing rich, meaningful occupational repertoires leads to an increase in life satisfaction and overall well-being (Christiansen & Townsend, 2010; Hasselkus, 2002; Yerxa, 1998). Based on recent research (Vaught & Wittman, 2011), it is apparent that the problems ACOAs face expand beyond the parameters of biopsychological studies and into the realm of occupational science and therapy. In doing so, ACOAs can participate in intervention programs over the lifespan through occupational therapy to optimize their quality of life through occupational engagement. As renowned flow theorist Mihaly Csikszentmihalyi (1993) states regarding meaningful engagement in valued occupation as it relates to one's happiness: "…when persons learn to enjoy complex activities that provide high challenges commensurate to their skills, they are more likely to have a positive sense of self, will enjoy more work, will develop further their innate abilities, and will be happier over-all" (p. 41). Through this perspective of individuals as occupational beings and considering quality of life as it relates to occupational behaviors, quality of life can be understood "as the extent to which a person perceives basic psychosocial areas of life as fulfilling" (Bruscia, et al, 2008, p. 983; Anderson & Burckhardt, 1999).

Specifically related to the occupational engagement of individuals who self-identify as ACOAs, Vaught and Wittman (2011) found that individuals raised in an alcoholic family environment are likely to experience occupational deprivation of varying degrees. This may be secondary to the prevalence of parentification common in alcoholic family environments as part of the experience of being raised by a parent with a substance abuse disorder. Additionally, individuals who self-identify as ACOAs expressed high instances of occupational engagement limited to solitary occupations, as well as occupations limited to social contribution and work (Vaught & Wittman, 2011).

A gap in the existing literature presents a need for further research in order to acknowledge and understand whether a relationship exists between occupational behaviors and quality of life, as well as the implications of growing up with an alcoholic parent and/or guardian in regards to its influence on the occupational behaviors and quality of life of ACOAs in comparison to non-ACOAs. Therefore, this study was designed to answer the following research questions related to occupational behaviors and quality of life:

1. Is there a significant difference in overall quality of life score (as measured by the Flanagan) between ACOA and non-ACOA groups?

2. Is there a significant difference in satisfaction with occupational behaviors (as measured by the Occupational Behaviors Satisfaction Checklist) between ACOA and non-ACOA groups?

Methods

Design

In order to answer the research questions, a survey design was selected. A survey design was chosen as a means of collecting a variety of qualitative data, while also allowing for selective input on the part of the subjects. Upon choosing to participate in the study, subjects used an online survey tool to complete a brief demographic questionnaire, the adapted 16-item Flanagan Quality of Life Scale, and an Occupational Behaviors Satisfaction checklist. Participants self-identified their non-ACOA or ACOA status in the demographic portion of the survey and were asked to indicate which parent(s) and/or guardian(s) they identified as an alcoholic. Participants were also provided the option to identify "not sure" regarding their ACOA status and elaborate further in a comments section of the demographics questionnaire.

Subjects

The subjects involved in this study included a true random sample of all full-time faculty and staff, including non-ACOA population and self-identified ACOA population at a major university in central Kentucky. Participants included all gender identities, ethnicities, and adults (18+) living in the central Kentucky area who were raised by and/or within a household with an alcoholic parent(s) and/or guardian(s) and those who were raised by non-alcoholic parent(s) and/or guardian(s).

A random sample of 400 participants was solicited via e-mail based upon random selection of the overall population. This sample size was chosen as an allocated sample for a stratified random sample based on the perceived prevalence of adult children of alcoholics in the general population (approximately 30%). This sample size was also based on sought level of statistical significance (95%) and typical response rates expected of the general population. As it is one's choice to respond, consent was implied by those that voluntarily agree to participate and complete the online survey instruments.

