THE RELATIONSHIP BETWEEN PERCEIVED FAMILY OF ORIGIN MENTAL HEALTH AND DEPRESSION IN ADOLESCENTS IN RESIDENTIAL TREATMENT

JANET KNICKERBOCKER GILL

To the Graduate Council:

I am submitting herewith a thesis written by Janet Knickerbocker Gill entitled "The Relationship Between Perceived Family of Origin Mental Health and Depression in Adolescents in Residential Treatment." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Guidance and Counseling.

Dr. Stuart Bonnington, Major Professor

We have read this thesis and recommend its acceptance:

Accepted for the Council:

Dean of the Graduate School

STATEMENT OF PERMISSION TO USE

In presenting this thesis in partial fulfillment of the requirements for a Master's degree at Austin Peay State University, I agree that the Library shall make it available to borrowers under rules of the Library. Brief quotations from this thesis are allowable without special permission, provided that accurate acknowledgment of the source is made.

Permission for extensive quotation from or reproduction of this thesis may be granted by my major professor, or in his absence, by the Head of Interlibrary Services when, in the opinion of either, the proposed use of the material is for scholarly purposes. Any copying or use of the material in this thesis for financial gain shall not be allowed without my written permission.

Signature Janet K. Hill

Date 5-27-94

THE RELATIONSHIP BETWEEN PERCEIVED FAMILY OF ORIGIN MENTAL HEALTH AND DEPRESSION IN ADOLESCENTS IN RESIDENTIAL TREATMENT

A Thesis

Presented to the

Graduate and Research Council of

Austin Peay State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

by

Janet Knickerbocker Gill

August 1994

DEDICATION

This thesis is dedicated to my husband

Robert Todd Gill

and to my children

Kathryn Elizabeth Gill and

Rachel Ann Gill

who have provided me continuing support during this project.

ACKNOWLEDGMENTS

The author wishes to express sincere appreciation to Dr. Stuart B. Bonnington, Chair & Associate Professor of Psychology, Austin Peay State University, for his aid, guidance, and time given during the study.

Appreciation is extended to Dr. Garland Blair and Dr. Samuel Fung for their assistance and support in making this study possible. The residents of the Action for Youth/Harriet Cohn adolescent group facilities who participated in the study are greatly appreciated for their valuable time in making this study a reality.

Special thanks for the permission granted from Dr. Aaron T. Beck of the Center for Cognitive Therapy of the University of Pennsylvania to use and reproduce the Beck Depression Inventory.

ABSTRACT

This study was an investigation of the relationship between perceptions of family of origin mental health and depression in adolescents in residential treatment. The basis of the study involved administering the Beck Depression Inventory and the Family of Origin Scale to adolescents living in residential state custody. Data were then analyzed using the Pearson product-moment correlation technique. The study did not reveal a significant linear relationship between perceived family of origin mental health and depression. It was noted that this does not preclude the possibility of a relationship but rather may reflect certain attributes of the population. Another measure of depression, specific age reference points, and other family assessment measures were suggested for future studies.

TABLE OF CONTENTS

CHAPTER 1

Review of Literature

Perception of family of origin mental health is an understudied dimension of adolescent-parent relations. Adolescents are confronted with a range of novel situations and interpersonal events that may be facilitated by actual and perceived family of origin mental health. Although this perception of family mental health is not synonymous with actual mental health, this perception may be an important dimension related to depression. The effective prevention and treatment of adolescent depression requires the identification of those factors that are important in it's etiology. This study is an attempt to verify the correlation of one of these factors, adolescent perceptions of the family of origin mental health, with depression.

Regarding adolescent perceptions of the family of origin (the family with which one spent most of their childhood years), it is important to note that the perception may not in fact be valid. The adolescent's view may be configured in a way that is not a true reflection of reality. However the belief about the state of the family may according to the person be a reality of belief and thus the perception takes on a certain level of validity for them.

According to the Diagnostic and Statistical Manual of Mental Disorders (Third Edition-Revised), depression is characterized by depressed mood, irritable mood, loss of interest and pleasure in almost all activities, sleep and appetite disturbances, decreased energy level/fatigue, feelings of inadequacy, excessive or irrational guilt, and difficulty in memory and general thought processes. There may be suicidal ideations with or without a plan accompanying the above symptoms.

