Revisiting the Concept of Adaptive Familial Roles and Adult Children of Alcoholics (ACOA): Forty Years Later

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Abstract

The term “adult children of alcoholics” (ACOAs) refers to adults who have grown up in a home with at least one alcoholic parent. ACOAs have often been studied as a homogenous group without examining type of family dysfunction. The present study investigated the relation between demographics, personality, and parenting measures and Wegscheider’s (1981) ACOA adaptive familial roles of Hero (responsible overachiever), Mascot (family clown), Scapegoat (rebellious/disruptive behaviours), and Lost Child (withdrawn/isolated). Data were collected from 327 participants (*M* age = 35.3 years) who self-identified and were grouped as ACOA, Abused, ACOA+Abused, or Control. Generally, the ACOA group was similar to the Control group in terms of family roles and measures of personality and parenting but differed from both the Abused and the ACOA+Abused groups, with the exception of the Lost Child role. Higher scores were found for the positive Hero and Mascot roles in the Control and ACOA groups compared to the Abused and ACOA+Abused groups. Conversely, higher scores for the negative Scapegoat role were found among the Abused and ACOA+Abused groups compared to the Control and ACOA groups. There was a strong influence of personality related to the adoption of family roles whereas the influence of parenting was small in comparison. Individuals from the family type groups were more likely to adopt the Lost Child role compared to the Control group but the influence of family type group was negligible for the other family roles. The significance of this study’s findings and clinical relevance are discussed.

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Overview

In the last four decades, we have come to appreciate that human development is a function of very complex, dynamic processes, involving numerous ongoing transactional exchanges between nature and nurture, and between people. This development continues over the lifespan. We also understand that typical development informs our understanding of atypical development. By identifying specific aspects of dysfunctional behaviours, developmental considerations can guide the selection of ideal interventions. There has also been tremendous progress in the field of developmental psychopathology whereby we can now identify the ongoing dynamic interactions of different aspects of the environment (e.g., home environment) with individual characteristics such as gender, education, and personality. In addition, we realize, with the concept of emerging adulthood, that university undergraduates do not represent the adult population. The present study was conducted with adult offspring (not university students) from families with an alcoholic parent, an abusive parent, or an alcoholic and abusive parent, as well as a control group. The present dissertation is an investigation of the relation between demographic variables, personality variables, parenting styles, perceived reciprocity with parents, and family types and the role that children played in their complex family environment.

The study focused on Adult Children of Alcoholics (ACOAs), the roles they played as children according to the Family Systems Theory (Satir, 1972; Minuchin, 1974), and their present mental health. Note that Satir and Minuchin's work was conducted over 40 years ago. Shortcomings of that research include: the fact that the family roles had not been examined in other dysfunctional groups of families; often "adult children" typically meant first-year university students who do not represent an adult population; abuse was not necessarily identified as an important variable within the ACOA group; different demographic variables

(e.g., socioeconomic level of the family) had been ignored; and the roles adopted by the child in a family were likely influenced by multiple interacting variables including the child's individual personality, parents' parenting styles, and the possible development for perceived parental reciprocity in which emerging adults and parents perceive one another as relatively equal in a respectful manner. These issues needed to be addressed before examining the long term mental health issues of the ACOA individuals and the potential for the most effective intervention and treatment alternatives.

Revisiting the Concept of Adaptive Familial Roles and Adult Children of Alcoholics (ACOA): Forty Years Later

The term "adult children of alcoholics" (ACOAs) refers to individuals who have grown up in a home with at least one alcoholic parent (Jones, Perera-Diltz, Salyers, Laux, Cochrane, 2007). Popular or clinical literature has described an array of negative symptomatology and outcomes for ACOAs. As a result, theorists and clinicians have held a belief that ACOAs have distinct characteristics compared to non-ACOAs (Black, 1981; Woititz, 1983; Jones et al., 2007). Researchers have investigated whether the characteristics that ACOAs portray are unique to parental alcoholism or whether they are a result of general family dysfunction. Many researchers have focused their attention on the examination of ACOAs to help develop a treatment protocol that could be tailored to their clients' or patients' specific needs. However, the empirical findings of ACOAs related to personality, mental health, and family functioning have been mixed. Some research illustrates that many ACOAs are at risk for psychopathology, but others demonstrate that they are not affected negatively. Some of this variability may be attributed to combining ACOAs with ACOAs who were also abused into one group. Others have only focused on college-aged participants or primarily on clinical samples and further lack data regarding demographic information. No study has been able to find a particular clinical profile to describe all ACOAs. Therefore, although being an ACOA is recognised as a risk factor: not all ACOAs have a personality disorder, mental illness, or are necessarily negatively affected. In fact, early studies by Werner and Smith (1977, 1982) demonstrated the resiliency of some children who had grown up with an alcoholic parent. Werner (1986) found variables associated with the caregiving environment that contributed to the resiliency of children who grew up with an alcoholic parent. These included extra attention from the primary caregiver, absence of prolonged separation

between parent and child, absence of conflict between parents, no other siblings born during the first two years of life, and a non-conflictual relationship with parents in adolescence. In addition, particular characteristics of the child were also advantageous to their resiliency, such as reading and writing aptitude, achievement orientation, positive temperament that elicited a positive response from caregivers, a sense of responsibility, positive self-concept, and an internal locus of control.

Clinicians have described four adaptive roles that are taken on by children growing up in alcoholic environments (Black, 1981; Wegscheider, 1981), namely, the Hero, Lost Child, Mascot, and Scapegoat roles. Historically, these roles are highly influenced by Family Systems Theories (Satir, 1972) which originally proposed that certain communication styles were taken on by family members in an attempt to bring stability and homeostasis to a family environment. Thus, one member's communication style affects another's. Satir's communication styles are described as Placating (i.e., accepting blame even if one is not to blame and pacifying by assenting to any requests whether good or bad), Super-Reasonable or Computing (i.e., being excessively reasonable to handle stress without acknowledging emotions), Blaming (i.e., accusing others of the problem, "finger pointing"), Irrelevant (i.e., reacting in a way that has nothing to do with the current situation, thus the context is missing), and Congruent (i.e., reacting in a way that is appropriate to the current situation).

Similarly, the ACOA roles were exclusively developed for the use in understanding children of alcoholic parents. These roles are believed to help ACOAs survive in an alcoholic family and to bring some stability to an otherwise unstable alcoholic environment (Black, 1989; Minuchin et al., 1975). Black and Wegscheider posited that all ACOAs were faced with a problematic family life and would suffer as adults because the formerly adaptive roles would no

longer be helpful or useful to them later in life. It was not until later that these roles were hypothesised to be applicable to children of other types of dysfunctional and 'normal' families. Atkins (1991), has proposed that children of divorce and siblings of children with disabilities also choose adaptive family roles and thus, these roles are not necessarily unique to ACOAs alone and are not only related to parental alcoholism.

Questions remain as to how children come to take on these family roles. Researchers have only examined gender and birth order in relation to these family roles (Veronie & Fruehstorfer, 2001), but have not explored what other characteristics may be associated with them. Could family roles of Hero, Lost Child, Mascot and Scapegoat also be a function of individual differences in personality or environmental characteristics of parenting constructs, or both?

To address these concerns, the present study examines individual personality factors and characteristics of parenting (i.e., parenting styles and parent-child reciprocity) which may contribute to the adoption of particular family roles. Because we question limiting the roles to just ACOA groups, data were collected from adult participants who fall into four groups, namely ACOA, those who have experienced abuse (Abused), those who are both ACOA and Abused, and those who are neither ACOA nor Abused (Control).

Literature on ACOAs in general will be introduced followed by a discussion of the clinical and empirical literature related to ACOA adaptive family roles. The Theory of Developmental Psychopathology (Cicchetti, 1984; 2006; 2016; Cicchetti & Cohen, 1995) as it relates to research on ACOAs will be presented, followed by research on differences between ACOAs and non-ACOAs as it relates to personality and psychopathology. An examination of research on personality in regard to its contribution to the roles will be reviewed. Family Systems

Theory (Minuchin, 1974; Satir, 1972) will then be discussed as it pertains to these roles and research relevant to the parenting constructs that are examined in this study. Finally, a brief examination of ACOAs and individuals from other dysfunctional families is provided.

Theorists have purported that ACOAs, compared to children who grew up in non-alcoholic environments, are more likely to display a syndrome that includes numerous social, emotional, and psychological problems. Emotionally, adolescents with an alcoholic parent may share a diverse array of feelings towards their parents which includes love, shame, disgust, pity, loyalty, and embarrassment (Priest, 1985). This conflicted relationship can lead to temperamental outbursts of anger as well as isolation. Many of these adolescents develop low self-esteem and poor self-image that carries into adulthood (Berkowitz & Perkins, 1988; Bogdaniak & Piercy, 1987; Powell, Gabe, & Zehm, 1994). Psychological problems such as depression and anxiety are also common among ACOAs (Chassin, Pitts, DeLucia, & Todd, 1999; Kashubeck & Christensen, 1992; Knowles & Schroeder, 1990; Parker & Harford, 1988). In addition, ACOAs have been found to exhibit particularly negative cognitions and outlook on life, and some develop alcohol disorders themselves (Black, Bucky, & Wilder-Padilla, 1986; Chassin et al., 1999; Harter, 2000; Parker & Harford, 1988; Sher, 1997).

The “adult child” phenomenon has been extensively studied by Woititz (1983; 1990), who developed a list of characteristics for adults who grew up in homes with an alcohol-dependent parent. Woititz characterised all ACOAs similarly; the list states that ACOAs typically guess at what normal behaviour is, have difficulty following a project through from beginning to end, lie when it is easy to tell the truth, judge themselves without mercy, have difficulty having fun, take themselves very seriously, have difficulty with intimate relationships, overreact to changes over which they have no control, constantly seek approval and affirmation,

usually feel that they are different from other people, are overly responsible or irresponsible, are extremely loyal, even in the face of evidence that the loyalty is undeserved, and are impulsive.

Black's (1989) theory about ACOAs posits that the two basic rules ACOAs learn as children are the "don't talk" and "don't trust" rules. Black hypothesizes that overall, by nine years of age, children who grow up with an alcoholic parent develop a denial system about what is actually occurring in their family and they quickly learn not to acknowledge the truth because nothing positive will emerge from it. Furthermore, adults in the home will teach their children to remain quiet about their family situation, which makes it difficult for these children to talk as they feel they are betraying their family by telling someone outside of the home. Also, according to Black's theory, the "don't trust" rule is quickly learned because ACOAs discover that their parents are unreliable and their lack of confidence, honesty, and consistency impedes the development of trust.

Although much of the clinical literature adheres to the ACOA syndrome, researchers have not found consistent evidence to support the ACOA syndrome. Opponents of the ACOA syndrome propose that differences between ACOAs and non-ACOAs have not been found because of the lack of focus on general family dysfunction or patterns of abuse (Cermak & Rosenfeld, 1987; Fisher, Jenkins, Harrison, & Jesch, 1992; Hall & Webster, 2002; Harter, 2000; Harter & Taylor, 2000; Sher, Walitzer, Wood, & Brent, 1999; Tweed & Ryff, 1991; West & Prinz, 1987). Treating ACOAs as a homogenous group may account for the fact that few researchers have found consistency in differences between ACOAs and non-ACOAs (e.g., on family functioning, mental health, personality). It has also been suggested that previous studies have not found a difference in personality between ACOAs and non-ACOAs because researchers have often relied on college-aged participants who represent a narrow band of the adult

population (Arnett, 2000; Berkowitz & Perkins, 1988; Harter, 2000; Jones et al., 2007; Lyon & Seefeldt, 1995; Wintre, North, & Gates, 2007).

Particular attention has been paid to the various adaptive roles that children growing up in alcoholic families adopt. Not all children react to parental alcoholism in the manner that the ACOA syndrome portrays. Wegscheider (1981) and Black (1981) borrowed the terms from Satir (1972) and Family Systems Theory to describe potential roles taken when living with an alcoholic parent. Black (1989) proposed that four adaptive roles (Hero, Mascot, Scapegoat, and Lost Child) were adopted by children to survive in the "inconsistent and unpredictable" environment of an alcoholic family. Alcoholic families often lack the structure that is typically provided by a non-alcoholic home environment. In a two-parent family, the alcoholic parent no longer fulfills her or his parental duties and the non-alcoholic parent often spends a disproportionate amount of time caring for the alcoholic parent and is unavailable to appropriately support her or his children. This situation becomes more problematic if both parents are alcoholic or if a single parent or guardian is an alcoholic. The children are often left unsupervised and the eldest child's life often becomes more difficult as s/he has to take on the responsibilities of an adult at a very young age, a process referred to as parentification (Wegscheider, 1981; Pasternak & Schier, 2012). Pasternak and Schier (2012) found that ACOAs experienced emotional parentification and a sense of unfairness in both the past and present more often than non-ACOAs. In general, the children of the family take on various roles that may fulfill other aspects of the family system such as the child who brings humour to the family to offset the mood of the home, the child who withdraws from the family and remains detached, and finally the child who displays many problematic, acting-out behaviours, possibly to shift attention away from the alcoholic parent.

The Roles of the ACOA

Most children who grow up in functional homes learn a number of behaviours and adopt traits which facilitate functioning normally in society. Some of these characteristics and behaviours include open communication, positive coping strategies, higher academic competence, positive psychosocial development, being sensitive to others' feelings, positive self-esteem, disapproval for heavy drinking, being flexible, low levels of problem behaviours, and adopting a variety of roles depending on their situation (Black, 1989; Kritzas & Grobler, 2005; Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Wood, Read, Mitchell, & Brand, 2004). Unfortunately, children growing up in dysfunctional alcoholic families rarely get the opportunity to view normal behaviours, let alone learn them (Ackerman, 1987; Black, Bucky, & Wilder-Padilla, 1986; Matthews, 2006). Wegscheider (1981) and Black (1981) proposed that children of alcohol-dependent parents take on roles that are perceived to be beneficial for their survival. These roles are investigated in this study and include the Hero, Lost Child, Mascot, and Scapegoat. These roles are also perceived to bring stability to a chaotic family unit (Black, 1981; 1989). However, some researchers believe these roles may not be exclusive to children with an alcoholic parent (Atkins, 1991), but may be used in other dysfunctional family contexts. Furthermore, not all families with an alcoholic parent are necessarily chaotic or dysfunctional. There are many ACOAs who grew up with an alcoholic parent but are well adjusted (Berkowitz & Perkins, 1988; Werner, 1986; Werner & Smith, 1982).

The theory behind the roles states that individuals from dysfunctional families, where at least one parent has an alcohol-use disorder, will adopt a particular role in childhood to survive. As the child grows up, these early roles are thought to become more rigid as they continue into adulthood (Harris & MacQuiddy, 1991). These roles, which may have been helpful in childhood

to cope, become more problematic in adulthood (Kier & Buras, 1999). Therefore, there is a progression of the roles from childhood to adulthood and similar characteristics are associated with the roles over time.

It is important to note that the following descriptions of the four adaptive roles are based on the Black (1981) and Wegscheider (1981) conjectures about ACOAs. These descriptions are based on anecdotal observations and are more hypothetical in nature and as such are not based on empirical research.

The children who take on the Hero role often tend to be the responsible eldest child (or the only child) of the family, and are often female (Fischer & Wampler, 1994; Wegscheider, 1981). The Heroes provide stability and consistency to the family by taking on parental responsibilities. Rarely do these children get into trouble or misbehave. They become surrogate parents by providing their siblings with goals, care, and leadership skills. Parents are not looked up to for direction or stability because the Heroes soon realize that they must provide it for themselves and for their siblings. Upon reaching adulthood, these survival roles cause problems for the ACOAs in their daily lives. The Hero role continues into adulthood with the ACOA continuing to take on too much responsibility. As adults they often continue to take care of others, many with careers in caretaking (Wegscheider, 1981, p. 115). The positive side to doing so is the Hero's ability to take a leadership role, set goals, and make decisions. However, these adults feel intense anxiety, are depressed, rigid, lonely, and feel separated from other people (Black, 1989). Most of these adults did not get the chance to acquire normal developmental skills and often feel the need to be in control and find it difficult to follow direction or ask for input. These individuals are often successful, but overextend themselves to others while ignoring their own needs. The Hero continues to be the enabler and is often not assertive in their relationships

with their spouse and children. Feelings of inadequacy and guilt are proposed as characteristics of adult Heroes (Wegscheider, 1981, p. 115).

The Mascot, also referred to as the "placater", is described as the most emotionally sensitive of the roles taken on by ACOAs because of their high emotional involvement. These children cope with family problems by trying to fix the problems and in turn decrease their own and the family's tension. As children they are described as constant jokers. These coping mechanisms help the placaters divert attention from the family's issues and instead place the attention on themselves. Hence, the placaters take on this safe role and do not disclose their own pain but distance themselves from it behaviourally. The Mascot continues to take care of others at a personal or professional level in adulthood. The Mascot's own needs are often ignored for the sake of others and they often develop depression due to their inability to receive help from others. They feel lonely because they give too much of themselves and thus feel detached from those surrounding them (Black, 1989). Since they have never dealt with their own problems, they often continue to take an immature approach to their own stressors and problems (Wegscheider, 1981) which makes them more distressed. Also, from a young age they may have begun a pattern of drug use (often prescribed to them by their doctor) to decrease pain and fear and it is believed that more individuals of this role may try to commit suicide (Wegscheider, 1981).

Children who take on the role of the Scapegoat, also called the acting-out role, display delinquent, negative problem behaviours that reflect a dysfunctional family environment. Some behaviours that have been commonly observed from childhood into the teenage years include performing poorly in school, dropping out of school, teen pregnancies, underage drinking, drug abuse, and socially inappropriate behaviours (Powell, Gabe, & Zehm, 1994). These types of negative behaviours temporarily take the attention off the parental alcoholism and place it on the

acting-out child. Approximately 20% of COAs exhibit such behaviours for this purpose (Powell et al., 1994). In adulthood, the Scapegoat tends to continue to find conflict in her/his life and interacts with others in socially unacceptable ways. They usually do not feel good about themselves and start abusing alcohol or drugs at an early age (Wegscheider, 1981). These ACOAs are more prone to becoming alcoholics than those adopting the other ACOA roles (Black, 1981, 1989). The risk of becoming a substance abuser continues into adulthood because they feel they cannot change, which leads to self-hatred (Wegscheider, 1981). Many children do not receive intervention or therapy, but if treatment does take place the emphasis is often put on the individual problem behaviours instead of their purpose or cause. If they enter treatment they often respond well to a program. However, Wegscheider emphasised that treatment should ideally take place for the entire family as the behaviours of the Scapegoat are initially triggered by the alcoholic family system.

