



PERSONALITY, SELF-ESTEEM AND DEPRESSION IN PEOPLE FROM FAMILIES WITH ALCOHOL-RELATED PROBLEMS

OSOBOWOŚĆ, SAMOOCENA I DEPRESJA U OSÓB POCHODZĄCYCH Z RODZIN Z PROBLEMEM ALKOHOLOWYM

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Abstract

Introduction: Growing up in a family with an alcohol-related problem may have an impact on personality traits, self-esteem and a predisposition to depression in adulthood. The aim of the current research was to analyse whether there are differences between people raised in families with or without alcohol history in personality traits, self-esteem and depression.

Material and methods: The study included 190 persons; 94 from families with an alcohol problem and 96 from the control group. The Rosenberg's Self-Esteem Scale (SES), Ten Item Personality Inventory (TIPI) and Beck's Depression Inventory (BDI) were used in the study.

Results: The study showed that people from families with alcohol-related problems were charac-

Streszczenie

Wprowadzenie: Dorastanie w rodzinie z problemem alkoholowym może mieć wpływ na cechy osobowości w wieku dorosłym, samoocenę i predyspozycje do depresji. Celem badań było określenie różnic między cechami osobowości, samooceną i depresją u osób pochodzących z rodzin z problemem alkoholowym i tych bez problemu.

Materiał i metody: W badaniu wzięło udział 190 osób, z czego 94 osoby z rodzin z problemem alkoholowym i 96 osób z grupy kontrolnej. Wykorzystano Skalę Samooceny Rosenberga (SES), Inwentarz Osobowości (TIPI-PL) oraz Inwentarz Depresji Becka (BDI).

Wyniki: Badanie wykazało, że osoby z rodzin z problemem alkoholowym charakteryzowały się niższym

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terised by lower self-esteem and higher intensity of depression symptoms compared to the control group. It has also been shown that people from families with alcohol problems are characterised by a greater intensity of neuroticism. Statistically, significant correlations were found between personality traits, self-esteem and depression.

Discussion: According to presented results, an alcohol-related problem in the family history has a negative impact on the adult's personality, self-esteem and the tendency to depression. Those who scored low on conscientiousness, emotional stability, extraversion, openness to experience and agreeableness have a risk of lower self-esteem and subsequently increased risk of depression. These conclusions are consistent with previous research and partially with theoretical assumptions.

Conclusions: Results show that people from families with an alcohol-related problem differ from the control group in terms of the level of self-esteem, intensity of depression and certain personality traits. These results can inspire further research and the creation of specialised therapeutic programmes.

Keywords: Depression, Self-esteem, Personality, Family, Alcoholism.

poziomem samooceny i większym nasileniem objawów depresji w porównaniu z grupą kontrolną. Wykazano również, że osoby pochodzące z rodzin alkoholowych cechują się większym poziomem neurotyzmu. Stwierdzono istotne statystycznie korelacje między cechami osobowości, samooceną i depresją.

Omówienie: Problem alkoholowy w rodzinie może negatywnie oddziaływać na rozwój osobowości, samoocenę i skłonność do depresji osób wychowujących się w tej rodzinie. Osoby, które osiągają niskie wyniki w zakresie sumienności, stabilności emocjonalnej, ekstrawersji, otwartości na doświadczenia i ugodowości, są narażone na ryzyko obniżenia samooceny, co następnie zwiększa ryzyko depresji. Te wyniki są zgodne z wynikami innych badań oraz częściowo potwierdzają założenia teoretyczne.

Wnioski: Osoby pochodzące z rodzin z problemem alkoholowym różnią się od grupy kontrolnej pod względem poziomu samooceny, nasilenia depresji i niektórych cech osobowości. Wyniki te mogą stanowić inspirację do dalszych badań i tworzenia specjalistycznych programów terapeutycznych

Słowa kluczowe: depresja, samoocena, osobowość, rodzina, alkoholizm.