Research has consistently found substantial and significant positive correlations between self-reported depression and a composite of internal, stable, and global attributions for negative events (Kaslow, Rehm, & Siegel, 1984; Nolen-Hoeksema, Seligman, & Girgus, 1986). Failure to attribute positive events to internal, stable, and global causes may be related to differences in the frequency of anhedonia or the ability to take pleasure in positive events. This is a more likely characteristic of adolescent depression than childhood depression (Ryan, et al., 1987). However, in these studies, attributional style accounted for a limited proportion of the variance in depressive severity. This indicates the importance of assessing other dimensions of cognitive functioning in adolescent depression.

Rehm (1977) described depression as a dysfunction in self-monitoring, self-evaluation, or self-reinforcement.

The understanding of the effect of these dimensions of cognitive functioning on depression is important in the understanding of depression.

Brubeck and Beer (1992) found that high school students who scored high on the Coopersmith Self-esteem Inventory scored low on the Beck Depression Inventory (BDI). This suggests the conjecture that self-esteem and depression are negatively correlated. Ehrenberg, Cox, and Koopman (1991) also found that self-efficacy was negatively correlated with adolescent depression.

In a study by Robertson and Simons (1989), perceived parental rejection was the only family factor associated with depressive symptoms once controls were introduced. This study found that perceived parental rejection showed both a direct effect and an indirect effect through self-esteem. Self-esteem displayed a strong concurrent association with depression but did not predict subsequent levels of depression once initial levels of depression were controlled. The authors contended that perceptions of self-worth tend to be variable over time for some people, with dramatic reductions in self-esteem causing depressive symptoms. They also suggested that a self-blaming attributional style develops in response to a perceived family environment of excessive parental criticism, shaming, belittling, and the like. Thus, the authors developed a model which posits that perceived parental

rejection is a potent cause of depressive symptoms among young people.

Research has demonstrated relationships between adolescents' self-esteem and their perceptions of their parents' supporting and controlling behavior (Barber & Thomas, 1986; Felson & Zielinski, 1989; Gecas & Schwalbe, 1986). Parental supportive behavior has been found to be positively related to self-esteem, and negative controlling behaviors were found to be negatively related to self-esteem. Also, several research studies have indicated that strong emotional ties by adolescents with the family are associated with higher levels of self-esteem and self-efficacy (Burke & Weir, 1979; Hoelter & Harper, 1987).

Demo, Small, and Savin-Williams (1987) suggested that adolescents and their parents have similar but distinct perceptions of their relationships. They also suggested that self-perceptions of these relationships are important in predicting levels of self-esteem for both adolescents and their parents. They found that, in general, the reports of adolescents on family relations were more congruent with the reports of mothers than of fathers. This may reflect the central role of the mother in interpersonal family relations. Furthermore, their findings suggest that the self-esteem of boys, compared to that of girls, is more strongly related to family relations.

Gecas and Schwalbe (1986) found that adolescent self-esteem is more strongly related to adolescents' perceptions of parental behavior (i.e., control, support, and participation) than it is to parental reports of their behavior. In fact, they found that parents' reports of their behavior had very little effect on their children's self-esteem. Barber and Thomas (1986) found that four dimensions of parental support (i.e., general support, physical affection, companionship, and sustained contact) are positively correlated with self-esteem worth. Kaplan (1976) and Rosenberg (1965) found that children with low self-esteem are likely to be defensive and depressed.

A study by Windle and Miller-Tutzauer (1992) supports a three-factor structure of the Perceived Social Support-Family measure (Procidano & Heller, 1983) for adolescent boys and girls. The three factors, labeled Support Received, Support Provided, and Family Intimacy, had moderate to high levels of internal consistency and test-retest stability. The three family support factors also correlated significantly with adolescent reports of depressive symptoms. Results of this study showed significant inverse correlations between perceived family mental health and adolescent problem behaviors. Lower levels of perceived family mental health were associated with higher levels of depressive symptoms.

It was expected that depressed adolescents perceived their families' mental health differently than adolescents who were not depressed. This study hypothesized that adolescents who score high on the BDI would score low on the FOS. Thus, a significant negative correlation, between scores on the two scales, was expected.

CHAPTER 2

Methodology

Subjects

Thirty-six adolescents, twelve females and twenty-four males, presently living in residential state custody served as voluntary subjects. The age range was from twelve to seventeen. These subjects live in a group home under Action for Youth care. This is a "step-down" program for adolescents who have been in more restrictive facilities due to various behavioral disorders. This is a Harriet Cohn Mental Health Care Facility affiliate.