Finally, the Lost Child does not take responsibility for anyone, including herself or himself. These children adjust to any type of situation by remaining in the background to avoid bringing attention to themselves. No action is taken to prevent problems or to solve them. Rather, these children remain isolated and detached from the family, often spending more time alone. They may appear selfish because of their lack of involvement or lack of attention paid to the family. These characteristics follow them into adulthood. Often quiet, they do not have many friends and may have a lot of difficulty forming an intimate relationship. They may never marry. Because of their difficulty with relationships, they may place more emphasis on materialistic things which they try to collect to compensate for their low self-worth (Wegscheider, 1981). The Lost Child as an adult avoids any role in which she or he has to take control and still lacks direction and responsibility as an adult. The adults go on to view life as tumultuous in which they

feel they have no options and lack power. Their inability to make decisions as adults stems from their childhood in which they avoided any decision-making opportunity (Black 1981). The Lost Child may also abuse alcohol or drugs as binges. Wegscheider (1981) proposed that few of them as adults would seek out any form of counselling or therapy.

Much of the clinical literature that has been reviewed is based on speculation and anecdotal observation. Empirical research which has investigated the adaptive roles will be reviewed next.

Empirical Research with Roles

According to Wegscheider (1981) and Black (1981), the adaptive roles described above were applicable to all ACOAs; however, similar rigid roles have been found in families for siblings of children with learning disabilities (Atkins, 1991). Atkins found that regardless of type of roles adopted, for example acting out or over-achieving, the siblings still experienced low self-esteem. Such roles may also exist in dysfunctional families where children have survived physical or sexual abuse. Randolph, Anderson, Smith, and Shipley-Clarke (2003) examined roles among undergraduate college students related to defense styles and social desirability. In general, 76% of participants adhered to the Hero role, 17% fit the Mascot role, and only 4.3% were in either the Scapegoat or Lost Child category. The Hero role was positively related to social desirability and adaptive defences, thus providing evidence for the clinical literature that labels the Hero role as a more positive family role. Research has shown that as interactions in families become more dysfunctional, the roles become more rigid and impermeable and are maintained into adulthood (Buelow, Bass, & Ackerman, 1994; Harris & MacQuiddy, 1991). In fact, Sigvardsson, Bohman, and Cloninger's (1987) longitudinal study found that current adult self-

reports of role-identification were consistent with reports made by their teachers regarding their behaviours in childhood.

A few studies have empirically examined the adaptive roles discussed by Wegscheider (1981) and Black (1981). In particular, Scharff, Broida, Conway, and Yue (2004) examined psychological symptoms and family functioning in ACOAs and non-ACOAs of an undergraduate sample by grouping them according to their family role instead of focusing on them as homogenous groups. They used the Millon Clinical Multiaxial Inventory-II (MCMI-II) (Millon, 1987) subscales to examine levels of psychological symptoms. The MCMI provides a measure of 14 personality disorders (e.g., avoidant, depressive, antisocial, borderline, and schizotypal) and has 10 clinical syndrome scales (e.g., anxiety, alcohol dependence, and somatoform disorders). In general, they found that although as a group the undergraduates did not reach levels of diagnosable problems on average, participants in the Lost Child role reported the most psychological symptoms (e.g., on scales of anxiety, somatoform disorders, and self-defeating behaviour), whereas participants in the Hero role had the lowest average ratings of psychological symptoms and only scored high on scales assessing desirability and compulsivity. ACOA Scapegoats scored very high on 18 of 25 MCMI subscales, whereas the non-ACOA Scapegoats scored far below the means for these scales (e.g., for the subscales assessing aggressive-sadistic, passive-aggressive, borderline, alcohol-dependent, and drug dependent). Individuals who came from more dysfunctional families had poorer psychological profiles compared to individuals from non- or low-dysfunctional families. An interaction between role and parental alcoholism was found for the antisocial, aggressive-sadistic, passive-aggressive, borderline, alcohol dependency, and drug dependency disorders, such that many of these disorders were found for the ACOA who adopted the Scapegoat role. For non-ACOAs, the least

adaptive category was the Lost Child role, which yielded the highest mean scores for the disorders.

According to Nardi's (1981) ACOA literature review, the selection of a family role is related to a variety of social and psychological variables. It is for this reason Nardi believed that research of ACOA's required a clearer focus on familial role. Veronie and Fruehstorfer (2001) found that there was "no consensus as to the process by which children in alcoholic families came to identify with a particular family role" (p. 58). They completed a study in which role category was examined as the dependent variable. The researchers examined participant birth order, participant gender, and alcoholic parent gender related to the adaptive roles among a sample of participants receiving treatment at an addictions community mental health clinic. A smaller proportion of participants came from Alcoholics Anonymous, Al-Anon, or ACOA meetings. Their findings for birth order were inconclusive as the association between the Hero role and birth order was only found when the group of eldest siblings was merged with the group of participants who were identified as "only child"; although the ANOVA examining birth order was significant for the Hero role, their post-hoc tests were not. In general, females had a stronger identification with the Lost Child than males, whereas males associated more strongly with the Mascot characteristics than females. Finally, children with two alcoholic parents were less likely than those with one alcoholic parent to take on the Mascot role. This study is informative for the present study because it is one of the few that has studied the adaptive roles as dependent variables to understand which factors related to them.

The various functions that a child can play in her or his family differ depending on a variety of issues. The development of the ACOA role acquisition may be attributed to a number

of factors including disadvantaged demographics, biological precursors, personality, and parenting practices. These factors will be discussed next.

The Development of the ACOA Syndrome

How does the ACOA syndrome develop? To understand the development of psychopathology better, researchers have stated that the "origins and course of individual patterns of behavioural adaptation" (Sroufe & Rutter, 1984, p. 18) must be studied. Thus, the cognitive, emotional, or social pathways to the development of psychopathology must be identified and brought together with an individual's 'inner' personality characteristics and 'outer' environmental characteristics (Cicchetti, 1986). These characteristics may either promote or hinder adaptation. Early research such as the Kauai study (Werner & Smith, 1977; Werner & Smith, 1982) examined protective and risk factors of children at ages two, ten and 18 years. Many children from lower SES families developed emotional problems by the time they were age 18. However, some high-risk children did not go on to develop mental health problems. The researchers divided the two-year-olds at high clinical risk into three groups: those who developed problems by age 10 years, by age 18 years, and those who did not develop any problems. The examination led them to assess which factors had been protective for the children who did not develop any mental health issues. These protective factors included "good temperament, favourable parental attitudes, low level of parental conflict, counselling and remedial assistance, small family size, and a smaller load of stressful life experiences" (Sameroff, 1987, p. 120). More importantly, these protective factors would be beneficial for children who were faced with a number of negative life events to help offset any negative effects (Sameroff, 1987, 1989).

In a review of the research on ACOAs, Park and Schepp (2015) reported that children of alcoholics can display an array of negative issues such as anxiety, depression, substance abuse,

relationship difficulties, and externalising problems, which can follow them into adulthood, as a result of being exposed to parental substance abuse. They summarised risk and protective factors to the exposure of parental drinking problems. Individual factors of low self-esteem, low self-regulation, low academic or cognitive ability, and a difficult temperament increased vulnerability to the negative effects of parental alcoholism, whereas the opposite of these increased resilience. They also summarised parental and family-level factors which are protective, including a positive parent-child relationship, low parentification, positive and consistent parenting, a secure attachment to the non-alcoholic parent, low family violence, and a positive family climate. Again, the opposite of these positive parental and family factors increased risk for ACOAs.

Many children growing up with an alcoholic parent do not have many of these protective factors and instead are faced with stressful and negative life events associated with the dysfunctional environment (Black, 1981; Black et al., 1986; Harter & Taylor, 2000; Harter, 2000; Barocas, Seifer, & Sameroff, 1985). Similarly, Sameroff and Chandler (1975) found that SES and family mental health were important moderators of child development, such that poor mental health and social status interfered with optimal child rearing. Thus, the focus should not be on any one variable but on the identification of a multitude of risk factors that may impede normal development, because as the number of risk factors increases, developmental outcomes become worse.

Sameroff (1985) discussed how individuals fit into society by examining family and cultural socialisation patterns that together create the “environtype”. The environtype is made up of subsystems that interact with the child and one another; one subsystem is the influence of family on child outcome. This perspective is similar to Bronfenbrenner’s (1977) description of the ecological systems theory, which provides a model for understanding the impact of the

environment on individual development. The four hierarchical levels of environmental influence, which consist of the microsystem, mesosystem, exosystem, and macrosystem, are nested within this framework. Person-environment interactions, referred to as proximal processes, occur within the microsystem (e.g., in this case the family). These interactions change with the development of the person (Bronfenbrenner, 1989, Cicchetti & Cohen, 2006). This study concentrates on the first level, the microsystem, which examines the immediate interactions of an individual with her or his home and family.

Developmental psychopathology incorporates both environtype and ecological systems theory to understand the development of abnormality (Cicchetti & Cohen, 1995). Therefore, developmental psychopathology combines individual factors, parental factors, family factors, and other social and environmental factors to understand development better. A focus of developmental psychopathology is the examination of at-risk populations to increase the understanding of the effect of malfunction in normal development. At the same time, the understanding of abnormality enhances the knowledge of normal functioning. Thus, a comparison between abnormal and normal development must be implemented to fully understand pathology (Cicchetti, 1984; Cicchetti, 2006; Cicchetti, 2016).

Empirical Research with ACOAs: Personality and Pathology

To understand individual "inner" variables such as personality and their association to the adaptive roles, it is important to examine the literature on personality traits found in individuals prone to alcohol disorders and ACOAs. Certain heritable personality characteristics have been associated with a predisposition to developing alcohol-use disorders (Cloninger 1987; Martin & Sher, 1994; Tarter, 1988; Sher, 1997). However, few studies have found key differences in personality or mental health between ACOAs and non-ACOAs that can be used for diagnostic

purposes. In fact, there is some inconsistency among empirical studies regarding the psychological, personality, and gender differences between ACOAs and non-ACOAs. Many researchers have conducted their research with young post-secondary students. These participants are younger, higher functioning, and have better coping skills than those who did not enter college or are in treatment, thereby limiting the generalizability of the results (Berkowitz & Perkins, 1988; Hall & Webster, 2007; Harter, 2000; Lyon & Seefeldt, 1995; Scharff et al., 2004; Schuckit & Sweeney, 1987; Sher, 1997; Sher et al., 1991). Others have used small samples when examining ACOAs, which probably limit the generalization of the results to the larger population (Beaudoin, Murray, Bond, & Barnes, 1997; Hibbard, 1989). Many researchers who have used college participants found mixed results, with many illustrating no major personality or pathology differences (Sher, 1997), whereas those examining a clinical sample or older participants have found differences (Kashubeck & Christensen, 1992; Parker & Harford, 1988; West & Prinz, 1987). Thus, disagreement as to the personality characteristics and pathology of ACOAs seems partially due to the different methodologies used in the investigations.

A few studies have used the comprehensive, empirically derived five-factor model of personality widely referred to as the Big-5, Agreeableness, Conscientiousness, Extraversion, Neuroticism, and Openness (Costa & McCrae, 1991; Costa & McCrae, 1992a; Costa & McCrae, 1999) when examining those who have a familial risk for alcohol-use disorders. The Big-5 model is unique because its factors have been found in various gender and racial groups, are believed to be inherited, and exhibit stability over time (Costa & McCrae, 1991; Costa & McCrae, 1992a; Costa & McCrae, 1999). Martin and Sher (1994) assessed the relationship between parental alcoholism, young adult alcoholism, and young adult personality using this measure. Their study found that college ACOAs scored lower on conscientiousness and

agreeableness but were more open to experience than non-ACOAs. In addition, young adults with an alcohol diagnosis also had lower conscientiousness and agreeableness and higher neuroticism compared to those who were never diagnosed. Loukas, Krull, Chassin, and Carle (2000) also found lower levels of agreeableness and higher levels of neuroticism in young ACOAs, and both traits mediated the relationship between parental alcoholism and offspring alcohol diagnosis. However, even after taking personality into account, the researchers found that neuroticism and agreeableness only partially mediated the relationship between parental and offspring alcoholism; therefore other variables play a role in the intergenerational transmission of alcoholism.

Sher et al. (1991) also found that individuals at risk of becoming alcoholics scored high on measures of personality traits assessing behavioural undercontrol, including novelty seeking, psychoticism, and impulsiveness. These findings are similar to those found by Jacob, Windle, Seilhamer, and Bost (1999). Once Sher et al. (1991) excluded individuals whose parents suffered from mental illnesses not related to alcoholism, the effects decreased. Thus, it is also important to examine family mental health when investigating personality characteristics. Differences on the neuroticism scale were found between ACOAs and non-ACOAs, but this difference was not attenuated when individuals whose parents suffered from non-alcohol related mental illnesses were excluded.

Evidence of similarities between alcoholic ACOAs and depressed ACOAs has also been found. Beaudoin et al. (1997) examined personality traits in these two clinical groups compared to a non-ACOA\ depressed group. They examined the hypothesis that low self-esteem, high neuroticism, and high psychoticism were prevalent among both alcoholic and depressed ACOAs (these symptoms together are referred to as “Winokur’s propensity,” Winokur, 1983). The

personality of ACOAs differed from non-ACOAs in that ACOAs had scores that were higher on neuroticism and psychoticism and lower on self-esteem. Also, alcoholic ACOAs shared similar personality traits with depressed ACOA participants, both showing Winokur's propensity, as had been hypothesised. The authors concluded that growing up with an alcoholic parent can lead into Winokur's propensity as either an alcoholic ACOA or a depressed ACOA.

In contrast to the above findings, Berkowitz and Perkins (1988) did not find many personality differences between ACOA and non-ACOA college participants. Overall, no differences were found on six of eight measures between these two groups. However, ACOAs had higher ratings of self-depreciation and autonomy compared to non-ACOAs. Berkowitz and Perkins (1988) concluded that young-adult ACOAs were quite resilient given their negative family environment and were close in personality to their non-ACOA counterparts (e.g., no differences were found for impulsiveness, directiveness, other-directedness, need for social support, sociability, and lack of tension). These findings were similar to those found by Werner (1986), whose longitudinal study revealed that many ACOA children did not develop any psychopathology.

Harter (2000) reviewed the literature on ACOAs to examine the evidence of a particular ACOA syndrome or clinical picture that was unique to this group. Overall, Harter (2000) stated that there was not a conclusive set of particular personality traits attributed to ACOAs. Again, Harter noted that part of the difficulty in distinguishing ACOAs from non-ACOAs is the comorbidity of parental pathology, family dysfunction, and abuse (Harter, 2000). To address this problem, the present study examines ACOAs, ACOAs that have been abused, and abused individuals (compared to a Control group) to investigate if there are actual differences between these groups on factors which may lead them to identify with particular roles.

When examining psychopathology, Belliveau and Stoppard (1995) found that college student ACOAs had higher levels of depression and general maladjustment compared to college-age non-ACOAs. With an older participant group (*M* age = 44.5 years), Parker and Harford (1988) also found that females who had an alcoholic parent were more at risk for developing depression. Relationship problems were also noted such that both male and female ACOAs were at risk for separation or divorce. Hibbard (1989) found that ACOAs in general exhibited more pathological characteristics in personality such that males scored high on the histrionic and hypomanic scales, females scored high on the dysthymic scale, and both had higher scores on the Negativistic and Cycloid scales of the Millon Clinical Multiaxial Inventory.

Sher et al. (1991) reported that ACOAs comprised a broad group that was complex in their characteristics. First-year college students who had alcoholic fathers consumed a higher rate of alcohol than first-year students with non-alcoholic fathers. ACOAs also had higher levels of psychiatric symptoms than non-ACOAs. Major depressive episodes and anxiety disorders (i.e., agoraphobia, social phobia, and generalised anxiety disorder) were found at a higher rate among ACOAs than among non-ACOAs, with some being attributed to a history of parental psychopathology. This finding is consistent with other research findings (Tweed & Ryff, 1991).

Gender Differences

Gender differences have been found in ACOA research, but results have been mixed. For example, female ACOAs were found to have more self-depreciating thoughts than male ACOAs (Berkowitz & Perkins, 1988). These findings were replicated by Ackerman and Gondolf (1991), who found higher scores on self-condemnation for females compared to males. Berkowitz and Perkins also found that women whose fathers were alcoholic were more likely to report greater self-depreciation than women who had alcoholic mothers. On the other hand, male ACOAs

scored higher on the autonomy scale compared to non-ACOA males; this difference was not attributable to which parent was alcoholic. Hibbard (1989) also found that female ACOAs tended to exhibit more internalising psychiatric problems, such as dysthymia, whereas male ACOAs exhibited more externalising problems and scored high on scales measuring histrionic and hypomanic domains. These findings support previous research that has found gender differences related to mental health such that females are more prone to depression, low self-esteem, and poorer mental health than males (Reifler, 1971; Russell, Henderson, & Blume, 1985; Stangler & Printz, 1980; Strickland, 1988). In contrast, Kashubeck and Christensen (1992) found that male ACOAs reported higher levels of distress than female ACOAs. However, Belliveau and Stoppard (1995) found that generally the gender of the ACOA was not a significant predictor of ACOA psychopathology.

Gender differences for parents have also been examined. Berkowitz and Perkins (1988) found that daughters of alcoholic fathers were more emotionally affected by their father's drinking and tended to internalise these events more than daughters with alcoholic mothers and more than sons. In contrast, no relation was found between males' well-being to either parent's drinking. In accordance, Fisher et al. (1992) found no gender effects of the alcoholic parent on a questionnaire examining ACOA adult characteristics of which 12 of 20 items were adopted from Woititz's (1983) ACOA characteristics (e.g., I guess at what normal is, I have difficulty having fun). Kashubeck and Christensen (1992) also found no relation of gender of alcoholic parent to the psychological distress of the ACOA. These findings were replicated by Belliveau and Stoppard (1995), who found no relation between ACOA psychopathology (including anxiety, depression, psychoticism, and neuroticism) and parent gender or ACOA gender.

Family Systems Theory and the Parent-Child Relationship

Traditionally, alcoholism has been viewed as a disease of the individual. Theories based on genetics, biochemical changes, and psychology have generally explained alcoholism as a problem that originated in and is perpetuated by the individual. As research progressed, examination of context of the family environment and its influence on the system as a whole has given a different perspective on the maintenance of alcoholic behaviours (Black, 1981; Steinglass, 1989; Woititz, 1985). Although the etiology of alcohol-use disorders is not always attributed to the family, the maintenance of alcoholic behaviours can be related to characteristics of the family. Researchers have proclaimed that alcoholism affects all members of a family system and as such it is viewed as a family disease.