Measures

Flanagan Quality of Life Scale

The Flanagan QOLS (see Appendix A) utilized in this study is a 16-item generic instrument used to measure the quality of life of individuals across the following domains of life: physical and material well-being; relations with other people; social, community, and civic activities; personal development and fulfillment; recreation; and independence (Burckhardt & Anderson, 2003). To complete the QOLS, individuals rate their satisfaction on a seven-point Likert scale with responses range from "delighted" to "terrible." While the QOLS has been most extensively used with clients experiencing chronic conditions, its use spans a diverse array of age, health status, language, and geographic location to provide an overall "subjective, global evaluation" of quality of life (Asnani, Lipps, & Reid, 2009, p. 2). The QOLS is classified as a generic measure of quality of life, as it measures quality of life within the five domains previously discussed and is not inclusive of health status as a predictor of quality of life. The QOLS is typically self-administered and can be completed in as little as five minutes. The QOLS is scored by adding up individual item numbers to yield a total score, which may range from 16 to 112. The item scaling of the QOLS is such that higher scores represent a higher quality of life, with the average total healthy population score being about 90 (Burckhardt & Anderson, 2003). In its popular use among study populations, the QOLS has repeatedly demonstrated good test-retest reliability and internal consistency. Additionally, the QOLS has repeatedly demonstrated criterion validity, as well as convergent and discriminant construct validity (Burckhardt & Anderson, 2003; Burckhardt, Anderson, Archenholtz, & Hägg, 2003).

Occupational Behaviors Satisfaction Checklist

The Occupational Behaviors Satisfaction Checklist (OBSC) was created for the purposes of this research study

to gauge participants' level of satisfaction in a wide variety of chosen, personally-meaningful occupations. The OBSC (see Appendix B) is comprised of 28 occupations, diverse in nature and reflective of the four domains of the Lifestyle Performance Model. This instrument was used to collect information about participants' chosen occupations—including with whom they engage in this occupation, frequency of engagement, and satisfaction with level of engagement. Additionally, it provides participants the opportunity to share information about other, unlisted meaningful occupations and occupations which they would like to engage in, though they presently do not.

The OBSC utilizes a scale reflective of the Flanagan QOLS. This 7-item Likert scale format (anchored with "delighted" and "terrible") was chosen based on literature regarding this format, as well as for ease of data analysis following data collection. The OBSC can be self-administered, or used as an assessment tool in a clinical setting to gather general information about individuals' level of occupational engagement, enjoyed occupations, and level of satisfaction regarding their occupational engagement. The OBSC is scored by adding up individual item numbers to yield a total score, which may range from 28 to 196. While the average total healthy score found in typical adult populations is yet to be established, the item scaling of the OBSC is such that higher scores represent a higher level of occupational engagement and satisfaction with level of occupational engagement. This assumption is based on foundation beliefs of occupational science and therapy that occupational engagement enriches the human experience and increases overall health and well-being, and quality of life.

Procedures

Following approval by the Institutional Review Board, a random sample of 400 was generated through the Office of the Registrar at the Central Kentucky University. E-mails were constructed and addressed using the contact information for the random sample. Following this initial use of contact information solely by the primary researcher, the file including the contact information for all potential participants was permanently deleted.

A personalized initial e-mail (see Appendix C) included a letter of invitation to participate in this research study and informed potential participants that participation in this research study would require only an estimated 20 minutes of their time. This letter of invitation also included a description of the purpose of this research study, as well as a brief statement outlining the rationale of the instruments chosen and inclusion criteria to be a participant in the study. Upon meeting inclusion criteria, participants then chose to participate or not participate through completing the research instruments through the online survey tool. Informed consent from voluntary participants was assumed through participation in the research process. Through this use of personal e-mail communication, subject's comments, questions, and/or concerns were addressed personally and privately through e-mail communication.

Data Collection

400 surveys were randomly distributed via personal e-mail contact. Three individuals who completed the survey instruments entirely were excluded from data collection based on "not sure" and "prefer not to disclose" responses regarding their self-identified ACOA status. Of the useable responses, 23 self-identified as ACOAs and 55 self-identified as non-ACOAs; this was a 19.5% return rate of useable responses.

Data Analysis

Data included all information gathered from the demographics questionnaire, Flanagan Quality of Life Scale (QOLS), and Occupational Behaviors Satisfaction Checklist (OBSC). Variables include satisfaction as indicated by the mean total score on the Flanagan QOLS and satisfaction as indicated by the mean total score on the OBSC. Mean scores were found for both populations on each of the completed instruments. As instructions for scoring the QOLS indicate, missing data was treated by entering the mean score for the missing items. Therefore, data analysis was completed using adjusted mean scores following treatment for missing data.