■ INTRODUCTION

The human family is a natural environment that acts as the primary source of attachment, nurturing and socialisation. A family with an alcohol problem is one where someone drinks excessively, disruptively or uncontrollably. This family might be treated as a dysfunctional system in which member's drinking is an integral part of this system. The alcoholism of one becomes a point of reference for the experiences, attitudes and behaviours of his/her family members. The dependent member is a source of life, financial and emotional problems to all others [1], because his excessive alcohol consumption is stressful for the entire family system. It is estimated that approximately 13% of young people are brought up in families with an alcohol-related problem [2].

Research indicates that people growing up in families of this kind may more often show certain, varied personality traits like impulsiveness,

passivity, depressiveness, fear of rejection, intense emotional instability and criticality [3]. Park and Schepp [4] claim that growing up in a family with alcohol-related problems leads to many issues like, for example, a higher risk of depression, anxiety, suicidal ideation, substance abuse and specific interpersonal difficulties. Alcoholism in the family system may contribute to developing maladaptive personality traits. Research specified three groups of adult children of alcoholics (ACOAs) – “low-symptom profile”, “depressive-anxiety profile” and “high-symptom profile”. The first group was characterised by proper general adaptation level; their most common symptoms included: adaptation problems, vigilance, suspicion, shyness and depressive traits. People from the second group showed a trend to exaggerating difficulties, introversion, depressive and anxiety symptoms, lack of confidence and impulsiveness. The last group was characterised by low general adaptation levels and deep, serious affective disorders [5].

Numerous studies show the connection between growing up in a family with an alcohol problem and depression. Anda *et al.* [6] found the relationship between the number of adverse childhood experiences reported and the risk of alcoholism and depression. Some studies show that ACOAs manifested more symptoms of depressive disorders than non-ACOAs [7, 8]. Other studies show that drinking behaviours in families influenced attachment behaviours and self-esteem but did not influence depression [9].

Depression is often associated with low levels of self-esteem. The relationship between these two variables has been demonstrated in many studies on different populations [10-13]. There are also theoretical models explaining this relationship [11, 14]. Self-esteem refers to an individual's subjective evaluation of their own self-worth. People with low self-esteem are more likely to feel sad, lonely and depressed. Some researchers suggest that self-esteem can be a crucial factor in the aetiology of depression. People who had low self-esteem had a greater tendency for depression, both at clinical levels and in its milder forms. Self-esteem can also be one of the symptoms of depressive disorders. Depressed people are more likely to feel worthless and incompetent. Research also indicates that low self-esteem is not only associated with the occurrence of depression symptoms but is also a predictor of depression [11, 15]. The research demonstrated that low self-esteem in adolescence was a predictor of depression in adulthood. Individuals who suffered from low self-esteem during the adolescent years were more likely to exhibit symptoms of depression two decades later as adults [15]. In other studies, as regards depression predictors among teenagers, researchers found that the strongest was self-esteem [16, 17].

The family environment is one of the most important factors affecting the development of self-esteem. Studies show that people from families with alcohol problems have low self-esteem – a sense of inferiority makes the person feels ashamed of themselves. ACOAs work through their low self-esteem in two ways: 1) by setting high expectations for themselves and 2) by avoidance behaviours, which means withdrawing from difficult tasks to avoid failure [18]. People who grew up in families with alcohol-related problems are often exposed to violence and other adverse experiences. Studies showed that people who

experienced violence during childhood or observed the violence between parents have lower self-esteem in adult life [19]. Other studies showed that female juvenile offenders often had a history of childhood abuse and other adverse childhood experiences (ACE) while a relationship between ACE, aggression, depression, and low self-esteem was also observed [20]. ACOAs often have higher rates of depression, anxiety, and low self-esteem compared to non-ACOAs [21].

Studies show that there is a relationship between personality traits and self-esteem. Di Giunta *et al.* [22] demonstrated that personality traits like conscientiousness and openness to experience are positively correlated with self-esteem. In turn, the results of the Robins *et al.* research show that people with high self-esteem were characterised by low levels of neuroticism, high levels of extraversion and conscientiousness as well as a moderate level of agreeableness and openness to experiences. Moreover, the Big Five accounted for 34% of the self-esteem variance [23].