For instance, Steinglass (1989) suggested that alcoholism be approached using the Family Systems Model of Satir (1972) and Minuchin (1974) even though this model was not primarily constructed to be used with families in which alcoholism was an issue. The Family Systems Model examines the members of a family unit to understand how the family is organised, which transactional patterns exist in the unit, and the roles that each member takes in the system (Minuchin, 1974). As mentioned earlier, Satir (1972) proposed the communication styles (Placating, Super-Reasonable, Blaming, Irrelevant, and Congruent) that family members take on to bring stability to the family environment. Family Systems Theory also purports that when there is a problem within the family, each member plays a role in further perpetuating the problem. In a so-called “normal” family system, the parents act as the executive subsystem and the children form a sibling subsystem. However, when problems arise, parents may diffuse the boundaries within a family to have children side with one of them and thus, different subsystems form because of conflict in the system (Minuchin, 1974; Minuchin et al., 1975).

Steinglass (1989) maintained that the interest in approaching alcoholics through the Family Systems Model was sparked for a few reasons. First, many alcoholic families are intact and, as such, they have to adapt to their environment to deal with the alcoholics' behaviours. The adaptation of individuals to their dysfunctional family (e.g., by taking on roles or by enabling the alcoholic) is believed to help maintain the disorder and, therefore, researchers wanted to examine how individual family members are affected, and in turn how they affect the family system. Black (1981) and Wegscheider (1981) have hypothesized about the common adaptive roles that children can adopt because of an alcoholic parent's behaviours. According to the Family Systems Model, roles that are taken on are best explained by a child's attempt to maintain the family system at its homeostatic level. Second, Steinglass found that only approximately half of alcoholic cases could be explained by biomedical models and, thus, the contribution of the environment needed to be considered to explain alcoholism for the non-medically related cases. Finally, family treatment approaches, support the fact that alcoholism is not simply an individual disease (Barnett, 2003; Saatcioglu, Erim, & Cakmak, 2006).

These points regarding the maintenance of alcoholism can also be used to examine how family roles taken by a child can be attributed to the parenting styles used to raise the child, the environment and interactive patterns of the child with her or his alcoholic parent, and the level of reciprocity in the parent-child relationship; all of which are aspects of the parent-child relationship.

Depending on the type of interaction a child has with her or his family environment, the Hero, Mascot, Lost Child or Scapegoat family role may be taken. Although these roles are generally undesirable, overall the Hero and Mascot family roles are considered to be the more positive of the four family roles, whereas the Scapegoat and Lost Child are considered as the

more detrimental or negative of the roles (Fischer & Wampler, 1994). These roles may be assumed by a child to maintain the family regulatory system (Minuchin et al., 1975). Thus, the behaviours of the child are useful according to the Family Systems Theory for "maintaining stability, order, and control of family functioning" (Steinglass, 1989, p. 158). Family therapy, from a systems approach, would therefore help families shift their transactional patterns between family members and re-stabilise the system.

The influence that parents have on their children is related to the problems that ACOAs experience. Gallant, Gorey, Gallant, Perry, and Ryan (1998) found that having at least one alcoholic parent was related to parent-child role reversal where the child took on more adult-like responsibilities and there was less emphasis on the child's own needs. There was also more evidence of the use of physical punishment as a means of discipline than non-physical forms of punishment. Black, Bucky, and Wilder-Padilla (1986) found more abusive behaviours among alcoholic family members than among non-alcoholic families. Negative parenting and childhood abuse have been commonly found among the research on ACOAs (Harter & Taylor, 2000; Kelley et al., 2005). According to Harter (2000), ACOAs find it difficult to trust people because they were not satisfactorily nurtured by their parents, who instead placed more importance on their own needs. Tweed and Ryff (1996) also found that alcoholic parents were less nurturing and therefore, had a less secure parent-child attachment than non-alcoholic parents.

Kelley et al. (2008) noted that a multitude of factors were related to the psychological adjustment of ACOAs, but a major factor is the parent-child relationship. In general, ACOA participants indicated they received less warmth and support from their fathers and more anger in their relationship. Once researchers accounted for the gender of the alcoholic parent, no differences were found between ACOAs and non-ACOAs in their quality of attachment to their

father. However, ACOAs who identified their mothers as alcoholic perceived less support from them and less affective quality in their relationship compared to non-ACOAs.

Homes are considered healthy if the parents are loving, supportive, and provide rules and boundaries to the child without being overly controlling (Ruben, 2001), which is similar to Baumrind's (1971) definition of authoritative parenting. Individuals who grew up with parents characterised as authoritative are well-adjusted and competent (Baumrind, Larzelere, & Owens, 2010; Lamborn et al., 1991). Additionally, Ruben (2001) stated that it is important for a child to learn that she is not expected to be perfect and parents should support the independence of their child as she grows up. In contrast, a dysfunctional home contains parents who do not enable independence, are not supportive or loving, and are demanding and condescending (Ruben, 2001). This type of childrearing, in which the parent is controlling and expects the child to follow rules with no questions asked, is referred to as authoritarian (Baumrind, 1971). Research has illustrated that ACOAs tend to have early family environments with less father warmth and less acceptance from their mothers compared to non-ACOAs (Kelley et al., 2005; Senchak, Leonard, Greene, & Caroll, 1995). Senchak et al. (1995) found that conflict with parents disrupted the father-child relationship in ACOAs but not in families of divorce. The third parenting style, permissive parenting, is defined by Baumrind as the parents who are loving and highly responsive but have low demands and few rules to guide their children. An early family environment in which there is poor parenting (e.g., children are controlled or parents are uninvolved with their children) may facilitate the need for children to take on a different family role. It therefore is important to examine parenting styles when investigating the type of adaptive role an ACOA has taken to cope.

The parental reciprocity construct (Wintre, Yaffe, & Crowley, 1995) is also used in this study to examine its relevance to the adaptive roles. Reciprocity refers to the development of the emerging adult and parent perceiving one another as relatively equal in a respectful manner within an atmosphere of open, honest, and direct communication (Wintre et al., 1995). Reciprocity between a parent and child is based on the Theory of Social Relations, which states that the relationships children form with parents and peers help define their experiences of society (Youniss, 1980; Youniss & Smollar, 1985). Initially, the reciprocity that a child feels toward her or his parent is asymmetric such that the child idealises the parent as the one who knows everything (Youniss, 1980). During their adolescent years, children become more involved with peers and a shift in reciprocity occurs such that they become closer with their friends. The mutual trust and reciprocity they learn with their peers is then used as a template to create a more symmetric form of reciprocity with their parents.

When there is a high level of mutual reciprocity between a parent and emerging-adult-child, reciprocity is related to better mental health, for example higher self-esteem and less depression and perceived stress (Wintre & Yaffe, 2000). Studies have also found that the greater reciprocity one feels with one's parents, the easier it is to discuss important issues with them, such as education, intimate relations, and drugs and alcohol (McMaster & Wintre, 1996). However, in a dysfunctional environment, parent-child reciprocity may not truly form.

Related to parenting styles, Wintre and Yaffe (2000) found that the perception of mutual reciprocity with parents was positively associated with authoritative parenting and negatively associated with authoritarian parenting. Parental reciprocity has not been examined in the literature pertaining to ACOAs and individuals from dysfunctional families. Thus, this dynamic parent-child variable may be inter-related to the type of family role adopted by an individual. It

remains to be seen whether adaptive roles differ based on parenting measures and later developing parental reciprocity, and whether there are differences between ACOAs who grew up with an alcoholic parent who is also abusive and ACOAs who did not grow up in an abusive environment.

ACOAs and Individuals from Dysfunctional Families

Research has questioned whether ACOA adaptive roles are specific to children who have grown up with alcoholic parents. This question partly revolves around the argument that ACOAs are no different than children who grow up in dysfunctional homes or families. Research completed with a community sample in Ontario, Canada, found that the rates of childhood physical and sexual abuse were two times higher among families in which parents were substance abusers (alcohol and drugs) (Walsh, MacMillan, & Jamieson, 2003). Reports of "adverse childhood experiences", such as "emotional, physical, and sexual abuse; witnessing domestic violence; parental separation or divorce; and growing up with drug-abusing, mentally ill, suicidal, or criminal household members" were more likely to occur with parental alcoholism (Anda, Whitfield, Felitti, Chapman, Edwards, et al., 2002). The present study defines participants from dysfunctional families as those who were physically or sexually abused. Although it is understood that other forms of abuse, such as emotional abuse and neglect, do exist, they were not included in the present research which is in an investigational phase. Cermak and Rosenfeld (1987) noted many similarities between ACOAs and adults who were physically abused as children, and Fisher et al. (1992) also compared ACOAs to adults who came from dysfunctional families (i.e., physical abuse, sexual abuse, divorce, or death of a parent). Individuals who reported coming from families in which there was abuse, divorce, or parental death, but no parental alcoholism, were compared to both ACOAs and non-ACOAs from non-dysfunctional

families. No significant differences on Woititz's ACOA traits were found between ACOAs and the two other groups other than ACOAs having more difficulty with intimate relationships. Unfortunately, no definitive conclusions could be made due to the overlap between dysfunctional family's events and the occurrence of these events in the ACOA group (e.g., death of parent, divorce, etc.). Fisher et al. (1992) concluded that the two groups are more similar to each other in personality and pathology than they are different.

Cermak and Rosenfeld (1987) found that ACOAs and adults who were physically abused as children had similar coping methods and defense mechanisms to manage their emotions and negative life events. They state that both groups of individuals have an "omnipotent belief in the ability to control events" (Cermak & Rosenfeld, 1987, p. 17). They posited that both ACOAs and survivors of physical abuse experienced chronic stress during childhood and would therefore have more similarities between them. In particular, the prediction is that both groups of individuals assume responsibility for their parents' behaviours and attempt to control situations by changing their own behaviour in hope that they will have a 'good parent.' The method by which they try to achieve this result may differ but the defense mechanisms help them cope. When examining the parenting styles of mothers who were sexually abused in childhood or ACOA mothers, both adopted a permissive parenting approach for their children (Ruscio, 2001). However, after accounting for physical abuse, socioeconomic status, and parental alcoholism, sexual abuse survivors had more difficulty implementing structure, clear expectations, and discipline for their children and practiced less authoritarian parenting. Data from the United States National Alcohol Survey found that women who were physically or sexually abused as children were more likely to have problems with alcohol (e.g., heavy episodic drinking, alcohol

dependency, etc.) even after accounting for parental alcoholism (Lown, Nayak, Korcha, & Greenfield, 2011)

In contrast, findings have also illustrated the variability in ACOA traits. Scharff et al. (2004) proposed that the different findings may be related to the heterogeneity among individuals who are labelled as ACOA. This prediction was validated by Hinrichs, DeFife, and Westen's (2011) study which reported ACOAs were not a homogenous group and examination of personality traits was imperative to understanding them. Harter (2000) stated that the definitive ACOA personality profile that the clinical literature describes does not exist in the empirical literature, possibly due to the overlap between parental alcoholism and abuse. Harter and Vanecek (2000) found that adults who reported childhood abuse (e.g., physical, sexual, and/or emotional abuse) also expressed more distress in the form of anxiety, depression, somatization, and interpersonal sensitivity. When they controlled for abuse, parental alcoholism alone was not associated with distress. In fact, family environment, as related to parenting styles and relationships, was more related to cognitive assumptions about oneself (e.g., self-worth) than childhood abuse and parental alcoholism. For the purpose of this study, the dysfunctional family is defined as one in which a child experienced physical or sexual abuse within the family (Wade, 1997). Both emotional abuse and neglect were not included in Wade's (1997) study. Wade noted that the negative outcomes found in abused children were not found in children of divorce or parental death; thus, the latter groups should not be labelled as dysfunctional.

Unfortunately, many ACOAs were also abused as children and this issue has not always been addressed in the literature. Harter and Taylor (2000) studied ACOAs and examined their history of childhood abuse (e.g., sexual, physical, and emotional abuse) to understand the relationship of alcoholism and abuse to distress and social maladjustment. The abused group

experienced more distress; parental alcoholism alone did not explain symptomatology once abuse history was accounted for. Parental alcoholism alone also did not account for social adjustment; however, it did interact with abuse history to reveal low functioning in only one area, work and school roles; while ACOAs with no abuse history functioned the best (Harter & Taylor, 2000). Thus, according to this study, those who were abused suffer more and in turn experience more mental distress compared to individuals who had an alcoholic parent who was not abusive.

The question remains as to whether the ACOAs being investigated in this study will differ from those that were abused. In an effort to clarify the lack of consensus regarding the long-term consequences of dysfunctional families, the present study examines the relations between personality traits and parenting characteristics with the four family roles (Hero, Mascot, Lost Child and Scapegoat) in four family-type groups, ACOAs, abused ACOAs, abused participants, and a Control group of adults whose parents were neither alcoholic nor abusive.

In summary, the clinical literature describes a single profile for all ACOAs, whereas the empirical literature on ACOAs has been mixed. Some of these differences may be related to the emphasis on college-age participants or primarily clinical samples. It is evident that substantial heterogeneity is found among ACOAs. The present study will therefore investigate individuals from four family type groups: ACOA, Abused, ACOA and Abused, and Control, to decipher if there are differences among these groups on the measures of interest. Identification with particular family roles (Hero, Mascot, Lost Child and Scapegoat) has also been proposed as a mechanism that helps ACOAs cope with their family situation as children but becomes less adaptive in adulthood (Black, 1981; Woititz, 1990). According to the research reviewed above,

differences in both personality attributes (e.g., high neuroticism and low conscientiousness and agreeableness) and environmental characteristics (e.g., negative parenting, poor parental attachment, and high parent-child conflict) have been found among ACOAs compared to non-ACOAs and therefore may contribute to the adoption of particular family roles for ACOAs to cope. Family Systems Theory (Satir, 1972, Minuchin, 1974) emphasises the contribution of parent and family variables and Developmental Psychopathology (Cicchetti, 2006; 2016) stresses the importance of examining a multitude of variables (biological, social, and environmental) in both clinical and normal groups. Therefore, this study will examine the environmental factors (type of family dysfunction, parenting styles, and parental reciprocity) and personality characteristics (Big-5 for the offspring) that may contribute to adult children's adoption of particular family roles.

Hypotheses

The following hypotheses are related to the examination of which parenting and personality factors lead to the four adaptive family roles. The hypotheses are grouped according to the association between child roles and dysfunctional family group, parenting styles, perceived reciprocity, and personality (Appendix A).

Dysfunctional Groups and Child Roles:

Hypothesis 1. Given that adaptive roles can be taken on by individuals from a variety of family dysfunctional situations and the variability found among ACOAs in the empirical literature, it is predicted that individuals from different dysfunctional groups or a Control group may adopt any of the family roles (Hero, Mascot, Lost Child, Scapegoat); however, it is predicted that the Control group will have the highest Hero and Mascot role scores and the lowest Lost Child and Scapegoat role scores because this group does not include any form of

family dysfunction and the Hero and Mascot roles are considered as the more positive of the four familial roles.

Hypothesis 2. The ACOA group will be the least different from the Control group in the scores for the four family roles because the participants in this group were not abused as opposed to the Abused and ACOA+Abused groups in which family dysfunction is prevalent.

Hypothesis 3. The Abused and ACOA+Abused groups will have higher scores for the Lost Child and Scapegoat roles and lower Hero and Mascot role scores compared to the Control and ACOA groups.

Parenting styles and Child Roles:

Hypothesis 4. Given the research related to Baumrind's (1971) parenting styles, authoritative parenting will be positively associated with and more strongly related to the Hero and Mascot roles than authoritarian parenting, and negatively associated with the Lost Child and Scapegoat roles.

Hypothesis 5. Authoritarian parenting will be positively associated with and more strongly related to the Lost Child and Scapegoat roles than authoritative parenting, and negatively associated with the Hero and Mascot roles.

Hypothesis 6. Permissive parenting will be positively associated with the Lost Child and Scapegoat roles, and negatively associated with the Hero and Mascot roles.

Perceived Reciprocity with parents and Child roles:

Hypothesis 7. High parental reciprocity will be positively associated and more strongly related to the Hero and Mascot roles than the Lost Child and Scapegoat roles.

Hypothesis 8. High parental reciprocity will be negatively related to the Lost Child and Scapegoat roles.

Personality Big-5 and Child Roles:

Hypothesis 9. Conscientiousness, Openness, and Agreeableness will be positively associated with the Hero role, whereas Neuroticism will be negatively associated with this role.

Hypothesis 10. Extraversion and Openness will be positively associated with the Mascot role, whereas Conscientiousness, Neuroticism, and Agreeableness will be negatively associated with this role.

Hypothesis 11. Neuroticism and Agreeableness will be positively associated with the Lost Child role, but Extraversion and Openness will be negatively associated with this role.

Hypothesis 12. Neuroticism and Extraversion will be positively associated with the Scapegoat role, but Agreeableness, Conscientiousness, and Openness will be negatively associated with this role.

Methods

Participants and Procedure

Data were collected by Ph.D. graduate students Navneet Kaur Dhami and Shawn Gates as part of both of their dissertations. Gates (2011) used a subset of the data for his research which entailed the examination of family group and childrens' categorical family role to the association of their adult mental health. Dhami used a subset of the data for her research on the association with family groups and roles adapted by children.

Participants were recruited through advertisements and fliers about this study that were posted in the community, hospitals, clinics, and through contacts who knew of individuals that were appropriate for this study. Participants also included individuals from mental health clinics and self-help groups (e.g., Al-Anon). Approximately 325 participants between the ages of 25 and

60 years were recruited for this study. Participants fell into one of four groups based on self-identified criteria:

1) Adult children of Alcoholics (ACOAs): adult children who grew up in a home with one or more alcoholic parent(s).

2) Abused group (Abused): adult children from non-alcoholic parents but were physically or sexually abused by a parent, another family member, or a person outside the family.

3) Adult Children of Alcoholics plus Abused group (ACOAs + Abused): adult children from alcoholic parents who were also physically or sexually abused.

4) Control Group: adult children who are non-ACOAs and were not abused.

Participation was purely voluntary and all information remained confidential. Individuals who decided to participate were entered into a draw for two prizes of $50.00. Information regarding the purpose of this study was provided in a consent form which was completed by interested participants prior to beginning the study (Appendix B). This study was vetted by an ethics committee by the Faculty of Graduate Studies at York University and approval was obtained before proceeding with data collection.

The measures were completed as an on-line survey for easy access to participants. However, potential participants who did not have access to the Internet were given the option of completing a paper version of the survey.