Further data analysis was completed through sample t-tests to compare mean total scores on the QOLS and OBSC for individuals who self-identified as an ACOA in comparison with non-ACOA participants. Additionally, adjusted mean scores were found for all participants on each of the completed instruments to gain an overall understanding of the relationship between occupational engagement and quality of life based on information gathered from survey instruments. Data included all information gathered from the demographics questionnaire, QOLS, and OBSC.

Results

Results are reflective of the adjusted means of a true random sample of 78 participants (11.75% usable response rate). Of this, 55 self-identified as non-ACOA and 23 self-identified as ACOA. Within the portion of the sample who self-identified as an ACOA: 5 participants identified having been raised by a mother with alcoholism, 16 participants identified having been raised by a father with alcoholism, one participant identified having been raised by a stepfather with alcoholism, and one participant identified having been raised by a mother and father with alcoholism. No participants identified being raised by a stepmother with alcoholism.

The mean age of respondents was 46.96 years (range of 26 to 69 years). Additionally, 49 were women and 29 were men. Educational levels of participants yielded the following information: 28 have earned a doctoral degree or are presently enrolled in a doctoral degree program; 29 have earned a graduate degree or are presently enrolled in a graduate degree program; 15 have earned an undergraduate degree; 4 have completed some college; 2 have graduated from high school or earned a GED. Thus, this sample is inclusive of a variety of ages, stages of life, and educational levels.

Following data analysis using paired sample t-tests, it was found that between ACOAs ($n = 23$) and non-ACOAs ($n = 55$), no significant difference was detected on the Flanagan QOLS ($p = .059$). However, while it cannot be reported that a significant difference exists between these two populations regarding Flanagan QOLS scores based on the inadequate sample size, the p-value (.059) is indicative of an existing difference in quality of life between ACOAs and non-ACOAs.

Also using paired sample t-tests, no significant difference was found between ACOAs ($n = 23$) and non-ACOAs($n = 55$) on the OBSC ($p = .133$). Due to the non-standardization of this survey instrument, however, it was not expected that a significant difference may be detected through statistical analysis. This is a result of the lack of evidence and literature which provides support and baseline measures on the OBSC regarding the satisfaction with occupational engagement for a healthy, typical population versus an atypical population.

Despite the lack of significant difference on the individual instruments between the two populations sampled, a moderate positive linear correlation ($p = .312$) was detected in comparing overall scores on the Flanagan QOLS and OBSC for both populations. This moderate positive linear correlation is indicative of a relationship between quality of life and satisfaction with occupational engagement. See Table 1 for these results.

Table 1: Mean QOLS and OBSC scores for ACOAs and Non-ACOAs

	ACOA	Non-ACOA
Mean Flanagan QOLS Score	86.85 (SD ± 8.24)	91.9 (SD ± 11.1)
Mean OBSC Score	136.3 (SD ± 15.8)	145.1 (SD ± 25.9)

Source: Vaught, E. & Wittman, P. (2011), "Occupational Behaviors and Quality of Life: A Comparison Study of Individuals Who Self-Identify as Adult Children of Alcoholics and Non Adult Children of Alcoholics."

Limitations of this study include a limited sample size following a low response rate, as well as use of a non-standardized survey instrument in data collection.

Discussion

Intervention Programs

Research has looked at a number of interrelated factors in the design and provision of intervention programs for COAs, as well as ACOAs. Conceptualized mediating and moderating variables have included: intrapsychic (self-awareness) and interpersonal (social support), intelligence, temperament, coping strategies, and adjustment style (Emshoff & Price, 1999). As a result, three factors have been identified as having a strong influence on "stress-adjustment relationship in children" (Emshoff & Price, 1999, p. 1113). These three factors include individual-level, family milieu, and environmental. At present, emerging and established intervention programs aimed at improving quality of life often take place within schools and use short-term, small-group approaches to target areas such as alcoholism education, stress management, social supports and the development of social competence, and training in coping mechanisms (Emshoff & Price, 1999; Price & Emshoff, 1997). Additionally, the use of family and community-based programs have shown promise with this population. (Examples of such programs include: Strengthening Families Program (SFP), Alateen, Al-Anon, and The Midwestern Prevention Project).