Materials

To determine the relationship between perceptions of family of origin mental health and depression, two scales were used. These two scales were the Family-of-Origin Scale, or FOS (Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985) and the Beck Depression Inventory, or BDI (Burns, 1980). The BDI is found in Appendix C and the FOS for adolescents is found in Appendix D.

Items for the BDI were derived from both clinical and research sources. They tap current affective, cognitive, motivational, and physiological symptoms of depression.

The FOS is a 40 item, self-report instrument, devised to measure perceptions of mental health in the family of origin. The FOS focused on the interrelated concepts of

autonomy and intimacy. The scale items were developed based on 10 constructs of family mental health. In the FOS conceptualization, intimacy in the family of origin is developed by encouraging the expression of feelings, creating a warm atmosphere in the home, dealing with conflicts without undue stress, encouraging sensitivity in family members and trusting in the goodness of human nature. In this paradigm, the healthy family develops autonomy by emphasizing clarity of expression, personal responsibility, respect for other family members and openness to others in the family and by dealing openly with separation and loss. The FOS does not purport to measure the "reality" of the situation but is a measure of the person's subjective evaluation of mental health in the family of origin.

The FOS for adolescents is a modified version of the FOS developed by Hovestadt et al. (1985). This modification consists of changing the scale from past to present tense. Manley, Searight, Binder, & Russo (1990) established that the adolescent version of the FOS exhibits construct validity. Furthermore, Manley, Searight, Skitka, Russo, and Schudy (1991) reported high test-retest reliability and internal consistency reliability for the adolescent version of this instrument.

Kauth and Zettle (1990) reported on four measures of depression that were administered to adolescents. They

found only two of these measures were able to discriminate among the three adolescent populations in the study (i.e., a normative sample, a nondepressed psychiatric group, and a depressed psychiatric group). One of these measures was the BDI, a widely used measure of depression.

The BDI uses a rating Likert scale of 0 to 3. The higher the score the more severe the depression. The range of scores is from 1 to 63.

The FOS consists of 40 items on a 5-point Likert scale. The most healthy response, for each item, is a score of 5. On this scale an overall high score indicates a healthy perception of the family environment. The least healthy response, for each item, is a score of 1. The range of scores is 40 to 200. The score is a sum of the ratings on the 40 items and is a relative ranking.

The Pearson r was used to analyze the data.

Procedure

Subjects were given a consent form to read and sign (Appendix A). One classroom in each of three Harriet Cohn residential homes was used to administer the scales in a group setting. Unlimited time was given to finish the two measures. The results were anonymously collected.

CHAPTER 3

Results

A Pearson product-moment correlation failed to reveal a significant negative correlation between perceived family of origin mental health and depression in adolescents in residential treatment (r = .065, p > .05). The means and standard deviations for this study are summarized in Table 1.

The mean on the FOS was 119.08 and the standard deviation was 19.18. These can be compared to adults seeking psychotherapy who were administered the FOS with M = 114.55 and SD = 29.80 (Lee, Gordon, & O'Dell, 1989).

The mean on the BDI was 12.29 and the standard deviation was 10.60. These can be compared to a heterogeneous group of high school boys and girls who were administered the BDI with M = 10.87, SD = 11.38 (Brubeck & Beer, 1992).

Table 1

Means and Standard Deviations

	n	Mean	Standard Deviation
Beck Depression Inventory	36	12.29	10.60
Family of Origin Scale	36	119.08	19.18

r = .065
p > .05

CHAPTER 4

Discussion

The present data did not establish a negative correlation between perceptions of family of origin mental health and depression in adolescents in residential treatment. A portion of the low BDI and FOS scores could be accounted for by the unstable nature of depression in adolescents. Specifically, scoring low on the BDI or on the FOS on a given day does not necessitate scoring low on another date.

It is plausible that because the population utilized in this study was largely comprised of behaviorally "acting-out" adolescents, there would be a lesser likelihood of higher scores on depression. The rationale being that the negative behaviors expressed by the adolescents absorbed most if not all of the negative energy which would otherwise demonstrate itself in the form of depression. Another measure of depression, more specifically designed for adolescents than the BDI, could perhaps have assessed the adolescent's depression more accurately.