Measures

Participants were first asked to complete a demographics form which included questions regarding gender, age, marital status, socioeconomic status, and education. Questions regarding parental alcoholism and abuse were also addressed (Appendix C). Participants were asked if during the time they were living at home with their family (up to age 18 years) they had

experienced living with an alcoholic parent, which parent(s) abused alcohol, how old they were when their parent started to drink, and if and when their parent stopped drinking. A higher percentage of fathers were identified as alcoholic in comparison to mothers; 68.1% of ACOA fathers versus 54.2% of ACOA+Abused fathers, and 26.4% of ACOA mothers versus 22.0% of ACOA+Abused mothers. The ACOA group identified 5.6% as having both alcoholic parents and ACOA+Abused group identified 23.7% as both parents being alcoholic. Next, participants completed questionnaires which examined different aspects of behaviour.

The Child Roles Inventory (CRI; Potter & Williams, 1991). The CRI was developed to measure the four distinct roles proposed by Black (1981) and Wegscheider (1981): Hero, Mascot, Lost Child and Scapegoat. The CRI is made up of 60 items, with 12 items per role, each asking participants to rate their agreement to a statement following the question stem "when I was a child, I…" using a five-point Likert-type scale ranging from 0 "very unlike me" to 4 "very like me" (Appendix D).

The CRI has exhibited good internal consistency with alphas ranging from .90 to .93 for the Hero role, .89 to .90 for the Mascot role, .90 to .91 for the Lost Child role, and .95 for the Scapegoat role (Potter & Williams, 1991). Predictive validity was found between the roles and self-esteem; self-esteem was positively associated with the Hero and Mascot roles and negatively associated with the Scapegoat and Lost Child roles (Potter & Williams, 1991). Alphas in the present study by family role were .91 for Hero role, .93 for Mascot role, .93 for Lost Child role, and .95 for Scapegoat role. Family roles were examined as continuous variables, not categorical, in this study.

Parental Authority Questionnaire (PAQ; Buri, 1991). The PAQ consists of 30 items (each given twice, once for each parent) designed to assess the type of authority that was

exercised by the participant's mother and father from the perspective of the son or daughter (Appendix E). The items are divided into three categories based upon Baumrind's (1971) definitions of permissive, authoritative, and authoritarian parenting styles. The items are scored on a five-point Likert-type scale ranging from "strongly disagree" (1) to "strongly agree" (5). An example item is "As I was growing up, my mother would get very upset if I tried to disagree with her."

Internal consistency alpha values for the categories were reported as .75 for mother's permissiveness, .85 for mother's authoritarianism, .82 for mother's authoritativeness, .74 for father's permissiveness, .87 for father's authoritarianism, and .85 for father's authoritativeness (Buri, 1989). Test-retest reliabilities over two weeks ranged from .77 to .92 (Buri, 1991). Overall, the PAQ has been found to be a valid measure of a parent's authority (Buri, 1991). In the present study, alphas were .79 for mother permissiveness, .91 for mother authoritarianism, .94 for mother authoritativeness, .79 for father permissiveness, .94 for father authoritarianism, and .94 for father authoritativeness.

Perception of Parental Reciprocity Scale (POPRS; Wintre et al., 1995). The POPRS consists of 43 items used to measure the reciprocity perceived by a teen or emerging adult from her or his parent or guardian (Appendix F). This scale is based upon Youniss' (1980) Theory of Social Relations. Item responses on the POPRS use a six-point Likert-type scale ranging from "strongly disagree" (1) to "strongly agree" (6). Example items are "I can communicate as well with my mother as I can with friends" and "I often feel that my mother is talking at me and not with me." The POPRS is divided into three subscales: a general subscale comprised of 9 items, a mother subscale comprised of 17 items, and a father subscale comprised of 17 items. Only the mother and father subscales were used in this study.

The POPRS has demonstrated high alpha reliabilities of .92 to .94 for the overall scale, .87 to .90 for the mother subscale, and .88 to .91 for the father subscale (Wintre et al., 1995). Test-retest reliabilities over two weeks were .93 for both the mother and father subscales (Wintre et al., 1995). Overall, POPRS has been found to correlate with parental attachment, self-esteem, adult consultant choice, and attitudes toward private personal authority (Wintre et al., 1995). Present study alphas were .96 for the mother subscale and .95 for the father subscale.

NEO-Five Factor Inventory (NEO-FFI; Costa & McCrae, 1991; 1992b). The NEO-FFI is a 60-item self-report questionnaire that examines the five domains of personality as defined by Costa and McCrae (1991). The five personality factors are (1) Neuroticism, characterized by psychological distress and poor coping skills, (2) Extraversion, characterized by sociability, talkativeness, and high energy level, (3) Openness, characterized by liking variety, being imaginative, and aesthetic appreciation, (4) Agreeableness, characterized by an altruistic nature, helpfulness, and compassion, and (5) Conscientiousness, characterized by self-control, determination, and purposefulness (Costa & McCrae, 1992b). Each factor is measured on a scale comprised of 12 items.

The NEO-FFI has good internal consistency; alpha values for the five scales ranged from .73 for Openness to .87 for Neuroticism, similar to the coefficients reported by authors of the NEO (Holden & Fekken, 1994). Validity has been demonstrated for the NEO-FFI from its correlations with spousal (correlations range from .44 to .65) and peer ratings (correlations range from .33 to .48) of personality and its use with patients and non-patients to assess personality attributes (Costa & McCrae, 1992b; Pereira, Huband, & Duggan, 2008). Coefficient alphas in the present study were .66 for Openness, .79 for Agreeableness, .86 Conscientiousness, .85 for Extraversion, and .87 for Neuroticism.

Results

The results section is comprised of analyses to describe 1) the dataset as a whole and by group and 2) to test the hypotheses. First, a full demographic description of the participants is presented for the entire sample and then by group (Control, ACOA, Abused, and ACOA+Abused). Second, an analysis of the assumptions to establish which types of analyses were appropriate to test the hypotheses is reviewed. Finally, correlation and regression analyses were performed to examine the relation between participants' parents' parenting styles, perceptions of mutual reciprocity, and participants' personality and the four family roles (Hero, Mascot, Scapegoat, and Lost Child).

Demographics

Data were collected from 327 participants. The participants fell into one of four groups as follows: 72 participants in the ACOA group, 58 participants in the Abused group, 122 participants in the combined ACOA+Abused group, and 75 participants in the Control group. A demographic description of the four groups is provided below.

Overall Sample Demographics

The overall mean age of the participants was 35.3 years (*SD* = 9.96). Although efforts were made to collect data from a larger sample of male participants (i.e., from various clinics, hospitals, and clinical groups), an adequate proportion of males was not obtained and thus an investigation of gender differences was not completed. Of the 326 participants who reported their gender, 88.5% were female and 11.5% were male. When asked about marital status, 34.5% of participants reported being single, 32.1% were married, 16.7% were living as common-law, and 14.8% were separated or divorced. Regarding whether they had children, 50.3% reported having children while 49.7% had no children. Participants also reported their parents' marital status;

37.5% were living together, 34.8% were divorced or separated, 12% reported their mother was a widow and 3.7% reported their father as a widower, and 9.5% reported that both parents were deceased.

Demographics by Family Type Group

All demographic variables were examined by family type group and Chi-square tests were used to assess if there were differences between the groups. If adjusted residuals, after performing chi-square tests, were at or above 1.96, they are considered significant at $p < .05$. Given that multiple analyses were completed, a Bonferroni correction was made by the number of comparisons performed. Given that the adjusted residuals did not have p-values associated with each residual value after completing these analyses in SPSS, the *p*-values were then calculated using Beasley and Schumacker's (1995) procedure and compared to the adjusted Bonferroni corrected *p*-values. If these calculated *p*-values were lower than the adjusted Bonferroni corrected *p*-values it indicated where the significant differences were present between the groups. For example, when examining GSC (i.e., GSC-0, GSC-1, GSC-2, and GSC-3) amongst the four family type groups (i.e., Control, ACOA, Abused, and ACOA+Abused), 16 comparisons were made. A Bonferroni correction of $p < .05$ divided by 16 equals $p < 0.0031$. After completing the Beasley and Schumacker (1995) procedure the calculated *p*-values were compared to $p < .0031$ and the adjust residuals with *p*-values that were lower were considered significantly different. The results of the chi-square analyses are presented below.

The mean age for the ACOA group was 35.81 years ($SD = 10.10$), the Abused group was 35.05 years ($SD = 10.53$), the ACOA+Abused group was 37.38 years ($SD = 9.25$), and the Control group was 31.89 years ($SD = 9.91$). There was a higher percentage of females within each individual group (Table 1).

A significantly greater number of individuals in the Control group (54.7%) reported that their marital status was single and the fewest from this group reported they were living together as common-in-law compared to all other groups.

A large percentage of the Control group reported their parents' marital status as living together (68%) whereas the lowest reported percentage of married parents was in the ACOA+Abused group at 23.8%. The Control group also had the lowest percentage of separated/divorced parents (14.7%) in comparison to the other groups. Father's country of birth was reported as Canada by only 36% of the Control group, a significantly lower percentage in comparison to 76.4% of the ACOA group, 75.9% of the Abused group, and 77% of the ACOA+Abused group. Mother's country of birth was reported as Canada by 33.3% of the Control group, again the lowest in comparison to 73.6% of the ACOA group, 74.1% of the Abused group, and significantly highest at 80.3% for the ACOA+Abused group. Generational Status-Canadian, a classification system used to identify whether or not participants and participants' parents were born in Canada, was used to examine the participants in this study. Participants were placed into one of four categories: GS-C0: participant and parents are immigrants, GS-C1: participant born in Canada but both parents are immigrants, GS-C2: participant and one parent born in Canada, and finally, GS-C3: second-generation Canadians, meaning participant and both parents born in Canada. GS-C3 was prevalent within all family type clinical groups; ACOA reported 69.6%, Abused 69%, ACOA+Abused 74.4%, and the Control group significantly differed on this measure as only 26.4% were second-generation Canadians. The Control group had a significantly greater percentage of immigrants in their group (GS-C0) in comparison to the other groups. A majority of participants from the ACOA, Abused, and ACOA+Abused groups reported their Ethnic group as White (refer to Table 2 for full

breakdown) and English as their first language and in comparison the Control group reported the lowest percentages for White as ethnicity and English as their first language (Table 1).

Participants' level of education (Table 3) was reported as below high school, completion of high school, completion of college, university Bachelor Degree, or as an advanced degree (e.g., Masters, Ph.D., or professional degree). Participants in the Control group had, at minimum, completed high school or greater for their education. In general, the Control group was most similar to the ACOA group's education level. The Control group is overall more educated than the ACOA+Abused group. Parent education was also reported and is presented in Table 3. A higher percentage of participants' fathers that fell in the family type groups did not complete high school in comparison to the Control group. Few participants' mothers completed a Masters, PhD, or professional degree.

Participants' income was primarily reported in the $20,000 to $40,000 range by all four groups (Table 1). Few participants reported their income falling in the $81K to $100K range.

In contrast to participant income, family income significantly differed by family type group, $F(3, 299) = 5.67$, $p < .001$, such that the Control group, overall, had a significantly higher family income compared to the Abused and combined ACOA+Abused group, but not the ACOA group.

Analysis of Assumptions

The data were examined to assess whether they met basic linear regression assumptions. First, the relation of each independent variable to the dependent variables was assessed to see if they met linearity. To assess the bivariate relation of each independent variable (i.e., personality, parenting styles, parental reciprocity) with each dependent variable (i.e., family roles), the relations between them were examined by using scatter plots to assess which function (i.e.,

linear, quadratic, logarithmic, or cubic) best fit the relation between the variables. There was a linear relation between all independent and dependent variables except for the association between the dependent variable Lost Child and independent variable mother permissive parenting style. A quadratic function best fit the relation between these two variables. Therefore, a square transformation was performed for mother permissive which resulted in a linear relation between these variables.

Second, multivariate normality was checked for all variables by checking histograms and Q-Q plots. Third, although multicollinearity is not an assumption of regression the variables were examined to check for excessive collinearity. Multicollinearity was assessed by computing correlations and the Pearson *r* values were checked. After linear regressions were performed the variance inflation factor (VIF) was also examined to assess collinearity; any VIF above 4 was considered problematic. No VIF scores fell above 4.

Finally, the residuals from the regressions models were assessed for normality, that is the within group distributions were checked for normality. Studentized residuals were examined after regressions were completed for the four family role dependent variables by using the Shapiro-Wilks test for normality. The residuals from the regressions for dependent variables assessing the Mascot and Lost Child roles were normally distributed and the Shapiro-Wilks test was non-significant indicating normality. In contrast, the distribution of residuals for the Hero and Scapegoat role models were not normally distributed; the Shapiro-Wilks test was significant indicating a violation of normality. A square transformation of the Hero variable was performed and the regression residuals were reassessed and were normal. A log transformation was performed for the Scapegoat variable and the regression residuals were re-examined and normal.

Family Type Group Differences by Role

The four family type groups were examined using MANOVA to determine whether they differed by adaptive role scores. It is important to clarify that the familial roles were examined as continuous variables and participants were not assigned or categorised into a particular role based on their score for the four roles. Multiple preliminary analyses (i.e., MANOVA) were completed to assess whether demographic variables such as education, age, family income, GSC, and marital status were related to the different familial roles. Participant education remained as the only variable that significantly differed by role, $F(16, 962) = 4.00$, $p < .0005$, all other demographic variables that were analysed were non-significant. Participant education was significantly related to the Hero role $F(4, 318) = 10.67$, $p < .0005$, Mascot role $F(4, 318) = 2.99$, $p < .019$, Scapegoat role $F(4, 318) = 3.32$, $p < .011$, and the Lost Child role $F(4, 318) = 3.50$, $p < .008$. As a consequence of the preliminary analyses, only education was included in the demographic category for the MANOVAs.

The Control group had the highest Hero score but it did not significantly differ from the ACOA group's Hero score. There was a Hero score difference of the Control ($M = 59.60$, $SD = 10.69$) and the ACOA ($M = 58.38$, SD = 9.67) from the Abused ($M = 52.37$, $SD = 12.47$) and the ACOA+Abused ($M = 55.23$, $SD = 11.56$) groups. The Hero scores were similar between the Abused and ACOA+Abused groups. The Control group ($M = 50.14$, $SD = 12.12$) also had the highest mean score for the Mascot role; however, once a Bonferroni correction was made of $p < .05$ divided by the number of comparisons, four, $p = .013$, the difference between the Control and ACOA ($M = 45.60$, $SD = 11.80$) group Mascot scores was non-significant. The Control and ACOA groups Mascot role scores were significantly higher than the scores for the Mascot role for the Abused ($M = 45.60$, $SD = 11.80$) and ACOA+Abused groups ($M = 41.87$, $SD = 13.63$).

Therefore, the more positive family roles of Hero and Mascot were more prevalent in the Control and ACOA groups compared to the ACOA+Abused and the Abused groups.

The Scapegoat role means were highest for the Abused (M = 37.82, SD = 13.99) and ACOA+Abused (M = 36.13, SD = 15.45) groups and significantly differed from the lower Scapegoat means for the Control (M = 27.58, SD = 11.35) and ACOA (M = 31.83, SD = 13.57) groups. The difference between the Abused and ACOA+Abused Scapegoat mean scores was not significant. Finally, the Lost Child mean scores for all three family type groups were higher (ACOA: M = 45.79, SD = 10.90, Abused: M = 50.68, SD = 11.91, ACOA+Abused: M = 52.75, SD = 12.81) and significantly differed from the Control group mean (M = 38.83, SD = 13.67). Again, the difference between the Abused and ACOA+Abused Lost Child mean scores was not significant; however, the Lost Child mean scores for these two clinical groups were significantly greater than the Lost Child mean score for the ACOA group. Therefore, in synchrony with the finding for the positive roles, the two negative roles of Scapegoat and Lost Child are more prevalent in the ACOA+Abused and the Abused groups than the Control and ACOA groups.

Correlational Analyses

Correlational analyses between all family roles and predictor variables, including personality, parenting styles, and parental reciprocity, were completed (Table 4). Bonferroni corrections were applied by dividing an alpha level of .05 by the number of comparisons made. There were significant correlations among the family role scores and predictor variables. Consistent with the literature (Kier & Buras, 1999)**,** the Hero and Mascot roles were positively correlated (r = .166) and the Hero and Scapegoat roles were negatively correlated (r = -.424). As predicted, the Mascot role was negatively related to the Lost Child role (r = -.576), but,

unexpectedly, the Mascot role was also positively correlated with the Scapegoat role (r = .191). None of the other correlations among the family roles were significant.

As expected, Hero role scores were significantly positively correlated with the personality measures of Extraversion (r = .157), Agreeableness (r = .247), Conscientiousness (r = .522), and negatively correlated with Neuroticism (r = -.223). Also as predicted, the Hero role was significantly correlated with positive parenting relationships (mother authoritative and father authoritative parenting styles r's = .172 and .144, respectively; perception of mother and father reciprocity r's = .194 and .181, respectively).

As predicted, Mascot role scores were significantly positively correlated with Extraversion (r = .440) and negatively correlated with Neuroticism (r = -.242) but not significantly correlated with Conscientiousness, Agreeableness, or Openness (r's = .114, .034, and .130). As predicted, the Mascot role was also positively correlated with mother authoritative (r = .365) and father authoritative (r = .261) parenting but negatively correlated with mother authoritarian (r = -.231). Unexpectedly, Mascot and mother permissiveness were positively correlated (r = .178). There were also significant positive correlations between the Mascot role and reciprocity with mother (r = .361) and father (r = .260).

As hypothesised, the Scapegoat role was significantly negatively correlated with mother authoritative parenting (r = -.197), but the Scapegoat role was not significantly correlated with any of the other parenting style measures (all r's < .125). As predicted, the Scapegoat role was negatively correlated with reciprocity with mother (r = -.173), but not with father reciprocity (r = -.132). As expected, there were significant positive correlations between the Scapegoat role and Neuroticism (r = .253) and negative correlations between Scapegoat and Agreeableness,

Conscientiousness, and unexpectedly Extraversion (r = -.470, -.289, and -.148). The correlation between Scapegoat and Openness (r = -.026) was not significant.

As hypothesised, the Lost Child role was significantly negatively correlated with mother (r = -.404) and father (r = -.292) authoritative parenting, but positively correlated with mother (r = .314) and father authoritarian (r = .171). The correlations between the Lost Child role and permissive parenting styles were not significant (r = -.043 for mother and r = -.006 for father). As expected, the Lost Child role was also significantly negatively correlated with reciprocity with mother (r = -.383) and father (r = -.278). Finally, as predicted, the Lost Child role was significantly positively correlated with Neuroticism (r = .442), and significantly negatively correlated with Extraversion and Conscientiousness (r = -.529 and -.208). The correlations between Lost Child and Agreeableness (r = -.112) and Openness (r = 0.080) were not significant.