The abovementioned data suggest that people who grew up in a family with alcohol-related problems may differ from people who grew up in families without an alcohol problem in terms of some features. In our research, we focused on the relationship between personality, self-esteem and depression in people growing up in families with alcohol problems; a review of the literature showed a significant deficit in Polish research on people with ACOAs syndrome, especially taking into account all these variables. This topic seems to be most important due to the fact that alcoholism is a widespread problem. Moreover, there is no agreement among specialists regarding the existence of the phenomenon known as ACOAs, which makes study of this issue particularly more important. Our study seeks to fill this research gap by providing a better understanding of the psychological problems respondents have to face in their everyday life.

We assume that ACOAs have a higher risk of depression, lower self-assessment and different personality types than non-ACOAs. Our study aimed to analyse the differences in terms of personality traits, self-esteem and depression in people growing up in families with and without alcohol-related problems. Based on data from the literature, we hypothesise that: 1) people growing up in families with an alcohol problem will be

Table I. Percentage of answers about sociodemographic factors and the alcohol problem

Sociodemographic factors/alcohol problem	n (%)
Gender	
Man	130 (68.4)
Woman	60 (31.6)
Age	
18-20	25 (12.6)
21-30	133 (67.2)
31-40	19 (9.6)
41-50	8 (4.0)
51-60	3 (1.5)
61-70	1 (0.5)
Education	
Elementary	6 (3.16)
Vocational	7 (3.68)
Secondary	133 (70.0)
Higher	44 (23.16)
Place of residence	
Big city	58 (29.29)
Small town	95 (47.98)
Village	37 (18.69)
Alcohol problem in the family	
Yes, occurred	94 (49.47)
No, not occurred	96 (50.53)
The frequency of alcohol consumption by an alcoholic	
Binge drinking	24 (12.63)
Daily	31 (16.32)
A few times a week	29 (15.26)
Less than few times a week	10 (5.26)
No one in my family is addicted to alcohol	96 (50.53)

characterised by different personality traits, lower self-esteem and a greater tendency to depression compared to people who grew up in families without an alcohol problem while 2) personality traits are correlated with self-esteem and depression.

■ MATERIAL AND METHODS

Participants

The study included 190 subjects (average age 25.37; SD = 7.95) of which 130 were women (M = 26.01; SD = 8.86) and 60 were men (M = 23.97; SD = 5.36). The youngest was 18 years old and the oldest 68. Most came from a small

city (48%) and had a secondary-school education (70%). The research group consisted of 94 respondents (72 women and 22 men) from families with at least one person abusing alcohol most often every day. The control group consisted of 96 participants (58 women and 38 men) from families with no alcohol-related problems. The basic sociodemographic data are shown in Table I.

Procedure

Due to the epidemiological threat, study participants were recruited via ACOA social media support group websites (Facebook). The research was conducted between March and May 2020. All of the participants were over 18 years of age and were informed about the study purpose and their anonymity. It was also explained to them that they could stop filling in the survey at any time and without giving any reason. All respondents provided informed consent for participation in this study. After the data collection, we rejected 8 questionnaires due to missing data.

Measures

In our study, we asked **basic sociodemographic questions** about gender, age, education, and place of residence. We measured the prevalence of the alcohol problem on the basis of the following questions: Is/Was a member of your immediate family addicted to alcohol? Who is/was the addicted person for you? Is/Was the addiction correlated with aggression? (You can choose from: verbal aggression, physical aggression, destroying objects); How often, does/did the addicted person consume alcohol? (You can choose from: every day, a few times a week, less than a few times a week, alcohol binge); What kind of alcohol does/did the addicted person prefer (You can choose from: high percentage, low percentage).

The Rosenberg's Self-Esteem Scale (SES) [24] in Polish adaptation by Dzwonkowska *et al.* [25] was used in the study to measure self-esteem. It measures global self-esteem and positive and negative feelings about the self and is a 10-item questionnaire with 1 (strongly agree) to 4 (strongly disagree) scale. It showed good psychometric properties in the current study (Cronbach's $\alpha = 0.89$).