Occupational scientists and occupational therapists have a strong belief that occupational engagement positively impacts overall life satisfaction and quality of life. Therefore, participation in meaningful, personally-constructed patterns of occupational engagement and behavior increase life satisfaction, and provide sufficient opportunity for skill development, valued goal attainment, and social participation. Based on the moderate positive linear correlation detected between ACOAs and non-ACOAs on the research instruments, the results of this study do suggest that a relationship exists between occupational engagement and quality of life of ACOAs versus non-ACOAs. Responses of ACOA versus non-ACOA on the OBSC, noted no significant difference pertaining to occupational engagement. However, following use in this study, a better understanding of any differences in occupational engagement between the two populations can be noted in future research.

Findings from this study suggest that a lack of occupational engagement, such as that common in alcoholic family environments, may have implications on occupational engagement into adulthood (Vaught & Wittman, 2011). While it is widely known and accepted that ACOAs are at an increased risk for substance abuse and mental health concerns (Anda, et al, 2002), it is important that we also consider the implications of decreased occupational engagement secondary to growing up in an alcoholic family environment typical of this population (Vaught & Wittman, 2011) and, as a result, the associated risk for lower quality life. Confronting and re-

mediating such effects of occupational deprivation across the lifespan may lead to an overall increase in perceived quality of life.

Healthcare providers can play a pivotal role in appropriately and strategically encouraging posttraumatic growth and occupational engagement among clients "who have experienced a wide range of highly stressful situations" (Calhoun & Tedeschi, 1999, pg. 54) to increase quality of life. Therefore, the need exists for preventative occupation-based and early intervention service provision aimed at breaking the cycle of transgenerational substance abuse. As suggested by Emshoff and Price (199), such programs should include "information and education, skills building in the areas of coping and social competence, social support and an outlet for safe expression of feelings, and finally healthy alternative activities" (p. 1120). In doing so, we can not only lower healthcare needs and costs across the lifespan, but also increase the quality of life and improve adjustment styles of COAs prior to later issues that may be exacerbated across the lifespan.

Health care providers need training and guidelines not only for identifying and treating families in which children are exposed to adverse experiences, but also for identifying and treating ACOAs. Results from this study strongly suggest that prevention and treatment of limited occupational engagement, especially among individuals who have traumatic childhood experiences—such as being raised in an alcoholic family environment—will depend on clinicians' knowledge of familial disposition to substance abuse disorders and the long-term effects of such an experience, with which both alcohol abuse and mental health concerns are strongly associated.

Lastly, underutilized resources, such as school-based occupational therapists, psychologists, and social workers can expand their role in school systems to include drug and alcohol education, as well as parent and family training. Such community-wide supports and resources can reach more young people through effective occupation-based education and intervention strategies tailored to meet the widespread needs of adolescents and their families.

Further research is necessary to explore the occupational engagement and quality of life of ACOAs, as well as the development of the OBSC as a standardized measure of satisfaction with occupational engagement. This future research may seek to understand the personal meaning of being an ACOA to clients, and seek to establish skills which will foster rich and meaningful occupational engagement to increase overall function and quality of life. Additionally, it would benefit individuals following posttraumatic childhood experience to develop effective models of treatment and intervention in occupational therapy. In doing so, clinicians may use our unique skill set and therapeutic use of self to establish social support networks and to further supplement mental health treatment to achieve life satisfaction through meaningful occupational engagement.

Conclusion

In working with COAs, it may benefit clinicians to utilize a family systems approach to therapeutic intervention similar to proposed models of intervention for occupational therapy treatment of alcoholism (Moyers, 1991). As stated by Whitfield (1984, p. 20), "once recovery in the family occurs, the new and healthy adaptive adjustments can stabilize and maintain the recovery of the alcoholic." In using this approach, it is necessary to provide proper education and training to all healthcare professionals, due to the vast prevalence of children of alcoholics and adult children of alcoholics in both the general and clinical populations. Through educational curricula, it is necessary to integrate knowledge and treatment of substance abuse and prevention in conjunction with parenting skills, child abuse and/or neglect, mental health involvements, self-concept, and occupational engagement of children of alcoholics and adult children of alcoholics.

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