Regression Analyses

Four regression models were estimated, one for each child family role (i.e., Hero, Mascot, Scapegoat, and Lost Child). All independent variables (i.e., parenting measures and personality) and the interactions between all independent variables and family type group (i.e., Control, ACOA, Abused, and ACOA+Abused) were included in each model.

For the dependent variables of child family roles (i.e., Hero, Mascot, Scapegoat, and Lost Child), each model consisted of five blocks entered separately using hierarchical regression. Demographic variables, as explained previously contained only participants' level of education, were entered in Block One. Block Two contained the four family type groups; Control, ACOA, Abused, and ACOA+Abused group. Since family type groups are nominal variables they were examined by using dummy coding. The Control group was used as the reference category to compare to the other family type groups. In Block Three, participants' personality scores were

entered according to Bronfenbrenner's (1977) Ecological Systems Theory which places individual characteristics before the relationships between child and family (i.e., parenting measures) which take place in the first layer, the microsystem, of the nested layers. Therefore, Blocks Four and Five contained parenting styles and mutual reciprocity respectively. Developmentally, parenting style is influential before reciprocity between a parent-child relationship develops; from a developmental perspective, reciprocity develops in late adolescence or emerging adulthood (Wintre & Yaffe, 2000). Thus, parenting styles were entered in the block before mutual reciprocity based on this developmental theory. Finally, Block six contained any interactions between group and the independent variables. A summary of the regression results are presented in Appendix G.

The regression analysis for the dependent variable, Hero, was comprised of five blocks (Table 5). The overall percentage of explained variance, R^2, was 39.1%. Participants' level of education, the single control variable that was entered in Block One, remained significant after further blocks were entered into the model. As predicted, personality variables of Extraversion and Conscientiousness also remained significant. Both were positively associated with the Hero role. Measures of parenting styles and parental reciprocity were not significantly related to the Hero family role over and above the variables included in the previous blocks. No interactions remained significant for this model. After performing the regression analysis the residuals were assessed by plotting the studentized residuals as a histogram, checking Q-Q plots, and using the Shapiro-Wilks test for normality. It was evident that the residuals were not normally distributed. The Hero variable was transformed using a square transformation and the regression was rerun using the same blocks. The overall percentage of explained variance, R^2, was 39.3% (Table 6).

The results of the regression analysis were the same except the residuals were now normally distributed.

A regression analysis for the dependent variable Mascot was comprised of five blocks which examined the contribution of each independent variable to the Mascot role (Table 7). The overall percentage of explained variance, R^2, was 32.2%, with only four significant variables. Participants' level of education was not a significant contributor to this model. Although originally significant, the effect of Group was not significant after parenting styles were added to the next block, indicating that no differences were found for the Mascot role related to whether the participant was from the Control, ACOA, Abused, or ACOA+Abused groups. However, the personality variables of Extraversion and Openness were both significant and positively related to the Mascot role. As expected, Agreeableness was also significant, in a negative relation, to the Mascot role. Mother Authoritativeness was the lone significant parenting variable and was positively related as hypothesised to the Mascot role. However, once a Bonferroni correction was made this relation between the variables was no longer significant. No interactions were significant for the Mascot.

The regression analysis for the dependent variable Scapegoat was comprised of five blocks (Table 8). The overall percentage of explained variance, R^2, was 29.9%. Although the variable for participants' level of education was originally significant, it was not a significant contributor once other blocks were added to the model. The effect of Group was originally significant, indicating that the Abused and ACOA+Abused groups had higher Scapegoat scores in comparison to the Control group but it was no longer significant once the block for parenting styles was added to the model. The personality variables of Agreeableness and Conscientiousness were both significant and negatively related to the Scapegoat role. No other

personality measures were related to the Scapegoat role. No parenting measures or interactions were significant for this model. After performing the regression analysis the residuals were assessed by plotting the studentized residuals as a histogram, checking Q-Q plots, and using the Shapiro-Wilks test for normality which all indicated that the residuals were not normally distributed. The Scapegoat variable was transformed using a logarithmic transformation and the regression was rerun using the same blocks. The overall percentage of explained variance, R^2, was 29.6% (Table 9). The residuals were now normally distributed. The results of the regression analysis were generally the same except that the Abused group significantly differed from the Control group in regards to the Scapegoat measure.

A regression analysis for the dependent variable Lost Child consisted of seven blocks (Table 10). The overall percentage of explained variance, R^2, was 54.3%. In an unexpected finding, the variables in the model for the Lost Child role had the highest amount of explained variance compared to the models for the other family roles. Participants' level of education was originally a significant contributor to this model until the second block of Group was added to the model. The effect of Group was initially significant, with the Control group significantly different from all three family type groups. However, upon the addition of subsequent blocks these differences became non-significant. As predicted, the personality variables of Neuroticism and Agreeableness were both significant and positively related to the Lost Child role. Extraversion was also significant, but in contrast to the other traits, was negatively related to the Lost Child role. As hypothesized, Mother Authoritativeness was negatively (Table 8) related, whereas Mother Authoritarian and Mother Permissive were both positively related to the Lost Child role. An interaction between Group and Neuroticism was found, such that all three family type groups had higher ratings for Neuroticism for the Lost Child role (Figure 1). A significant

interaction between Group and Agreeableness revealed that the personality trait of Agreeableness increased as the association to the Lost Child role increased for the Control and Abused groups (Figure 2). In contrast, Agreeableness increased as the relation to the Lost Child role decreased for the ACOA and ACOA+Abused groups.

Discussion

The purpose of this study was multifaceted. The primary objective of this study was to update the research regarding child roles in dysfunctional families (Black, 1981; Woititz, 1983) by using more contemporary developmental psychopathology models (Cicchetti & Cohen, 1995, 2006; Cicchetti, 1984, 2006, 2016; Sameroff, 1987, 1989). The research entailed extending interactional variables to include demographics, personality, family interactions, and environmental circumstances related to the adoption of child-family roles. Although the initial area of interest for the project was the topic of Adult Children of Alcoholics (ACOAs), this was modified due to the fact that an initial review of the existing research revealed many problematic issues including the use of a non-representative sample of participants; the dearth of research of family roles in other types of dysfunctional families; and most importantly, the absence of information collected regarding ACOAs' background and whether abuse took place in their family of origin.

Thus, an objective of this study was to collect data from a wider range of older age groups (i.e., rather than college-age participants as representing adulthood) and from participants outside of clinical samples alone in order to address the inconsistencies in the clinical and empirical literature in regards to the ACOA research. This study also expanded upon previous research by collecting data from ACOA's and other types of dysfunctional families including those who were abused. In addition, ACOA's were differentiated based on their background of

whether they were abused or not to form three family type groups including the ACOA, Abused, and ACOA+Abused that were compared to a Control group in which no abuse or parental alcoholism was present. Finally, the relation of the Big-5 personality characteristics to the family roles and the relation of perceived parenting style and mutual reciprocity to the adoption of family roles was investigated.

Overall, a number of key findings were revealed in this study. First, and surprisingly, no unique differences were found between the ACOA and the Control group. In fact, these two groups were similar with respect to the family roles. In contrast, the Abused and ACOA+Abused groups were most similar to each other but these family type groups generally differed from the ACOA group. This emphasizes the need to differentiate offspring of alcoholic parents from those of alcoholic and abusive parents. It is ironic that the family roles were initially devised to describe the child roles of families of alcoholism (Black, 1981; Woititz, 1983) but are not significantly related to that particular clinical group.

Second, the relation of personality variables upon the adoption of a familial role was significant in all four models, ranging from accounting for 26.2 (Hero), 20.1 (Mascot), 20.4 (Scapegoat) and 26.8 (Lost Child) percent of the explained variance in the four models respectively.

Third, one of the most interesting findings was related to the model assessing the Lost Child, which accounted for the most explained variance (i.e., 54.3%). The greatest number of significant variables were found in this model; incorporating both personality and parenting measures. This was also the only model in which the ACOA group was significantly different from the Control group.

Fourth, the importance of examining a multitude of factors within the microsystem was confirmed in accordance with Bronfenbrenner's (1977) ecological systems theory, developmental psychopathology (Cicchetti & Cohen, 1995, 2006; Cicchetti, 1984, 2006, 2016), and family systems literature (Minuchin; 1975, Satir, 1972; Steinglass, 1989), which together emphasise the importance of including variables from various domains to better understand a concept such as familial roles. These findings will be discussed in more detail within the context of the hypotheses that were tested.

Group differences:

A primary focus of the present study was to investigate whether any significant differences between the Control group compared to the ACOA group existed, especially with groups that were not university undergraduates or just clinical samples. Previous research has been mixed, with some emphasising the unique characteristics of ACOA's and the need to categorise them separately from individuals who grew up in a typical, normal, loving family and from those who grew up in other types of dysfunctional families (e.g., physically abused, neglected, etc.), whereas others noted there were similarities between these groups (Ackerman, 1987; Berkowitz & Perkins, 1988; Harter, 2000; Harter & Taylor, 2000; Lyon & Seefeldt, 1995; Sher et al.; Tween & Ryff, 1991; West & Prinz, 1987). It is important to note that the Control group in this study was not the most ideal match to the three family type groups as it did not only differ by lack of family dysfunction but also reflected the natural differences in the Canadian population, which has more immigrants. Although the Control group is a legitimate reflection of the Canadian population within the Greater Toronto Area it was strikingly different from the other family groups in the study in which participants were primarily White.

The findings here revealed support for Hypotheses 1, 2, and 3. Overall, the ACOA group was often very similar to the Control group in terms of familial roles. In fact, no differences were found between the ACOA and Control group for the positive roles of Hero and Mascot and similarly, for the negative role of the Scapegoat. These two groups had the highest scores for the Hero and Mascot and lowest for the Scapegoat; thus, reflecting the difference between abused and non-abused individuals.

Furthermore, the two clinical groups of Abused and ACOA+Abused were similar to each other for all four roles. This similarity between these two family type groups is believed to be related to the fact that participant inclusion is based on their experience of abuse. They were, however, significantly different from the clinical ACOA group. These findings are informative, as researchers have sometimes lumped together all ACOAs (i.e., those with and those without abusive parent(s)) into one group. Upon examination of their life history, researchers have found that some ACOA participants, in addition to parental alcoholism, also endured a form of abuse that was either physical or sexual in nature, and this may explain why some researchers found notable differences between ACOAs and control groups (Cermak & Rosenfeld, 1987; Fisher et al., 1992; Harter & Taylor, 2000; Kelley et al., 2005). The Abused and ACOA+Abused groups had the highest scores for the Scapegoat role and lowest for the Hero and Mascot roles.

The Lost Child role is an exception to the similarities between the Control group and ACOA. The Control group had the lowest score for this familial role. In addition, all three clinical groups significantly differed from the Control group and had a much higher Lost Child role score; thus demonstrating the harmful association between a negative home environment and the adoption of this particular unfavourable role. Note, however, that the ACOA group, although significantly different from the Control group for the Lost Child, had a significantly

lower Lost Child score than the other two clinical groups. This suggests that the abused and combined group environments fared far worse for role adoption of Lost Child, even compared to individuals who grew up with alcoholic parent(s).

Analyses also revealed that the roles are applicable to a diverse range of family backgrounds, not only ACOA's. Black (1981) suggested that the roles are most likely applicable to individuals other than just the ACOA, as was demonstrated by Kier & Buras (1999). The influence of group on familial role diminished with the addition of trait characteristics, and parenting-interactive measures. Although the effect of group on the familial roles of Mascot and Lost Child originally existed, this disappeared with the addition of parenting measures. In regards to the Hero role, once education was taken into consideration, only the Abused group was negatively related to the Hero. Upon the addition of personality to the model, the Abused group also became non-significant. The influence of the Abused group was originally positively associated to the Scapegoat but also became non-significant once parenting variables were added to the final model for the Scapegoat role.

Family roles and their Relation to Group, Personality, and Parenting Measures:

As predicted, both personality and parenting variables were associated with the family roles. Consistent amongst all roles was the strong relation to measures of personality, compared to weaker relations with parenting measures. Past research was somewhat biased because data were either collected from individuals who were young and in college or from individuals who never entered college, were older, and in treatment (Berkowitz & Perkins, 1988; Hall & Webster, 2007, Harter, 2000; Kashubeck & Christensen, 1992; Parker & Harford, 1988; Scharff et al., 2004; Schuckit & Sweeney, 1987; Sher, 1997). In contrast, the present study gathered data from a mixed educational sample over a wide age range to improve upon past methodological

oversight. The findings will be discussed in terms of the more positive roles, the Hero and Mascot, followed by the negative roles of the Scapegoat and Lost Child.

Hero Role: Interestingly, although initial correlational analyses revealed a positive relationship between the Hero role and mother and father authoritative parenting and parental reciprocity, no parenting measures were found to be related to the Hero role in the final model. This finding is in contrast to Hypotheses 4 and 5 which predicted that positive forms of parenting, including authoritativeness and high parental reciprocity, would be related to the Hero role.

Extraversion, which encompasses characteristics such as talkativeness, social, assertiveness, and high energy, was positively associated to the Hero. Characteristics of reliability, hard work, organisation, and methodicalness fall under the personality trait of conscientiousness, which was also positively associated to the Hero role. These characteristics are considered to be advantageous and more beneficial compared to the traits of neuroticism and provide partial support for Hypothesis 6 that Conscientiousness would be positively related to the Hero. In fact, together, these personality traits explained close to 27% of the variance in the Hero role, thus exemplifying the importance of such personality traits to the adoption of the Hero role. Given these findings, future research examining the Hero role should include a measure of personality in addition to other variables of interest.

Mascot Role: Both parenting measures and personality were relevant for the Mascot family role. Partial support for Hypothesis 7 was found, such that personality traits of Openness and Extraversion were both positively related to the Mascot and Agreeableness was negatively related. These personality traits together fit with the profile that Black (1981) and Wegscheider (1981) outlined in their description of ACOA family roles. The Mascot is described as someone

who uses humour to cope with their issues, is socially frenetic, disengaged from their family, has an inability to receive help from others, and is generally emotionally sensitive (Black, 1989, Wegscheider, 1981). These individual characteristics are in agreement with the findings of personality characteristics. In contrast to the Hero role, a parenting measure was found in the final regression model for the Mascot. Partial support was found for Hypotheses 4 and 5. Although many positive parenting behaviours were correlated to the Mascot in the expected direction (e.g., positively to authoritative parenting and negatively to authoritarian parenting, and in a positive direction to parental reciprocity) only mother authoritative approached significance in the final model. This finding exemplifies the importance of parenting behaviours towards children in the adaptation to their environment. Positive parenting, such as the authoritative mother, is demanding but in a nurturing and responsive manner to their children. Thus, the authoritative mother provides the support required throughout development to become responsible, self-reliant, independent individuals (Baumrind, 1971). Theoretically, although the Mascot is not a desirable role, it is however considered one of the more positive roles adopted in a family as opposed to the Scapegoat and Lost Child which will be discussed next.

Scapegoat Role: In regards to the Scapegoat role, as expected, correlational analyses revealed a negative relationship between the Scapegoat role with mother reciprocity and mother authoritativeness. However, upon further analysis, parental reciprocity did not remain significant. Therefore, predictions initially made regarding the negative association of reciprocity to the Scapegoat role (i.e., Hypothesis 5) were not upheld. In accordance with Hypothesis 4, preliminary analyses revealed that parental authoritativeness was negatively and permissive parenting by mothers was positively related to the Scapegoat role. Although these measures of parenting were related in the expected direction, they no longer remained significant once the

personality variables were added to the model. Personality was strongly related to the Scapegoat role. In fact, partial support for Hypothesis 9 was found as traits of Agreeableness and Conscientiousness were both negatively related to this role and explained almost 21% of the variance. These measures were related in the expected direction and fit with the literature regarding the ACOA Scapegoat (Black, 1981, 1989; Woititz, 1990). The Scapegoat is considered to be the individual in the family that acts out in their younger years but continues to interact in socially inappropriate ways into adulthood. Being disagreeable, distant, and antagonistic, in addition to being unreliable and disorganised, fit with the theoretical presumptions and provide a consistent description of the Scapegoat.

Lost Child Role: The final role examined was the Lost Child. This role is described as the most negative among the four roles because an individual who adopts the Lost Child role is withdrawn, detached from the family, deficient in social relationships, quiet, lacks direction, and do not strive to take on responsibility. Therefore, in general, he or she tries to remain in the background to remove any form of attention from himself or herself (Black, 1989; Woititz, 1983; 1990). The findings of this study revealed the importance of both personality and parenting measures to the adoption of the Lost Child role, thus providing support for Hypotheses 4, 8, and 10. The trait of Extraversion was negatively related to this role and fits with the withdrawn status of the Lost Child. The interaction of Agreeableness and Neuroticism with Group revealed that the analysis of Lost Child by family group environment was imperative to understanding the adoption of this role. As an individual's Agreeableness increased, the relation to the Lost Child became stronger for the Control and Abused groups. In contrast, this relation was reversed for the ACOA and ACOA+Abused groups in that the relationship to the Lost Child decreased as Agreeableness increased. A possible explanation for this finding is that individuals, living in

environments in which alcoholism is prevalent, may feel less like the Lost Child if they cooperate and sympathise with the situation at home, and in turn they will be less likely to become the centre for attention within their family. This finding requires replication and further investigation in order to make a more definitive conclusion. An interaction between Neuroticism and group was found such that as neuroticism became stronger so did the association to adopting the Lost Child role. However, for the Abused group this association started to gradually taper off as Neuroticism increased, thus displaying a unique association between these two variables for the Abused group. These findings warrant future attention as they are the only ones that differentiate both Alcoholism groups from the Abused group and the Control group.

The significance of mother's parenting behaviours, regardless of type of family group, seems crucial to understanding the Lost Child. Measures of mothers' parenting styles all remained significant in the model for this role; however no measures of fathers' parenting remained in the model. As expected, positive authoritative parenting by mother was negatively associated with the Lost Child, while authoritarian and permissive maternal parenting were positively related to the role. Authoritarianism may be related to an increase of problematic issues associated with toxic dysfunctional family environment. In fact parenting practices appear to be more important in relation to the Lost Child role, over and above family type group. The variables associated with family/group type became non-significant with the addition of parenting measures to the Lost Child model. Thus, a dysfunctional family, in which the parents exhibit high demands and patronize their children instead of showing their love and support for them is the epitome of an unhealthy home. Parents who are overly controlling and less emotionally involved (Ruben, 2001; Senchak et al., 1995) contribute to the adoption of the most unhealthy family role.