Ten Item Personality Inventory (TIPI) in Polish adaptation (TIPI-PL) by Sorokowska *et al.* [26] is designed to measure personality traits based on

Table II. Descriptive statistics with Kolmogorov-Smirnov normality tests

	M	Me	SD	Skewness	Kurtosis	D	p
Extraversion	10.09	10.50	2.85	-0.55	-0.35	0.12	< 0.001
Conscientiousness	10.26	11.00	2.50	-0.44	-0.51	0.15	< 0.001
Emotional stability	7.69	8.00	3.25	-0.03	-0.76	0.09	< 0.001
Openness to experience	9.25	9.00	2.26	-0.10	-0.16	0.10	< 0.001
Agreeableness	10.17	10.00	2.55	-0.55	-0.23	0.12	< 0.001
Depression symptoms	11.12	8.00	9.76	0.97	0.33	0.14	< 0.001
Self-esteem	27.49	28.00	7.37	-0.22	-0.70	0.07	0.040
Age	25.39	22.00	7.97	2.41	0.74	0.24	< 0.001

D – Kolmogorov-Smirnov D statistic

Table III. Significance of differences for sociodemographic variables in the group with an alcohol-related problem in the family and the control group

	Alcohol-related problem group (n = 94)				Control group (n = 96)				p	r	η ²
	Mean rank	M	Me	SD	Mean rank	M	Me	SD			
Age	106.90	27.52	23.00	9.75	83.47	23.32	22.00	4.97	0.003	0.22	0.05
Residence ^a	101.66	2.19	2.00	0.74	89.47	2.03	2.00	0.66	0.095	0.12	0.01
Education ^b	97.24	3.16	3.00	0.61	93.79	3.10	3.00	0.62	0.590	0.04	< 0.01

^a1 – big city, 2 – small town, 3 – village. ^b1 – elementary, 2 – vocational, 3 – secondary, 4 – higher education, r and η² – effect size indicators

the Big Five model. This scale was developed by Gosling *et al.* [27]. It includes 10 items and the answers are checked on a seven-point scale, with 1 (strongly disagree) to 7 (strongly agree). The following reliability ratios were obtained in the reported study: extraversion α = 0.71, agreeableness α = 0.65, conscientiousness α = 0.64, emotional stability α = 0.70 and openness to experience α = 0.29. Some Cronbach's α coefficients were under the value considered as acceptable [28]. However, according to the authors [26], poor reliability in TIPI may be caused by the low number of items in subscales and this should not be taken as the indicator of appropriateness for this tool's application.

Beck's Depression Inventory (BDI) [29] in a Polish adaptation by Parnowski and Jernajczyk [30]. This scale is used to measure the severity of symptoms of depression. The questions concern the last month, and the answers are checked on a four-point scale from 0 to 3. The higher the test result, the more severe are the depressive symptoms. A score above 11 may indicate the possibility of depression, while scores above 26 indicate symptoms of severe depression. BDI results from this study showed good reliability (Cronbach's α = 0.91).

■ RESULTS

First, we calculated descriptive statistics with the Kolmogorov-Smirnov normality test (Table II). It appeared that all numeric variables are not distributed normally. The kurtosis value is between -2 and +2 for all numeric variables except age [31]. According to this, we decided to use parametric methods to test our hypothesis.

To assess whether, in addition to the family history of alcoholism, the study groups did not differ in terms of other variables, and due to the ordinal character of education and residence along with asymmetry of age distribution, a series of Mann-Whitney *U* tests were performed. There were no differences in place of residence size and education level though the group with alcoholic problem in their family history was slightly older ($M_{\text{alcoholic}} = 27.52$; $M_{\text{non-alcoholic}} = 23.32$; $p = 0.003$; $\eta^2 = 0.05$) (Table III).