The results of this study obviously reflect the perceptions of adolescents. It should be noted that had the subjects been young children, the results of the FOS may have been significantly different. Beavers, Hampson &

Hyman (1994) have shown that individuals recall and rate their families as more positive about all areas of family competence when they are young children. Individuals are less positive about family competence when they rate their family as recalled during their adolescent years. The results of this same study indicated that specifying the age of recall made a significant difference in how individuals rated his/her family.

Suggestions for improving a study correlating depression in adolescents and their perceptions of family of origin mental health include specifying the age and time period which is to be recalled when the FOS measure is used. Beavers, Hampson & Hyman (1994) have suggested that specific age reference points be used by individuals rating their families using the FOS, although this idea has not yet been utilized.

Schouten (1994) has questioned the overall utility of the FOS, given the scale's lack of specificity regarding family subsystems and doubtful relevance to clinical research and practice. The FOS should perhaps be used in conjunction with other family assessment measures in family research. Used as one part of a battery of family assessment measures, including self-report ratings from other family members, the FOS could be useful in determining overall family functioning. The aforementioned suggestions together with a more accurate measure of

suggestions together with a more accurate measure of adolescent depression than the BDI could have resulted in establishing a clearer relationship between perceptions of family of origin mental health and depression in adolescents in residential treatment.

Admittedly, there are shortcomings in a study of this size. While the statistical results did not establish a negative correlation between perceptions of family of origin mental health and depression in adolescents in residential treatment, there could indeed be a relationship. A larger population with a smaller age range could be helpful in showing a negative correlation between depressed adolescents and their perceptions of family of origin health.

REFERENCES

REFERENCES

American Psychiatric Association. (1987). Diagnostic and Statistical Manual of Mental Disorders, Third edition, revised. Washington, DC: American Psychiatric Association.

Barber, B. & Thomas, D. (1986). Dimensions of fathers' and mothers' supportive behavior: The case for physical affection. Journal of Marriage and the Family, 48, 783-794.

Beavers, W. R., Hampson, R. G. & Hyman, T. L. (1994). Age-of-recall effects on Family-of-Origin ratings. Journal of Marital and Family Therapy, 20, 61-67.

Brubeck, D. & Beer, J. (1992). Depression, self-esteem, suicide ideation, death anxiety, and gpa in high school students of divorced and nondivorced parents. Psychological Reports, 71, 755-763.

Burke, R. & Weir, T. (1979). Helping responses of parents and peers and adolescent well-being. Journal of Psychology, 102, 49-62.

Burns, D. (1980). Feeling Good: The New Mood Therapy. William Morrow: New York.

Demo, D., Small, S., & Savin-Williams, R. (1987). Family relations and the self-esteem of adolescents and their parents. Journal of Marriage and the Family, 49, 705-715.

Ehrenberg, M. F., Cox, D. N., & Koopman, R. F. (1991). The relationship between self-efficacy and depression in adolescents. Adolescence, 26, 361-373.

Felson, R. & Zielinski, M. (1989). Children's self-esteem and parental support. Journal of Marriage and the Family, 51, 727-735.

Gavin, L. A., & Wamboldt, F. S. (1992). A reconsideration of the Family-of-Origin Scale. Journal of Marital and Family Therapy, 18, 179-188.

Gecas, V. & Scwalbe, M. (1986). Parental behavior and adolescent self-esteem. Journal of Marriage and the Family, 48, 37-46.

Hoelter, J. & Harper, L. (1987). Structural and interpersonal family influences on adolescent self-conception. Journal of Marriage and the Family, 49, 129-139.

Hovestadt, A. J., Anderson, W. T., Piercy, F. P., Cochran, S. W., & Fine, M. (1985). A Family-of-Origin scale. Journal of Marital and Family Therapy, 11, 287-297.

Kaplan, H. (1976). Self-attitudes and deviant response. Social Forces, 54, 788-801.

Kaslow, N. J., Rehm, L. P., & Siegal, A. W. (1984). Social-cognitive and cognitive correlates of depression in children. Journal of Abnormal Child Psychology, 12, 605-620.

Kauth, M. R. & Zettle, D. (1990). Validation of depression measures in adolescent populations. Journal of Clinical Psychology, 46, 291-295.

Lee, R. E., Gordon, N. G., & O'Dell, J. W. (1989). The validity and use of the Family-of-Origin Scale. Journal of Marital and Family Therapy, 15, 19-27.