Demographics and the Importance of Education:

Participant education was included in the models as a control variable. Although education was insignificant for the final models assessing the Mascot, Scapegoat, and Lost Child roles, it was a significant variable for the Hero role. Education contributed 9.5% of the variance associated with the Hero role and it remained significant regardless of other variables that were added to the regression model. Heroes have been described as high achievers in school who strive to get good grades as they are considered to be perfectionistic (Black, 1981; 1989, Wegscheider, 1981). It appears that participants' educational achievement is related to the Hero adaptive role in the family. Given that the Hero is more of a positive role, education may act as a protective factor influencing the individual towards the Hero as opposed to the Scapegoat role. In fact, education appeared to be negatively related to the Scapegoat role. This finding also fits the theory that Scapegoats are less likely to achieve academically and are more likely to drop out of school. However, for the Scapegoat analysis, this finding became non-significant once participant group (e.g., Control, ACOA, etcetera) was added to the regression models.

Clinical Implications:

The present study provides valuable information for practitioners as the results can assist in understanding a client's schema for organising his or her life experiences. Fundamentally the findings related to the adoption of a familial role can better inform the development of treatment plans, which will benefit the client. For example, consider a family case in which one child adopted the Lost Child role and the other the Hero. It seems evident from their adopted roles that one has a more resilient personality. The Lost Child is more vulnerable to the negative impacts of his or her family of origin. Therefore, individual psychotherapy work may be more relevant for the Hero child, whereas a mix of family therapy, in addition to individual therapy, might be

more beneficial for the Lost Child when he or she is a child. Furthermore, work to assist the Lost Child develop self-compassion and self-expression through creative activity (e.g., artwork and writing) would also be beneficial in treatment (Harris & MacQuiddy, 2008).

Role type may also provide insight into what brought the client to therapy. Vannicelli (1989) noted that individuals entering group therapy would enact their adopted role which could be "explored and reworked" within the safe confines of a supportive therapeutic environment. Harris and MacQuiddy (2008) proposed heterogeneous therapy groups that included a mix of familial roles which would allow the individual to try new behaviours in a safe setting and receive feedback from the therapist and group members to assist in analysing their adopted role. Knowing what processes are related to the roles will allow practitioners to gather information regarding what influenced their adoption of their particular role. An exploration of their adaptive family role may also bring to light the positive survival aspects of their role, as well as any maladaptive qualities. For example, with a client who is a Hero, acknowledgment of their exceptional role in keeping their family together, as a protector and high achiever, can be highlighted as characteristics that protected him or her against some other more costly outcomes (e.g., Scapegoat or Lost Child) however, the maladaptive aspects of the Hero can also be highlighted by educating the client regarding the harm of limited self-care and placing high demands on oneself. Thus, data can be used to assist in shifting the negative personality types that a client may have adhered to and that have led to the identification with a certain role type. Related to the Scapegoat, a therapist can help the client shed this difficult role in exchange for a more benign one.

Given that, in today's community and hospital mental health systems, there is a push towards shorter therapy times, pressure is often placed on practitioners to provide care within a

time-limited approach. Veronie and Fruehstorfer (2001, p. 65) explained that “since the efficacy of clinical interventions significantly influences the length of time required for the client to attain his or her treatment goals, matching intervention with the client’s world view will benefit the client with a briefer course of more effective therapy”. The present research can be used to increase the efficiency of tailored treatment plans, such that knowing the familial role of the patient can assist the therapist in understanding the patient’s view of the world and can therefore assist in focusing treatment plans on how to better support them. For example, assisting a patient who has adopted the Hero role to shift their focus more to caring for oneself, or helping the Lost Child patient increase their compassion for themselves and to express themselves through a modality such as art, rather than remaining isolated and silent.

Limitations and Strengths:

One limitation of this study is the fact that a large majority of the participants were female (88.5% of entire sample). Male participants were difficult to recruit for this study. As discussed earlier, participation in this research was solely voluntary. As a result the lower number of males in this study may be related to the likelihood that females feel more comfortable with sharing their experiences than males from problematic families. As such, the study’s results, although including a small percentage of male participants (11.5%), may be more related to the female perspective.

Another limitation was the fact that the Generational-Status Canadian (GSC) was higher for the family type groups compared to the Control group which consisted of largely immigrants and children of immigrants or GS-C0. The Control group did differ from the other family type groups in regards to the variable of interest, family dysfunction. Individuals from the Control group did not experience growing up with an alcoholic parent(s), abusive parent(s), or both

however, a higher percentage of White participants were found in the three family type groups whereas the Control group had a greater mix of ethnicities. A majority of participants reported their first language as English; a higher percentage of these participants were found in the family type groups whereas the Control group reported a mix of languages. Therefore it is difficult to decisively state which condition (i.e., family dysfunction or ethnic mix) is functioning when using the Control group as a comparison group. The fact that fewer non-White participants were found in the dysfunctional family type groups may be related to the fact that some research has shown that the stigma associated with mental health illnesses and issues may also be related to fewer minorities taking part in psychology research related to mental health (Woodall, Morgan, Sloan, & Howard, 2010). Consequently, there is a need for future research to confirm that the results of this research do apply to individuals with a similar demographical background than the present Control group which differed according to both family dysfunction and ethnic distribution.

An additional limitation of this study is that the statistical analyses were correlational, therefore limiting causal inferences. Generally, a positive relation found between positive aspects of the NEO-FFI personality measures to the more positive family Hero and Mascot roles and vice versa for personality characteristics labelled as negative (e.g., neurotic) which were related to negative family roles of Lost Child and Scapegoat. Similar associations were found between positive forms of parenting with their respective positive family roles and between negative parenting styles and negative family roles. Although these variables were related to each other, we do not know if parents' parenting styles and participant personality cause family role adoption. We also do not know to what extent a child's personality affects parenting, but that question was beyond the scope of the present study.

Another limitation is related to the self-reporting of parental alcoholism and abuse. Participants self-identified as having an alcoholic parent or having been sexually or physically abused by answering categorically yes or no. There is a possibility that individuals may have under-reported the degree of their parent's alcoholism issues or experience of abuse. It would be beneficial to use a reliable and valid measure, such as the Childhood Trauma Questionnaire (Bernstein and Fink, 1998), as a self-report screening measure for history of abuse and neglect as a child and adolescent. This measure could better verify trauma in an adult's childhood history. This measure also includes a minimisation denial scale for individuals who may underreport trauma and allows for the interpretation of the degree of abuse as low, moderate, or severe.

A final limitation of this study is the fact that the data were retrospective in that participants were asked to recollect information about their past family life as well as current status. There is a possibility that participants may have had difficulty remembering certain aspects of their relationship with their parents or past events, or may have reorganized the past to fit a present narrative.

Despite these limitations there are a number of strengths in this study.

Strengths

The strengths of this research study are also important to highlight. First, this study has revisited the topic of family roles and ACOAs from a more contemporary theoretical perspective (Cicchetti & Cohen, 1995, 2006; Cicchetti, 1984, 2006, 2016; Sameroff, 1987, 1989) and has addressed many of the inconsistencies in previous research. Second, the study examined the ACOA population in a non-university sample and collected data from a large sample. Past research often opted for the convenience of undergraduate participants who are not representative of an adult population.

Third, a differentiation within the ACOA group was made by examining an ACOA only group and an ACOA+Abused group versus an Abused group compared to a Control. Past research has often placed ACOA's into one group of individuals, some of whom had also experienced abuse. In fact, on a number of measures the ACOA group appeared to be quite similar to the Control group but differed from the combined and abused groups, highlighting the need to distinguish between them.

Fourth, the importance of personality to the type of family role chosen was addressed. Previous research has looked at the personality of ACOAs related to their coping but not relative to their adopted familial role. The Big-5 personality traits accounted for a large proportion of the variance in the statistical models for each family role.

Fifth, the importance of examining parent-child interactions over the developmental stages as they relate to the adoption of a positive or primarily negative family role provides support to the Family Systems Theory (Satir, 1972; Minuchin, 1974) which proposes that individuals cannot be understood alone, but only as part of the family unit. The interactions and emotional complexities amongst a family are essentially multifaceted and this research was able to examine them in the context of parent-child relationships related to familial role.

A further source of strength for this research is the addition of multiple demographic variables to assess whether differences existed amongst the family type groups and Control group. Multiple preliminary analyses were completed to assess whether demographic variables such as education, family income, and GSC were related to the different family groups (i.e., ACOA, Abused, ACOA+Abused, and Control) or family roles. The importance of education to this study highlights the need to include such measures in order to check for the part that demographics play related to family roles.

A final strength of this study is that the same data set was employed in another research project to examine the symptomatology of adult children by investigating all family type groups and family roles in his research (Gates, 2011). That project examined the symptomatology as the dependent variable and family type group and family roles as the independent variables. Gates (2011) found that symptoms that makeup the ACOA syndrome were also found in other dysfunctional family environments, that is the Abused and ACOA+Abused groups. The exact symptomatology was dependant not only on family environment but also on family role; in particular individuals who adopted the Scapegoat or Lost Child roles were more associated with negative mental health. Although the Hero role was predominantly chosen across all four groups it did not necessarily contribute to better mental health. Interestingly, only a direct association between spousal reciprocity (Wintre & Gates, 2006) to psychological well-being was found such that a close and supportive relationship between couples was related to good mental health. No relation to family roles with spousal reciprocity and psychological well-being was demonstrated.

Future Research

Given the unique findings of this study there are important areas for future research. There is a need to increase the understanding of family roles amongst minority and ethnically diverse groups. This will require recruiting participants from various ethnic backgrounds. Interestingly, participants of different ethnic backgrounds were mainly found in the Control group. This may reflect a possibility that immigrant groups may not be seeking clinical help. Reducing the stigma associated with mental health issues might affect this bias.

Another direction for future research would be to improve the measures beyond self-report questionnaires. Self-report data can include inaccurate information. However, it should be noted that questionnaires were completed anonymously and, as such, participants are more likely

to feel at ease at responding honestly from a self-perception perspective. Research has shown that self-report measures assessing personality are valid (Chan, 2009; Korb, 2011). However, if questionnaire data are supplemented with clinical interviews the accuracy of self-report data can be confirmed and vice versa (Berney & Blane, 1997; Siegfried, 1982).

In addition, in the present study, a major advance was that participants in the clinical groups were differentiated as ACOA, ACOA+Abused, and Abused. However. the Abused and ACOA+Abused were not further differentiated by the type of abuse they experienced. Although participants did indicate whether the form of abuse they experienced was physical or sexual in nature, the sample sizes were too small for them to be grouped separately. Interestingly, physiological differences have been found in brain scans of individuals who were sexually abused versus emotionally abused (Heim, Mayberg, Mletzko, Nemeroff, & Pruessner, 2013). Emotional abuse has been linked to low self-esteem and sexual abuse to sexual problems (Heim, et al., 2013; Mullen, Martin, Anderson, Romans, & Herbison, 1996). Furthermore, additional groups can also be added to include participants who have been neglected or emotionally abused. Additional exploration of type of abuse encountered may result in unique findings regarding parenting behaviours and personality characteristics that are associated to the adopted familial role.

Finally, an examination of how best to provide intervention and counselling services for individuals who have adopted any of these roles is needed. For example, it seems imperative to provide therapy for someone who takes on the negative role of Lost Child. A number of negative parenting and personality measures were associated with the Lost Child. These findings allow for an increased understanding of the relation to the Lost Child family role and how it is associated to a participant's schema for organising his or her experiences. An initial assessment of family

role would allow practitioners to develop a more tailored effective treatment plan. Also useful would be reasons for seeking therapy, their goals for therapy, and what techniques are helpful to them. Gathering such information can assist in developing effective interventions for individuals who have adopted what appears to be a role that has limited adaptive qualities in adulthood (Gates, 2011).

In conclusion, this study provides a stepping stone for future exploration of ACOAs. The importance of understanding familial roles based on family group/type was demonstrated. Interestingly, ACOA s were in many important ways similar to the Control group whereas the clinical groups of Abused and ACOA+Abused differed from these two groups. This highlights the importance of including demographic variables and the addition of clinical control groups. It is also clear that personality and parenting measures are related to the adoption of family roles. The data showed that the Hero was the most positive role and the Lost Child was the more negative role. Finally, this type of research is important because the findings can inform clinicians and assist them in crafting treatment plans for individuals based on their family role

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Table 1

Demographic variables by Control group and each family type group.

Demographic Variable		Control % (n)	ACOA % (n)	Abused % (n)	ACOA+Abused % (n)
Gender	Male	12.0 (9)	13.9 (10)	8.6 (5)	10.7 (13)
	Female	88.0 (66)	86.1 (62)	91.4 (53)	89.3 (109)
Marital Status	Single	54.7 (41)	25.0 (18)	34.5 (20)	26.2 (32)
	Married	33.3 (25)	40.3 (29)	29.3 (17)	28.7 (35)
	Common-in-law	5.3 (4)	18.1 (13)	19.0 (11)	22.1 (27)
	Separated/divorced	5.3 (4)	13.9 (10)	15.5 (9)	21.3 (26)
Have Children		29.3 (22)	45.8 (33)	51.7 (30)	64.8 (79)
Parents' Marital	Living together	68 (51)	33.3 (24)	27.6 (16)	23.8 (29)
Status	Separated/divorced	14.7 (11)	31.9 (23)	46.6 (27)	41.8 (51)
	Mother widow	9.3 (7)	13.9 (10)	12.1 (7)	12.3 (15)
	Father widower	5.3 (4)	4.2 (3)	1.7 (1)	3.3 (4)
	Deceased	2.7 (2)	12.5 (9)	8.6 (5)	12.3 (15)
Born in Canada	Father	36 (27)	76.4 (55)	75.9 (44)	77 (94)
	Mother	33.3 (25)	73.6 (53)	74.1 (43)	80.3 (98)
Generational Status-	GSC-0	43.1 (31)	7.2 (5)	10.3 (6)	10.3 (12)
Canadian	GSC-1	18.1 (13)	13.0 (9)	8.6 (5)	6.0 (7)
	GSC-2	12.5 (9)	10.1 (7)	12.1 (7)	9.4 (11)
	GSC-3	26.4 (19)	69.6 (48)	69.0 (40)	74.4 (87)
First Language is English		69.3 (52)	91.7 (66)	93.1 (54)	90.2 (110)
Family Income	20-40K	12.0 (9)	19.4 (14)	29.3 (17)	32.8 (40)
	41-60K	20.0 (15)	27.8 (20)	29.3 (17)	18.0 (22)
	61-80K	17.3 (13)	18.1 (13)	15.5 (9)	13.9 (17)
	81-100K	18.7 (14)	18.1 (13)	6.9 (4)	12.3 (15)
	100K+	25.3 (19)	12.5 (9)	10.3 (6)	13.9 (17)
Participant Income	20-40K	53.3 (40)	54.2 (39)	62.1 (36)	58.2 (71)
	41-60K	17.3 (13)	18.1 (13)	15.5 (9)	23.0 (28)
	61-80K	13.3 (10)	16.7 (12)	3.4 (2)	7.4 (9)
	81-100K+	4.0 (3)	4.2 (3)	6.8 (4)	4.1 (5)

Table 2

Ethnic group of Participants in the Control group and each family type group

Ethnicity	Control (n = 75)	ACOA (n= 72)	Abused (n = 58)	ACOA+Abused (n = 122)
White	58.7% (n = 44)	94.4% (n = 68)	89.7% (n = 52)	86.9% (n = 106)
Black	0	0	3.4% (n = 2)	2.5% (n = 3)
Chinese	8.0% (n = 6)	0	0	0
South Asian (e.g., East Indian, Pakistani, Sri Lankan)	21.3% (n = 16)	1.4% (n = 1)	0	0
South East Asian (e.g., Cambodian, Vietnamese, Indonesian)	0	0	0	0
West Asian	0	0	1.7% (n = 1)	0
Arab	2.7% (n = 2)	0	0	0
Filipino	0	0	0	0
Latin American	5.3% (n = 4)	0	0	0
Japanese	0	0	0	0
Korean	0	0	1.7% (n = 1)	0
Other	4.0% (n = 3)	4.2% (n = 3)	3.4% (n = 2)	10.7% (n = 13)

Table 3

Participants' and Participants' Parents' Level of Education in the Control group and each family type group

Level of Education	Control (n = 75)	ACOA (n= 72)	Abused (n = 58)	ACOA+Abused (n = 122)
Father	%	%	%	%
Below High School	18.6 (14)	41.7 (30)	40.4 (23)	55.5 (65)
Completion of High School	16.0 (12)	15.3 (11)	24.6 (14)	22.2 (26)
Completion of College	21.3 (16)	18.1 (13)	22.8 (13)	13.7 (16)
Bachelor Degree (University)	16.0 (12)	11.1 (8)	3.5 (2)	4.3 (5)
Masters, PhD or Professional Degree (e.g., Law, Engineering, Medical, etc.)	28.0 (21)	13.9 (10)	8.8 (5)	4.3 (5)
Mother				
Below High School	22.7 (17)	27.8 (20)	29.8 (17)	49.2 (59)
Completion of High School	26.7 (20)	31.9 (23)	33.3 (19)	30.0 (36)
Completion of College	21.3 (16)	19.4 (14)	28.1 (16)	15.8 (19)
Bachelor Degree (University)	16.0 (12)	18.1 (13)	8.8 (5)	1.7 (2)
Masters, PhD or Professional Degree (e.g., Law, Engineering, Medical, etc.)	13.3 (10)	2.8 (2)	0 (0)	3.3 (4)
Participant				
Below High School	0 (0)	6.9 (5)	3.4 (2)	12.3 (15)
Completion of High School	17.3 (13)	16.7 (12)	20.7 (12)	24.6 (30)
Completion of College	20 (15)	20.8 (15)	36.2 (21)	39.3 (48)
Bachelor Degree (University)	33.3 (25)	31.9 (23)	29.3 (17)	17.2 (21)
Masters, PhD or Professional Degree (e.g., Law, Engineering, Medical, etc.)	29.3 (22)	23.6 (17)	10.3 (6)	6.6 (8)

Table 4
Correlational Matrix

V	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1.																
2.	.166^															
3.	-.022	-.576^^														
4.	-.424^^	.191^	.001													
5.	.172^	.365^^	-.404^^	-.197^												
6.	-.050	-.231^^	.314^^	.020	-.434^^											
7.	.004	.178**	-.043	.082	.302^^	-.573^^										
8.	.144*	.261^^	-.292^^	-.125	.516^^	-.150*	.073									
9.	-.095	-.143	.171**	.075	-.198^	.261^^	-.110	-.532^^								
10.	-.019	.090	-.006	-.012	.084	-.142	.404^^	.318^^	-.583^^							
11.	.194^	.361^^	-.383^^	-.173**	.766^^	-.573^^	.399^^	.302^^	-.140	.041						
12.	.181**	.260^^	-.278^^	-.132	.422^^	-.189^	.079	.785^^	-.587^^	.404^^	.346^^					
13.	-.223^^	-.242^^	.442^^	.253^^	-.252^^	.203^	-.086	-.235^^	.171**	-.066	-.305^^	-.268^^				
14.	.157*	.440^^	-.529^^	-.148*	.216^^	-.062	-.005	.245^^	-.154*	.044	.262^^	.231^^	-.497^^			
15.	.108	.130	.080	-.026	-.061	-.089	.100	-.029	.006	.001	.037	-.005	-.044	.105		
16.	.247^^	.034	-.112	-.470^^	.166**	-.022	-.103	.091	-.016	.015	.166**	.095	-.410^^	.307^^	.111	
17.	.522^^	.114	-.208^^	-.289^^	.098	-.024	-.020	.080	-.041	-.011	.157*	.113	-.404^^	.408^^	-.031	.304^^

^^ $p \leq 0.0001$ level, ^ $p \leq 0.001$, ** $p \leq 0.005$, * $p \leq 0.01$ level (all 2-tailed); Do not accept .05 significance level, Bonferroni correction of 0.05/4 = 0.0125. Note: Variables (Vs) included in the correlation matrix: 1. Hero, 2. Mascot, 3. Lost Child, 4. Scapegoat, 5. Mother Authoritative, 6. Mother Authoritarian, 7. Mother Permissive, 8. Father Authoritative, 9. Father Authoritarian, 10. Father Permissive, 11. Mother Reciprocity, 12. Father Reciprocity, 13. Neuroticism, 14. Extraversion, 15. Openness, 16. Agreeableness, 17. Conscientiousness.