To verify the differences between participants from families with alcohol-related problems and from the control group, we performed a MANCOVA analysis. Box's test of equality of covariances matrices suggests a general homogeneity of variances and covariances (Box's $M = 40.08$; $F = 1.37$; $p = 0.09$). Levene's test of equality of error variances shows that the assumption of homo-

Table IV. MANCOVA results for significances of differences between the alcohol-related problem family group and that with no problem (with control for age)

	Alcohol-related problem group (n = 94)		Control group (n = 96)		F	p	η^2
	M	SD	M	SD			
Extraversion	9.69	3.09	10.46	2.57	1.67	0.197	0.01
Conscientiousness	10.30	2.61	10.27	2.35	0.29	0.585	0.01
Emotional stability	6.94	3.25	8.48	3.03	8.63	0.004	0.04
Openness to experience	9.16	2.33	9.34	2.21	0.06	0.811	0.01
Agreeableness	10.15	2.75	10.24	2.32	0.01	0.948	0.01
Depression symptoms	14.07	10.47	7.94	7.35	15.39	< 0.001	0.08
Self-esteem	26.06	7.28	28.88	7.26	4.99	0.027	0.03

Alcohol problem: Wilk's $\lambda = 0.88$; $F = 3.39$; $p = 0.002$; $\eta^2 = 0.12$;
 Age: Wilk's $\lambda = 0.39$; $F = 0.99$; $p = 0.438$; $\eta^2 = 0.04$

F – ANOVA F-value results, η^2 – effect size indicator

Table V. Results for Pearson's *r* correlation

	M	SD	1.	2.	3.	4.	5.	6.
1. Extraversion	10.089	2.852						
2. Conscientiousness	10.258	2.499	0.30					
3. Emotional stability	7.695	3.245	0.52	0.25				
4. Openness to experience	9.253	2.261	0.42	0.15	0.18			
5. Agreeableness	10.168	2.554	0.20	0.17	0.12	0.17		
6. Depression symptoms	11.121	9.757	-0.59	-0.39	-0.63	-0.28	-0.27	
7. Self-esteem	27.489	7.368	0.44	0.29	0.35	0.26	0.18	-0.49

Bolded for $p < 0.05$

generality variances was not met only for depression symptoms ($F = 14.22$; $p < 0.001$), so caution should be exercised in interpreting this result. Results showed that an alcohol problem in family history significantly differentiates emotional stability – $F(1.188) = 8.63$; $p = 0.004$, depression symptoms – $F(1.188) = 15.39$; $p \leq 0.001$ and self-esteem – $F(1.188) = 3.99$; $p = 0.027$. Additionally, due to the difference in proportion of men to women in both groups and skewness of age, we tested whether sex and age interact with an alcohol problem in the family. As it turned out, these variables also do not change the effect of the alcohol problem in the family on personality, self-esteem and depression, gender was Wilk's $\lambda F = 3.68$; $p > 0.05$ and age was Wilk's $\lambda F = 1.58$; $p > 0.05$. Participants from families with an alcohol problem are characterised by a higher level of depression symptoms along with a lower level of emotional stability and self-esteem (Table IV).

We also checked the relationship between self-esteem and depression symptoms in a group

of people with an alcohol family problem; a simple regression analysis was used for verification purposes. Variance Inflation Factors (VIF) values were close to 1 which means that predictors were not colinear (VIF = 1.00-1.06). It turned out that this relationship is negative and statistically significant ($\beta = -0.541$; $SE = 0.088$; $t = -5.89$; $p < 0.001$, $R^2 = 0.27$). Adding age to the model does not change it significantly (p of F change = 0.679). The relationship follows the same direction as the control group but is stronger ($\Delta\beta = 0.11$; $\Delta R^2 = 0.10$).

The correlations between the variables were also examined (Table III) using Pearson's *r* analysis. All relationships turned out to be statistically significant except for the correlation of agreeableness with emotional stability. The strongest relationship is between depression symptoms and emotional stability ($r = -0.63$; $p < 0.05$) (Table V).

Additionally, in order to understand the personality trait interaction between self-esteem and depression comprehensively, partial correlation

analysis with control of age and remaining personality traits was calculated (Table VI).

Adding control of age and remaining personality traits weakened most of the correlations and make part of them statistically insignificant including the correlation of self-esteem with emotional stability and openness to experience as well as depression symptoms with openness to experience and agreeableness.

■ DISCUSSION

The study aimed to determine the differences and relationships between personality traits, self-esteem and depression in people growing up in families with or without alcohol-related problems. The analyses indicated the relationships between all tested variables were significant.