Manley, C. M., Searight, H. R., Binder, A. F., & Russo, R. J. (1990). The Family-of-Origin scale: Factorial validity for adolescents. Family Therapy, 17, 75-82.

Manley, C. M., Searight, H. R., Skitka, L. J., Russo, J. R., & Schudy, K. L. (1991). The reliability of the Family-of-Origin scale for adolescents. Adolescence, 26, 89-96.

Nolen-Hoeksema, S., Seligman, M. E. P., & Girgus, J. S. (1986). Learned helplessness in children: A longitudinal study of depression, achievement, and explanatory style. Journal of Personality and Social Psychology, 51, 435-442.

Procidano, M. & Heller, K. (1983). Measures of perceived social support from friends and from family: Three validational studies. American Journal of Community Psychology, 11, 1-24.

Rhem, L. P. (1977). A self-control model of depression. Behavior Therapy, 8, 787-804.

Robertson, J. F. & Simons, R. L. (1989). Family factors, self-esteem, and adolescent depression. Journal of Marriage and the family, 51, 125-138.

Rosenberg, M. (1965). Society and the Adolescent Self-Image. Princeton, NJ: Princeton University Press.

Ryan, N. D., Puig-Antich, J., Ambrosini, P., Rabinovitch, H., Robing, D., Nelan, B., Iyergan, J., & Twomey, J. (1987). The clinical picture of major depression in children and adolescents. Archives of General Psychiatry, 44, 854-862.

Schouten, P. G. W. (1994). A scale in search of a construct: Comments On Gavin and Wamboldt. Journal of Marital and Family Therapy, 20, 53-60.

Windle, M. & Miller-Tutzauer, C. (1992). Confirmatory factor analysis and concurrent validity of the perceived social support-family measure among adolescents. Journal of Marriage and the Family, 54, 777-787.

APPENDIX A

Informed Consent Statement

Your responses are confidential. At no time will you be identified nor will anyone other than the investigators have access to your responses. The demographic information collected will be used only for purposes of analysis. Your participation is completely voluntary. You are free to terminate your participation at any time without penalty.

The scope of the project will be fully explained upon your completion. Thank you for your cooperation.

I agree to participate in the present study being conducted under the supervision of a faculty member of the Department of Psychology at Austin Peay State University. I have been informed, either orally or in writing or both, of the procedures to be followed and about any discomfort which may be involved. The investigator has offered to answer any further inquiries that I may have regarding the procedures. I understand that I am free to terminate my participation at any time without penalty or prejudice and to have all data obtained from me withdrawn from the study and destroyed. I have also been told of any benefits that may result from my participation.

_____

Name (please print)

_____

Signature

_____

Date

APPENDIX B

Center for Cognitive Therapy

Please reply to:
Room 754, The Science Center
3600 Market Street
Phila., PA 19104-2648
215-898-4100
Fax: 215-898-1865

April 12, 1994

Janet Gill
Cumberland Valley Girls Home
404 Pageant Lane
Clarksville, TN 37040

Dear Ms. Gill:

On behalf of Aaron T. Beck, M.D., I am responding to your recent inquiry regarding our research scales.

You have Dr. Beck's permission to use and reproduce the scale(s) checked below only for the designated research project that you described in your letter. There is no charge for this permission.

However, in exchange for this permission, please provide Dr. Beck with a complimentary copy of any reports, preprints, or publications you prepare in which our materials are used. These will be catalogued in our central library to serve as a resource for other researchers and clinicians.

✓ Beck Depression Inventory (BDI)	___ Weekly Activity Schedule (WAS)
___ Beck Anxiety Inventory (BAI)	___ Daily Record of Dysfunctional Thoughts (DRDT)
___ Hopelessness Scale (HS)	___ Patient's Guide to Cognitive Therapy (PGCT)
___ Suicide Intent Scale (SIS)	___ Patient's Report of Therapy Session (PRTS)
___ Scale for Suicide Ideation (SSI)	___ Anxiety Checklist (ACL)
___ Cognition Checklist (CCL)	___ Beck Self-Concept (BSCT)
___ Sociotropy-Autonomy Scale (SAS)	___ Dysfunctional Attitude Scale (DAS)

If you have any further questions, feel free to contact me.

Sincerely,

K. A. Quinn

Karen A. Quinn
Assistant to Aaron T. Beck, M.D.