Table 5

Summary of Regression Analyses for Hero Role-Final Model

Variable	B	SE(B)	Beta	*p*	Explained Variance per Block (R^2/%)
Control Variable					
Participants' Level of Education	2.117	.524	.221	**.0001**	8.6
Family groups compared to Control					
ACOA	1.364	1.781	.052	.444	
Abused	-.423	2.176	-.014	.846	
ACOA+Abused	-1.087	2.013	-.047	.590	2.1
Personality					
Extraversion	-.204	.078	-.159	**.009**	
Conscientiousness	.738	.078	.533	**.001**	26.1
Parenting Styles					
No Significant Variables					1.6
Perception of Parental Reciprocity					
No Significant Variables					0.7
TOTAL R^2					**39.1**

Table 6

Summary of Regression Analyses for Transformed Hero Role-Final Model

Variable	B	SE(B)	Beta	*p*	Explained Variance per Block (R^2/%)
Control Variable					
Participants' Level of Education	243.137	.524	.221	**.0001**	9.5
Family groups compared to Control					
ACOA	73.336	1.781	.052	.699	
Abused	-118.856	2.176	-.014	.608	
ACOA+Abused	-38.158	2.013	-.047	.859	2.0
Personality					
Extraversion	-21.652	8.529	-.158	**.009**	
Conscientiousness	79.850	8.348	.541	**.0001**	26.2
Parenting Styles					
No Significant Variables					1.2
Perception of Parental Reciprocity					
No Significant Variables					0.5
TOTAL R^2					**39.3**

Table 7

Summary of Regression Analyses for Mascot Role-Final Model

Variable	B	SE(B)	Beta	*p*	Explained Variance per Block (R^2/%)
Control Variable					
Participant's Level of Education	-.819	.632	-.075	.196	0.9
Family groups compared to Control					
ACOA	-.102	2.149	-.003	**.**743	
Abused	-.849	2.625	-.024	.390	
ACOA+Abused	-1.341	2.428	-.051	.350	5.9
Personality					
Extraversion	.609	.094	.414	**.0001**	
Openness	.223	.110	.111	**.044**	
Agreeableness	-.281	.108	-.156	**.010**	20.1
Mother Parenting Styles					
Authoritative	.223	.114	.186	.053	5.1
Perception of Parental Reciprocity					
No Significant variables					0.3
TOTAL R^2					**32.2**

Table 8

Summary of Regression Analyses for Scapegoat Role-Final Model

Variable	B	SE(B)	Beta	*p*	Explained Variance per Block (R^2/%)
Control Variable					
Participants' Level of Education	-.754	.710	-.062	.289	2.9
Family groups compared to Control					
ACOA	3.877	.2.414	.117	.110	
Abused	5.770	2.949	.150	.051	
ACOA+Abused	4.394	2.728	.151	.108	5.0
Personality					
Agreeableness	-.792	.122	-.397	**.0001**	
Conscientiousness	-.307	.106	-.176	**.004**	20.4
Parenting Styles					
No significant variables					1.4
Perception of Parental Reciprocity					
No significant variables					0.2
TOTAL R^2					**29.9**

Table 9

Summary of Regression Analyses for Transformed Scapegoat Role-Final Model

Variable	B	SE(B)	Beta	*p*	Explained Variance per Block (R^2/%)
Control Variable					
Participants' Level of Education	-.023	.021	-.063	.286	2.8
Family groups compared to Control					
ACOA	.120	.073	.120	.100	
Abused	.185	.089	.161	.038	
ACOA+Abused	.134	.082	.153	.104	5.1
Personality					
Agreeableness	-.024	.004	-.397	**.0001**	
Conscientiousness	-.009	.003	-.177	**.004**	20.4
Parenting Styles					
No significant variables					1.10
Perception of Parental Reciprocity					
No significant variables					0.10
TOTAL R^2					**29.6**

Table 10

Summary of Regression Analyses for Lost Child Role-Final Model

Variable	B	SE(B)	Beta	*p*	Explained Variance per Block (R^2/%)
Control Variable					
Participant's Level of Education	.645	.562	.055	.252	3.0
Family groups compared to Control					
ACOA	1.067	2.089	.033	.610	
Abused	3.682	2.468	.100	.137	
ACOA+Abused	4.597	2.297	.164	.046	13.9
Personality					
Neuroticism	.845	.178	.624	**.0001**	
Extraversion	-.683	.084	-.437	**.0001**	
Openness	.207	.099	.097	.038	
Agreeableness	1.036	.209	.539	**.0001**	26.8
Parenting Styles					
Mother Authoritative	-.247	.104	-.193	**.018**	
Mother Authoritarian	.380	.081	.294	**.0001**	
Mother Permissive	.412	.125	.213	**.001**	7.3
Perception of Parental Reciprocity					
No Significant Variables					0
Interaction: Group x Neuroticism					
ACOA x N Scale	-.618	.225	-.201	**.006**	
Abused x N Scale	-.673	.246	-.194	**.007**	
ACOA+Abused x N Scale	-.595	.204	-.296	**.004**	0.70
Interaction: Group x Agreeableness					
ACOA x A Scale	-.885	.282	-.210	**.002**	
Abused x A Scale	-.631	.310	-.133	**.043**	
ACOA+Abused x A Scale	-.931	.256	-.312	**.0001**	2.7
TOTAL R^2					**54.3**

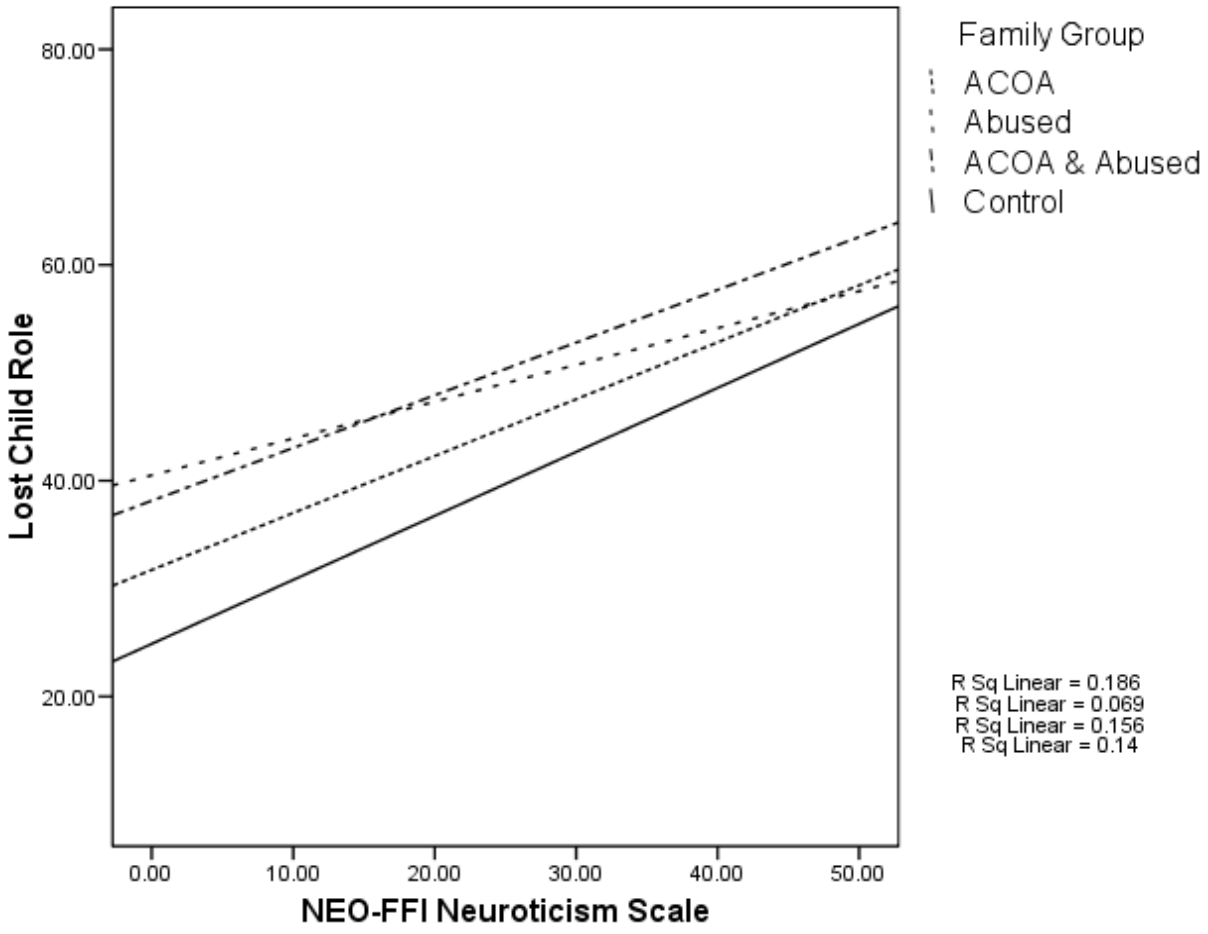

Figure 1: Interaction of the Neuroticism personality trait by Group for the Lost Child family role.

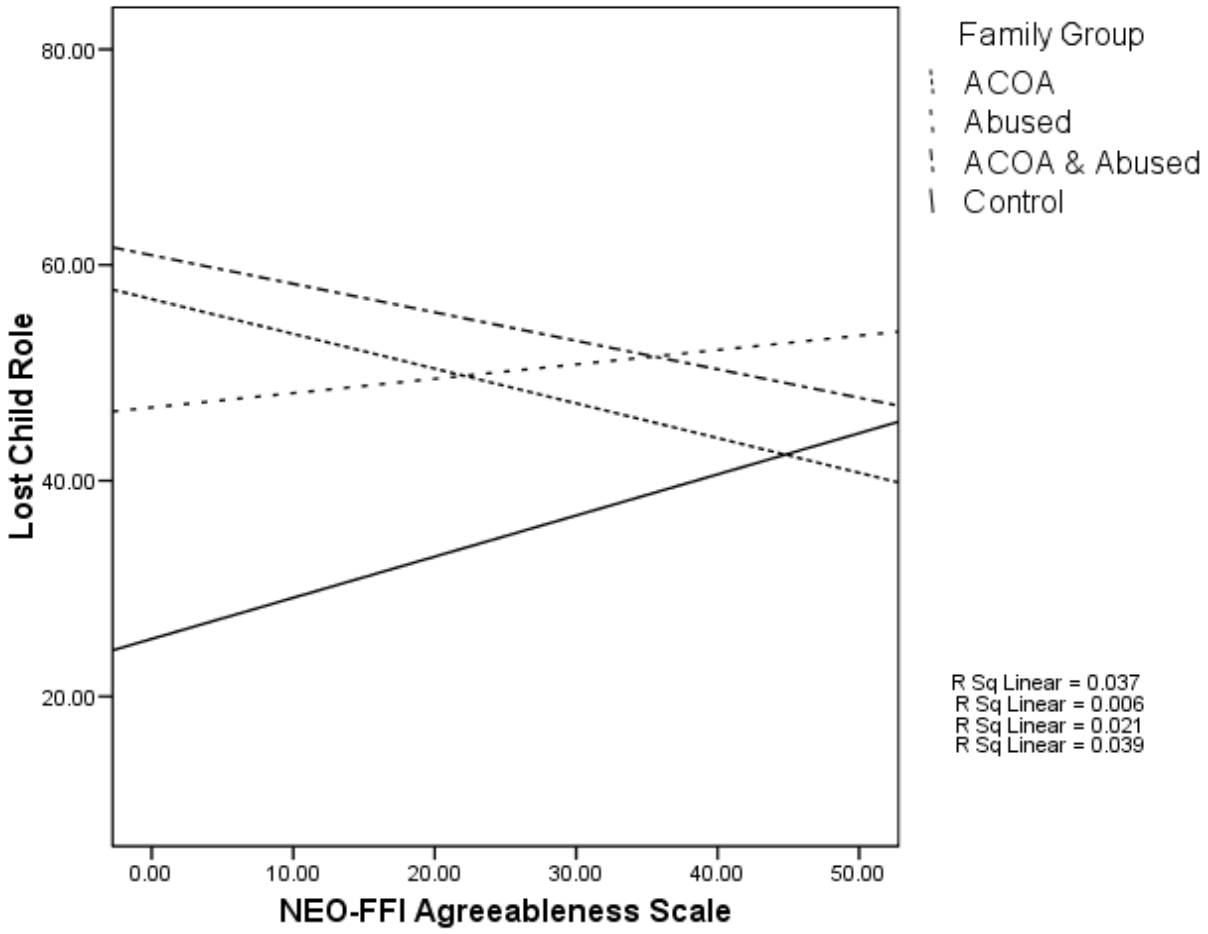

Figure 2: Interaction of the Agreeableness personality trait by Group for the Lost Child family role.

Appendix A: Hypotheses

The predicted relation between the independent variables and familial roles

IV's	HERO	MASCOT	SCAPEGOAT	LOST CHILD
Personality				
Agreeableness	+	-	-	+
Conscientiousness	+	-	-	-
Extraversion	-	+	+	-
Neuroticism	-	-	+	+
Openness	+	+	-	-
Parenting Styles				
Authoritative	+	+	-	-
Authoritarian	-	-	+	+
Permissive	-	+	+	+
Parental Reciprocity				
High Reciprocity	+	+	-	-

Appendix B: Consent Form

PLEASE READ THIS CONSENT FORM BEFORE BEGINNING

Study Name: **An examination of personality and parenting behaviours in relation to the Adult Child of Alcoholism adaptive familial roles**

Researchers: Navneet K. Dhami & Shawn Gates
Graduate Student, Psychology, York University
Email address: ndhami@yorku.ca, PH: 416-736-5115 (voice message may be left for researchers).

Purpose of the Research: This questionnaire is part of a study conducted by Ph.D. graduate students Navneet K. Dhami and Shawn Gates and at York University under the supervision of Dr. Maxine G. Wintre. The study examines personality and early relations with parents and the adaptive familial role they adopt in varying groups of participants (Adult Children of Alcoholics, Adult Survivors of Abuse, Adult Children of Alcoholics who were also abused, and individuals who have neither of these experiences). Participation is voluntary. However, we think that you will find the questionnaire interesting. The results of this study will be presented at international conferences and published in peer-reviewed journals.

What You will be Asked to Do in the Research: Should you choose to participate, you will be asked to complete a questionnaire, comprised of (5) measures. This questionnaire should take approximately one hour of your time to complete. In answering the questionnaires, you should not ponder too much over any question, but should pay attention to changes between rating scales for different questions. There are no right or wrong answers, we just want to know your real feelings. The questionnaire is available online at www.addresstobedetermined.com.

Risks and Discomforts: We do not foresee any risks or discomfort from your participation in the research; there are no risks involved greater than what one would expect in their normal day to day lives.

Benefits of the Research and Benefits to You: This study will help us understand what variables, including parenting measures and personality, are related to the adoption of particular familial roles in clinical and non-clinical groups. To thank you for your assistance in this project, participants who complete all questionnaires properly will be given the option to be entered into a lottery for two prizes of $50.00 each. Note: at the completion of the research, and once the data have been analyzed, you may obtain a summary of the research findings by contacting either of the primary researchers (Navneet Dhami [ndhami@yorku.ca], or Shawn Gates [sgates@yorku.ca], or by phone at 416-736-5115 [voice messages for both researchers]).

Voluntary Participation: Your participation in the study is completely voluntary and you may choose to stop participating at any time. Your decision not to volunteer will not influence the nature of your relationship with York University either now, or in the future.

Withdrawal from the Study: You can stop participating in the study at any time, for any reason, if you so decide (at which time any data you have provided will be removed from the data set, and questionnaires will be destroyed); or b) should you wish to participate, have the right not to answer any question(s) on the questionnaires that you wish not to. If you decide to stop participating you will still be eligible to be entered into the lottery for two prizes of $50.00. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researchers, York University, or any other group associated with this

project. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible.

Confidentiality: Rest assured that completed questionnaires will be treated with the strictest confidence. No one other than the primary researchers will have any access to this information, questionnaires will be completed on a secure website, completed data will be placed on a password protected disk and stored in a locked cabinet accessible only by the primary researchers, participant names will be replaced with ID numbers, and no individual participant will be described or identified in any reports. Hard copies of any consent forms and questionnaires will be retained for a minimum of two years following the completion of the project, in accordance with York University's ethics policies. At the time the completed hard copy questionnaires are disposed of, they will be shredded, and placed in locked disposal bins, following which they will be recycled. Confidentiality will be provided to the fullest extent possible by law.