The study showed differences in some personality traits between people growing up in families with alcohol-related problems and the control group. The greatest differences were observed in terms of neuroticism. Neuroticism is the opposite of emotional stability. Łukasiewicz [32] claims that neurotic people are characterised by strong emotional disturbance, low stress-resistant and a tendency for anxiety. They often feel unpleasant mood swings and guilt and also they are shy, irritable and have low self-assessment [33, 34].

So far, no unequivocal causes of neuroticism have been demonstrated. Research shows three basic theories. Karen Horney [35] explains the direction of personality development by referring to early childhood experiences. Costa and McCrae [36] draw attention to genetic factors that may influence the development of neuroticism. Physiologists indicate the role of excessive activity of the sympathetic nervous system. According to McAdams and Olson [37] and Caspi and Shiner [38], neuroticism in adulthood may develop based on negative emotionality during childhood. Furthermore, Briley and Tucker-Drob [39] in their studies showed that the main role in neuroticism development is genetics and environmental factors; this impact changes with age – the older the person is, the greater the influence of the environment while the influence of genetics decreases. The most important environmental factor influencing personality is the family of origin. Dąbrowska [40] draws attention to the role of the mother's negative attitude towards the child.

Table VI. Partial correlation analysis with control for age and remaining personality traits

	Self-esteem	Depression symptoms
Extraversion	0.22	-0.32
Conscientiousness	0.16	0.21
Emotional stability	0.14	0.45
Openness to experience	0.09	0.05
Agreeableness	-0.17	0.08

Bolded for $p < 0.05$

Aggressive, anxious, neurotic, overly scrupulous and demanding women may project these traits on the child, which has an impact on his neurotic personality development. Living in a family with alcohol problems is associated with a lack of stability, financial problems and violence, which generates feelings of guilt, shame and fear. Constant presence in an environment of this kind may lead to a sense of permanent stress, which also has a negative impact on adolescent children's physical and mental health.

According to the abovementioned studies, we can state that people who have grown up in family with alcohol problems will be characterised by a higher level of neuroticism than those who have grown in family without alcohol problems. This conclusion is consistent with the result of our study. Weiner [41] showed that ACOAs manifested a higher level of shame, depression and neuroticism, which is also consistent with our result. Furthermore, Belliveau's and Stoppard's studies [42] confirmed that ACOAs show a higher level of neuroticism, depression and psychoticism compared to the control group. Other research revealed that Adult Children of Alcoholics are characterised by increased levels of neuroticism, negative emotionality, impulsivity and disinhibition [43].

Our study results demonstrated statistically significant differences in self-esteem. Subjects from alcohol-related problem families had lower self-esteem than the control group. This could be due to several factors like members' mental and physical violence, bullying, incorrect parental bonds and lower socioeconomic status. Psychological violence has an important impact on lowering self-esteem, and in dysfunctional families violence is a common occurrence. Persons who often hear they are "nothing" that "it's all your fault" and "you will achieve nothing" internalise

the message, which makes them start perceiving themselves negatively. Włodarczyk [44] claims, that children who experience chronic emotional abuse, grow up with the feeling of guilt and have low self-esteem. Węgrzynowska [45] discussed the many negative consequences of bullying, like reduced self-esteem. In families with alcohol-related problems, the bond between children and parents develops incorrectly. Parental addiction absorbs most of the family members' attention, which pushes the child's needs aside. This situation influences the formation of a childhood insecure attachment style, which has an impact on development and self-esteem.

One of the consequences of alcohol abuse in the family is an unstable financial situation. Children who grew up in families like this often feel ashamed of being poorer than their peers. It makes them feel worse than others. Research shows, that mothers' poverty has a negative impact on their children's self-esteem development [46]. Data from multiple studies show that people from dysfunctional families have lower self-esteem, which is consistent with the results of our study. People who grew up in families with alcohol-related problems experience many consequences of parental alcoholism, which affects their whole life.