NOTE: Permission for inclusion of the BDI, BAI, HS, SSI, and BSCT in any publication must be obtained from The Psychological Corporation; telephone #: 1-800-228-0752.

APPENDIX C

Beck Depression Inventory

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and I can't snap out of it.
   3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life all I can see is a lot of failures.
   3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
   1 I don't enjoy things the way I used to.
   2 I don't get real satisfaction out of anything anymore.
   3 I am dissatisfies or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated by things than I ever am.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time now.

12. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14. 0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

APPENDIX D

Directions: The family of origin is the family with which you spend most or all of your time. This scale is designed to help you tell how your family of origin functions.

Each family is unique and has its own ways of doing things. Thus, there are no right or wrong choices in this scale. What is important is that you respond as honestly as you can.

In reading the following statements, apply them to your family of origin. Using the following scale, circle the appropriate number. Please respond to each statement.

Key:

5(SA) = Strongly agree that it describes my family of origin.
4(A) = Agree that it describes my family of origin.
3(N) = Neutral.
2(D) = Disagree that it describes my family of origin.
1(SD) = Strongly disagree that it describes my family of origin.

		SA	A	N	D	SD
1.	In my family, it is normal to show both positive and negative feelings.	5	4	3	2	1
2.	The atmosphere in my family usually is unpleasant.	5	4	3	2	1
3.	In my family, we encourage one another to develop new friendships.	5	4	3	2	1
4.	Differences of opinion in my family are discouraged.	5	4	3	2	1
5.	People in my family often make excuses for their mistakes.	5	4	3	2	1
6.	My parents encourage family members to listen to one another.	5	4	3	2	1
7.	Conflicts in my family never get resolved.	5	4	3	2	1

8.	My family teaches me that people are basically good.	5	4	3	2	1
9.	I find it difficult to understand what other family members say and how they feel.	5	4	3	2	1
10.	We talk about our sadness when a relative or family friend dies.	5	4	3	2	1
11.	My parents openly admit it when they are wrong.	5	4	3	2	1
12.	In my family, I express just about any feelings I have.	5	4	3	2	1
13.	Resolving conflicts in my family is a very stressful experience.	5	4	3	2	1
14.	My family is receptive to the different ways various family members view life.	5	4	3	2	1
15.	My parents encourage me to express my views openly.	5	4	3	2	1
16.	I often have to guess at what other family members think or how they feel.	5	4	3	2	1
17.	My attitudes and my feeling frequently are ignored or criticized in my family.	5	4	3	2	1
18.	My family members rarely express responsibility for their actions.	5	4	3	2	1
19.	In my family, I feel free to express my own opinions.	5	4	3	2	1
20.	We never talk about our grief when a relative or family friend dies.	5	4	3	2	1
21.	Sometimes in my family, I do not have to say anything, but I feel understood.	5	4	3	2	1
22.	The atmosphere in my family is cold and negative.	5	4	3	2	1
23.	The members of my family are not very receptive to one another's views.	5	4	3	2	1
24.	I find it easy to understand what other family members say and how they feel.	5	4	3	2	1
25.	If a family friend moves away, we never discuss our feelings of sadness.	5	4	3	2	1
26.	In my family, I learn to be suspicious of others.	5	4	3	2	1
27.	In my family, I feel that I can talk things out and settle conflicts.	5	4	3	2	1
28.	I find it difficult to express my own opinions in my family.	5	4	3	2	1

29.	Mealtimes in my home usually are friendly and pleasant.	5	4	3	2	1
30.	In my family, no one cares about the feelings of other family members.	5	4	3	2	1
31.	We usually are able to work out conflicts in my family.	5	4	3	2	1
32.	In my family, certain feelings are not allowed to be expressed.	5	4	3	2	1
33.	My family believes that people usually take advantage of you.	5	4	3	2	1
34.	I find it easy in my family to express what I think and how I feel.	5	4	3	2	1
35.	My family members usually are sensitive to one another's feelings.	5	4	3	2	1
36.	When someone important to us moves away our family discusses our feelings of loss.	5	4	3	2	1
37.	My parents discourage us from expressing views different from theirs.	5	4	3	2	1
38.	In my family, people take responsibility for what they do.	5	4	3	2	1
39.	My family has an unwritten rule: Don't express your feelings.	5	4	3	2	1
40.	My family is warm and supportive.	5	4	3	2	1