Questions About the Research? If you have any general questions, ethical concerns, or questions about your role in this research study, please feel free to contact: a) either principal investigator Navneet Dhami/Shawn Gates, Graduate Student, Ph.D. program in Clinical-Developmental Psychology, Room 205 BSB, York University, 4700 Keele St., Toronto, Ontario, M3J-1P3, 416-736-5115 (voice messages), e-mail: ndhami@yorku.ca or sgates@yorku.ca; or b) my Graduate supervisor - Dr. Maxine Wintre either by email (mwintre@yorku.ca), or by phone at (416) 736-5115, ext. 66144; or c) the Psychology Graduate Program Office, Room 296 BSB, York University, 416-736-2100, ext. 55297; This research has been reviewed and approved by the Human Participants Review Subcommittee (HRPC) of York University and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures: In choosing the "Yes" option (online version), or by signing this consent form (paper version) you are indicating that you have read the form and agree to participate in the study described. I (fill in your name here _____), consent to participate in the examination of personality and parenting behaviours in relation to the Adult Child of Alcoholism adaptive familial roles study conducted by Navneet K. Dhami. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent. On the second line below my signature indicates that I would like to be entered into the draw for a prize of $50.00

Signature _____ **Date** _____
Participant

Signature _____ **Date** _____
Enter me into the draw for a prize of $50.00

Signature _____ **Date** _____
Principal Investigator

Again, we **THANK YOU** for your participation.

Appendix C: Demographics Form

Please complete the following questions:

1. What is your gender? M_____ F_____

2. What is your age? _____ years

3. Marital Status:

Single_____ Married_____ Common Law_____
Separated/Divorced_____ Widow/Widower_____
If Married/Common Law, how long? _____
Is this your first marriage?_____
If Separated/Divorced, how long?_____
If Widowed, how long? _____

4. Are your parents:

Living together_____ Separated/Divorced_____ Mother a Widow_____
Father a widow_____ Both deceased_____

5. Do you have children? Y_____ N_____

If yes, how many and what are their gender and age? Please list them:
_____

6. Was YOUR father born in Canada?
____ Yes
____ No
If no, in what country was he born? _____

7. Was YOUR mother born in Canada?
____ Yes
____ No
If no, in what country was she born? _____

8. Were YOU born in Canada?
_____ Yes
_____ No
If no, in what country were you born?

9. Which ethnic group would you consider yourself to be a member of?
White_____
Black_____
Chinese_____
South Asian (e.g., East Indian, Pakistani, Sri Lankan) _____
South East Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese)_____
West Asian (e.g., Afghan, Iranian)_____
Arab_____
Filipino_____
Latin American_____
Japanese_____
Korean_____

Other _____ (Specify)_____

10. Is English your first language? Y_____ N_____

11. What is the highest level of education that YOUR father received?
    a) Elementary school or less
    b) Some high school
    c) Completed high school
    d) Completed community college
    e) Completed Bachelor's degree
    f) Completed MA or PhD
    g) Completed Professional Degree (Doctor, Lawyer, Engineer, etc.)

12. What is the highest level of education that YOUR mother received?
    a) Elementary school or less
    b) Some high school
    c) Completed high school
    d) Completed community college
    e) Completed Bachelor's degree
    f) Completed MA or PhD
    g) Completed Professional Degree (Doctor, Lawyer, Engineer, etc.)

13. What is the highest level of education that YOU received?
    a) Elementary school or less
    b) Some high school
    c) Completed high school
    d) Completed community college
    e) Completed Bachelor's degree
    f) Completed MA or PhD
    g) Completed Professional Degree (Doctor, Lawyer, Engineer, etc.)

14. Personal Income (in thousands): 20-40____ 40-60____ 61-80____ 80-100____ 100+____

15. Family Income (in thousands): 20-40____ 40-60____ 61-80____ 80-100____ 100+____

16. Did/or does your MOTHER have a history of diagnosed mental illness?
    _____ Yes
    _____ No
    _____ Don't know
    If yes, please specify the mental illness: _____
    How old were you when this started? _____
    Is it ongoing? _____

17. Did/or does your FATHER have a history of diagnosed mental illness?
    _____ Yes
    _____ No
    _____ Don't know

If yes, please specify the mental illness: _____
How old were you when this started? _____
Is it ongoing? _____

18. Have/or do YOU have a history of diagnosed mental illness?
_____ Yes
_____ No
_____ Don't know
If yes, please specify the mental illness: _____
How old were you when this started? _____
Is it ongoing? _____

19. In the time you were living at home with your family (up to the age of 18 years), did you experience any of the following events?:

a) Living with an alcoholic parent Y_____ N_____
If yes, which parent? Mother _____ Father_____ Both_____
How old were you when your parent(s):
Started Drinking_____
Stopped Drinking _____ How did they stop?_____
They always drank and did not stop _____
Have you ever received treatment with regards to this experience?
Y _____ N _____
If Yes, what type of treatment? _____ At what age? _____
For how long? _____ Is treatment ongoing? Y___ N___

b) Experience physical abuse Y _____ N _____

If yes, by whom? Mother _____ Father_____
Both Parents_____
Another Family Member _____ Who?_____
Someone Outside the Family _____ Who? _____
How old were you when the abuse:
Started _____
Stopped _____
Was the abuse ever reported to authorities (e.g., Police, Childrens' Aid)?
Yes_____
No_____
Have you ever received professional treatment with regards to this experience?
Y _____ N _____
If Yes, what type of treatment? _____ At what age? _____
For how long? _____ Is treatment ongoing? Y___ N___

c) Experience sexual abuse Y _____ N _____
If yes, by whom? Mother _____ Father_____

Both Parents_____
Another Family Member _____ Who?_____
Someone Outside the Family _____ Who? _____

How old were you when the abuse:

Started _____

Stopped _____

Was the abuse ever reported to authorities (e.g., Police, Children's Aid)?

Yes_____

No_____

Have you ever received professional treatment with regards to this experience?

Y _____ N _____

If Yes, what type of treatment? _____ At what age? _____

For how long? _____ Is treatment ongoing? Y___ N___

d) I did not experience any of these events _____

Appendix D: Children's Role Inventory (CRI)

Directions: The following words or phrases describe behaviours or characteristics of children. Circle the number that best fits how each word or phrase describes how you were or how you acted in the family in which you were raised.

0 = Strongly Disagree/Very Unlike Me
1 = Disagree/Unlike Me
2 = Undecided
3 = Agree/Like Me
4 = Strongly Agree/Very Like Me

When I was a child, I…

1	was an achiever	0	1	2	3	4
2	was aggravating	0	1	2	3	4
3	was aggressive	0	1	2	3	4
4	was animated	0	1	2	3	4
5	was annoying	0	1	2	3	4
6	was belligerent	0	1	2	3	4
7	was capable	0	1	2	3	4
8	was the center of attention	0	1	2	3	4
9	was charming	0	1	2	3	4
10	was cheerful	0	1	2	3	4
11	was comical	0	1	2	3	4
12	was deceitful	0	1	2	3	4
13	was defiant	0	1	2	3	4
14	was delinquent	0	1	2	3	4
15	was dependable	0	1	2	3	4
16	was depressed	0	1	2	3	4
17	was disobedient	0	1	2	3	4
18	was disruptive	0	1	2	3	4
19	was dutiful	0	1	2	3	4
20	was entertaining	0	1	2	3	4
21	was excitable	0	1	2	3	4
22	was friendly	0	1	2	3	4
23	was funny	0	1	2	3	4

24	was helpful	0	1	2	3	4
25	was hostile	0	1	2	3	4
26	was humorous	0	1	2	3	4
27	was hyperactive	0	1	2	3	4
28	was ill-mannered	0	1	2	3	4
29	was introverted	0	1	2	3	4
30	was irritating	0	1	2	3	4
31	was level-headed	0	1	2	3	4
32	was lonely	0	1	2	3	4
33	was a loner	0	1	2	3	4
34	was mature	0	1	2	3	4
35	misbehaved	0	1	2	3	4
36	was orderly	0	1	2	3	4
37	was organized	0	1	2	3	4
38	was outgoing	0	1	2	3	4
39	was passive	0	1	2	3	4
40	performed well	0	1	2	3	4
41	played alone	0	1	2	3	4
42	was playful	0	1	2	3	4
43	was quiet	0	1	2	3	4
44	was rebellious	0	1	2	3	4
45	was reserved	0	1	2	3	4
46	was sensible	0	1	2	3	4
47	was shy	0	1	2	3	4
48	was social	0	1	2	3	4
49	was solemn	0	1	2	3	4
50	was solitary	0	1	2	3	4
51	was submissive	0	1	2	3	4
52	was super-responsible	0	1	2	3	4
53	was successful	0	1	2	3	4

54	was timid	0	1	2	3	4
55	was thorough	0	1	2	3	4
56	was a trouble maker	0	1	2	3	4
57	was trustworthy	0	1	2	3	4
58	was unsocial	0	1	2	3	4
59	was withdrawn	0	1	2	3	4
60	was witty	0	1	2	3	4

Appendix E: Parental Authority Questionnaire (PAQ)

For each of the following statements choose the number on the 5-point scale that best describes how that statement applies to YOU AND YOUR PARENT. Try to read and think about each statement as it applies to you and your parent during the years growing up at home. We are looking for your overall impression regarding each statement. Don't spend a lot of time on any one item and be sure not to omit any items.

FEELINGS ABOUT YOUR MOTHER

Strongly Disagree	**Disagree**	**Agree Slightly**	**Agree**	**Strongly Agree**
1	**2**	**3**	**4**	**5**

____ While I was growing up, my mother felt that in a well run home the children should have their way in the family as often as parents do.

____ Even if her children didn't agree with her, my mother felt that it was for our own good if we were forced to conform to what she thought was right.

____ Whenever my mother told me to do something as I was growing up, she expected me to do it immediately without asking any questions.

____ As I was growing up, once family policy had been established, my mother discussed the reasoning behind the policy with the children in the family.

____ My mother always encouraged verbal give-and-take whenever I felt that family rules and restrictions were unreasonable.

____ My mother always felt that what children need is to be free to make up their own minds and to do what they want to do, even if this does not agree with what their parents want.

____ As I was growing up my mother did not allow me to question any decision she had made.

____ As I was growing up my mother directed the activities and decisions of the children in the family through reasoning and discipline.

____ My mother has always felt that more force should be used by parents in order to get their children to behave the way they are supposed to.

____ As I was growing up my mother did <u>not</u> feel that I needed to obey rules and regulations of behavior simply because someone in authority had established them.

____ As I was growing up I knew what my mother expected of me in my family, but I also felt free to discuss those expectations with her when I felt they were unreasonable.

____ My mother felt that wise parents should teach their children early just who is boss in the family.

Strongly Disagree	Disagree	Agree Slightly	Agree	Strongly Agree
1	2	3	4	5

____ As I was growing up, my mother seldom gave me expectations and guidelines for my behavior.

____ Most of the time as I was growing up, my mother did what the children in the family wanted when making family decisions.

____ As the children in our family were growing up, my mother consistently gave us direction and guidance in rational and objective ways.

____ As I was growing up, my mother would get very upset if I tried to disagree with her.

____ My mother feels that most problems in society would be solved if parents would <u>not</u> restrict their children's activities, decisions, and desires as they are growing up.

____ As I was growing up my mother let me know what behavior she expected of me, and if I didn't meet those expectations, she punished me.

____ As I was growing up my mother allowed me to decide most things for myself without a lot of direction from her.

____ As I was growing up, my mother took the children's opinions into consideration when making family decisions, but she would not decide on something simply because the children wanted it.

____ My mother did not view herself as responsible for directing and guiding my behavior as I was growing up.

____ My mother had clear standards of behavior for the children in our home as I was growing up, but she was willing to adjust those standards to the needs of each of the individual children in the family.

____ My mother gave me direction for my behavior and activities as I was growing up and she expected me to follow her direction, but she was always willing to listen to my concerns and to discuss that direction with me.

____ As I was growing up, my mother allowed me to form my own point of view on family matters and she generally allowed me to decide for myself what I was going to do.

____ My mother often felt that most problems in society would be solved if we could get parents to strictly and forcibly deal with their children when they don't do what they are supposed to as they are growing up.

____ As I was growing up, my mother often told me exactly what she wanted me to do and how she expected me to do it.

Strongly Disagree	Disagree	Agree Slightly	Agree	Strongly Agree
1	2	3	4	5

____ As I was growing up my mother gave me clear directions for my behaviors and activities, but she was also understanding when I disagreed with her.

____ As I was growing up, my mother did not direct the behaviors, activities, and desires of the children in the family.

____ As I was growing up I knew what was expected of me in the family and she insisted that I conform to those expectations simply out of respect for her authority.

____ As I was growing up, if my mother made a decision in the family that hurt me, she was willing to discuss that decision with me and to admit it if she had made a mistake.

FEELINGS ABOUT YOUR FATHER

Strongly Disagree	Disagree	Agree Slightly	Agree	Strongly Agree
1	2	3	4	5

____ While I was growing up, my father felt that in a well run home the children should have their way in the family as often as parents do.

____ Even if his children didn't agree with him, my father felt that it was for our own good if we were forced to conform to what he thought was right.

____ Whenever my father told me to do something as I was growing up, he expected me to do it immediately without asking any questions.

____ As I was growing up, once family policy had been established, my father discussed the reasoning behind the policy with the children in the family.

____ My father always encouraged verbal give-and-take whenever I felt that family rules and restrictions were unreasonable.

____ My father always felt that what children need is to be free to make up their own minds and to do what they want to do, even if this does not agree with what their parents want.

____ As I was growing up my father did not allow me to question any decision he had made.

____ As I was growing up my father directed the activities and decisions of the children in the family through reasoning and discipline.

____ My father has always felt that more force should be used by parents in order to get their children to behave the way they are supposed to.

____ As I was growing up, my father did not feel that I needed to obey rules and regulations of behavior simply because someone in authority had established them.

Strongly Disagree Disagree Agree Slightly Agree Strongly Agree

1 2 3 4 5

____ As I was growing up, I knew what my father expected of me in my family, but I also felt free to discuss those expectations with him when I felt they were unreasonable.

____ My father felt that wise parents should teach their children early just who is boss in the family.

____ As I was growing up, my father seldom gave me expectations and guidelines for my behavior.

____ Most of the time as I was growing up, my father did what the children in the family wanted when making family decisions.

____ As the children in our family were growing up, my father consistently gave us direction and guidance in rational and objective ways.

____ As I was growing up, my father would get very upset if I tried to disagree with him.

____ My father feels that most problems in society would be solved if parents would not restrict their children's activities, decisions, and desires as they are growing up.

____ As I was growing up my father let me know what behavior he expected of me, and if I didn't meet those expectations, he punished me.

____ As I was growing up my father allowed me to decide most things for myself without a lot of direction from him.

____ As I was growing up, my father took the children's opinions into consideration when making family decisions, but he would not decide on something simply because the children wanted it.

____ My father did not view himself as responsible for directing and guiding my behavior as I was growing up.

____ My father had clear standards of behavior for the children in our home as I was growing up, but he was willing to adjust those standards to the needs of each of the individual children in the family.

____ My father gave me direction for my behavior and activities as I was growing up and he expected me to follow his direction, but he was always willing to listen to my concerns and to discuss that direction with me.

____ As I was growing up, my father allowed me to form my own point of view on family matters and he generally allowed me to decide for myself what I was going to do.

____ My father often felt that most problems in society would be solved if we could get parents to strictly and forcibly deal with their children when they don't do what they are supposed to as they are growing up.

Strongly Disagree	**Disagree**	**Agree Slightly**	**Agree**	**Strongly Agree**
1	**2**	**3**	**4**	**5**

____ As I was growing up, my father often told me exactly what he wanted me to do and how he expected me to do it.

____ As I was growing up my father gave me clear directions for my behaviors and activities, but he was also understanding when I disagreed with him.

____ As I was growing up, my father did not direct the behaviors, activities, and desires of the children in the family.

____ As I was growing up, I knew what was expected of me in the family and he insisted that I conform to those expectations simply out of respect for his authority.

____ As I was growing up, if my father made a decision in the family that hurt me, he was willing to discuss that decision with me and to admit it if he had made a mistake.

Appendix F: Perception of Parental Reciprocity Scale (POPRS)

As you answer the following questions, please note the rating scale and indicate the extent to which you agree or disagree with each statement.

Strongly Agree Agree Slightly Agree Slightly Disagree Disagree Strongly Disagree

1 2 3 4 5 6

_____ 1. My **mother** lets me conduct my life as I please.

_____ 2. I often feel that my **mother** is talking "at" me and not with me.

_____ 3. My **mother** and I can enjoy each other's company and participate in shared activities.

_____ 4. I feel that my **mother** is approachable to discuss problems within our family.

_____ 5. My **mother** is comfortable expressing her doubts and fears with me.

_____ 6. Mutual respect is a term I can use to describe my relationship with my **mother**.

_____ 7. I am able to be myself with my **mother**.

_____ 8. I am usually very cautious about what I say to my **mother**.

_____ 9. When I try to share my concerns with my **mother**, her response usually makes me sorry I began the conversation.

_____ 10. I can communicate as well with my **mother** as I can with my friends.

My **mother** and I can meaningfully discuss the following issues:

_____ 11. Politics

_____ 12. My relationship with a spouse/significant other

_____ 13. Career decisions

_____ 14. Religion

_____ 15. Sexual relations

_____ 16. Educational decisions

_____ 17. Personal views on the role of the man and woman in the home

Please score the extent to which you agree or disagree with each statement.

Strongly Agree Agree Slightly Agree Slightly Disagree Disagree Strongly Disagree
1 2 3 4 5 6

_____ 1. My **father** lets me conduct my life as I please.

_____ 2. I often feel that my **father** is talking "at" me and not with me.

_____ 3. My **father** and I can enjoy each other's company and participate in shared activities.

_____ 4. I feel that my **father** is approachable to discuss problems within our family.

_____ 5. My **father** is comfortable expressing his doubts and fears with me.

_____ 6. Mutual respect is a term I can use to describe my relationship with my **father**.

_____ 7. I am able to be myself with my **father**.

_____ 8. I am usually very cautious about what I say to my **father**.

_____ 9. When I try to share my concerns with my **father**, his response usually makes me sorry I began the conversation.

_____ 10. I can communicate as well with my **father** as I can with my friends.

My **father** and I can meaningfully discuss the following issues:

_____ 11. Politics

_____ 12. My relationship with a spouse/significant other

_____ 13. Career decisions

_____ 14. Religion

_____ 15. Sexual relations

_____ 16. Educational decisions

_____ 17. Personal views on the role of the man and woman in the home

Appendix G: Summary of Regression Results

Summary of regression results between the independent variables and familial roles

IV's	HERO	MASCOT	SCAPEGOAT	LOST CHILD
Personality				
Agreeableness	ns	-	-	+
Conscientiousness	+	ns	-	ns
Extraversion	-	+	ns	-
Neuroticism	ns	ns	ns	+
Openness	ns	ns	ns	+
Parenting Styles				
Authoritative	ns	ns	ns	-
Authoritarian	ns	ns	ns	+
Permissive	ns	ns	ns	+
Parental Reciprocity				
High Reciprocity	ns	ns	ns	ns

Note: "ns" means not significant.