Another consequence of growing up in a family with alcohol problems is a higher risk of depression. Children of addicted parents are particularly vulnerable to mental disorders because alcohol becomes the drinker's priority, which can affect the quality of parenting [47]. Depression may be caused by many factors, which fall into endogenous, psychological and somatic categories [48, 49]. Growing up in this kind of dysfunctional families increases the probability of experiencing negative events in childhood, which may translate into problems in adult life. According to Anda *et al.* [6] those with alcohol-abusing parents more often suffered from depression and alcoholism than persons from the control group. They reported that more adverse childhood experiences in addition to parental alcoholism increased the risk of depression. Studies by Liu [50] also confirmed this phenomenon; people who have experienced adversities in early life suffered from a more chronic course for depression and had poorer treatment outcomes. Another research showed the connection between adverse childhood experiences and later low socioeconomic status, which was linked

to depression [51]. Studies prove that the domestic violence experienced by a child may have long-term consequences, e.g. the risk of depression in adulthood [52]. Furthermore, ACOAs develop adverse coping mechanisms and more personal dysfunction than non-ACOAs [53]. Studies comparing different diagnoses among family members have shown that family members' alcoholism is associated with a greater risk of depression, trauma and substance use disorders than with a diagnosis of diabetes or asthma [54]. These studies are consistent with our results.

Our study proved a relationship between self-esteem and depression; these variables correlated negatively with each other (the lower self-esteem, the higher level of depression). People with low self-esteem are more likely to feel sad, lonely and depressed. Beck's cognitive model of depression assumes the existence of the depressive triad (negative beliefs about self, environment and future). The first component of the triad is connected to low self-esteem and neglect of a person's capabilities [55]. Depressed people are more likely to feel worthless and incompetent. Research indicates that low self-esteem is not only associated with the occurrence of mood disorders but is also a predictor of depression [11, 15]. Fiorilli *et al.* [17] showed in their studies that self-assessment was the most important depression predictor in adolescents. It was also shown that the level of self-esteem in adolescence was a predictor for adult depression [15].

In the present study, it was shown that higher levels of extraversion, conscientiousness, emotional stability, openness to experience and agreeableness were related to higher self-esteem, which in turn was related to lower depression. Among the personality traits studied, emotional stability and extraversion should be noted first as characteristics most strongly associated with lower depression. Moreover, the study showed a difference in terms of emotional stability between people from families with alcohol-related problems and those without. More frequent occurrences of neuroticism may reduce self-esteem in this group, which may predispose those from families with alcohol-related problems to mood disorders. Personality traits like agreeableness and openness to experience are less consistently related to both self-esteem and depression [23, 56].

Limitations. The present study found differences in terms of emotional stability, self-esteem and depression between those from families with and without an alcohol-related problem. The main limitation is the lack of a longitudinal approach. Without including a temporal aspect in the development of depression symptoms and self-esteem, it is impossible to interpret results considering relationship causality. Moreover, the study was conducted via social media websites on support groups for ACOAs. There is a risk that the group was limited only to people with a specific approach to their problems like rejection or coping focused on social support making the group possibly not representative for ACOAs. The next limitation of our study is the lack of control of all variables which can affect the development of depression, self-esteem and individual personality traits. In addition, more variables that can affect an individual's life should take into account like alcohol

abuse by ACOAs, or actual contacts with alcoholic parents.

■ CONCLUSIONS

Our study showed that people from families with alcohol related-problem more often suffer from depressive disorders, have low self-esteem and may also be characterised by a higher level of neuroticism compared to the control group. The obtained results indicate what difficulties ACOAs may face, and what problems specialists should pay attention to, when working with such patients. Our research can be the basis for the creation of specialised therapeutic programmes for those growing up in a families with alcohol problems. It can also be an inspiration for further research in this area, which would lead to a better understanding of the problem and allow for more effective help for ACOAs.

Conflict of interest/Konflikt interesów

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Ethics/Etyka

The work described in this article has been carried out in accordance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) on medical research involving human subjects, Uniform Requirements for manuscripts submitted to biomedical journals and the ethical principles defined in the Farmington Consensus of 1997.

Treści przedstawione w pracy są zgodne z zasadami Deklaracji Helsińskiej odnoszącymi się do badań z udziałem ludzi, ujednoliconymi wymaganiami dla czasopism biomedycznych oraz z zasadami etycznymi określonymi w Porozumieniu z Farmington w 1997 roku.

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