3. Assessing Family Health And Distress: An Intergenerational-Systemic Perspective

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In the past several decades there has been a proliferation of interest and development of family systems theories. A unique aspect of a systems perspective is that human problems develop in and because of social interactions usually within the family, rather than solely from some internal process within an individual. A second innovation is the view that human behavior always occurs in a context, and that understanding the context is essential for understanding problem development and resolution. The empirical evaluation and validation of these perspectives has lagged behind theoretical and therapeutic developments. Further, research in this area has been hampered by a lack of reliable and valid measures of constructs of interest. During the 1980s there were significant developments concerning measurement issues and instrument development that facilitate the assessment of family relationships. This chapter will review and discuss issues and methods for assessing family health and distress.

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THEORETICAL AND PRAGMATIC ISSUES IN ASSESSING FAMILY HEALTH AND DISTRESS

What is a Healthy Family?

There are as many definitions of healthy and dysfunctional families as there are theories of family functioning and family relationships (Gurman & Kniskern, 1981; Walsh, 1982). Although many of these theories overlap in their perspectives, there are unique aspects that are important to consider in describing healthy family processes. A complete review of theories of healthy families is beyond the scope of this chapter. However, a brief discussion of common aspects of systems approaches to families and family health is provided to orient the reader to basic assumptions of this approach.

A systems perspective to families views each family member as part of an interdependent interactional system that mutually influences other aspects of the family system. Change within one aspect of the system is believed to produce change in other parts of the family through a process of reciprocal feedback and shared meanings between family members. This is referred to as circular causality because the focus is on patterns of interactions rather than linear explanations of causality. The nonsummativity principle views the entire family as greater than the sum of the parts. It is essential to examine the pattern of relationships rather than just the pieces. Thus, assessing components or subsystems of the family system will not provide a picture of the whole family. All behavior within the family is considered communication that transmits interpersonal messages. Communication includes both the content of the messages and the process or how the messages are transmitted (Watzlawick, Beavin, & Jackson, 1967). Homeostasis refers to the mechanism by which the family maintains a steady state and equilibrium. Homeostasis is maintained through deviation-reducing feedback loops within the family, similar to how a thermostat regulates the temperature within a room. Morphogenesis is the process by which families change and adapt to internal and external demands. Positive feedback loops within the family that are deviation amplifying contribute to system change. Equifinality refers to the belief that systems may start at the same beginning, but may end with different outcomes because of system organization and response to the social and environmental context. Multifinality is the same principle in reverse; families can start with divergent beginnings and end with the same outcomes. Some systems approaches to families also view family functioning in a multigenerational
perspective, with at least three generations considered (Bowen, 1978; Boszormenyi-Nagy & Ulrich, 1981; Kerr, 1981; Williamson & Bray, 1988). Learned patterns of relating, attitudes, unresolved emotional issues, and loyalties are presumed to be passed down through the generations and directly affect current family functioning.

Healthy families promote the well-being and functioning of each individual family member through the maintenance of clear and effective communication, mutually beneficial interactional patterns, clear boundaries between the generations and between family subsystems, and expectations that change over time to the internal demands of family members and external demands of the environment. A balance is maintained between the needs for family stability and change that promotes the health of individual family members. All families have problems as they go through transitions across the life cycle, and dysfunctional families have an inability to make these transitions without experiencing problems (Watzlawick, Weakland, & Fisch, 1974). “An ordinary family; that is, the couple has many problems of relating to one another, bringing up children, dealing with in-laws, and coping with the outside world. Like all normal families, they are constantly struggling with these problems and negotiating the compromises that make a life in common possible” (Minuchin, 1974, p. 6).

Individual pathology or dysfunction is considered to be the result of family dysfunction or the adjustment of an individual to a “crazy” situation (Haley, 1976). The symptoms of the individual may serve to stabilize the family through homeostatic processes (Minuchin, 1974) or because of positive feedback that escalates problematic family interactions (Watzlawick et al., 1974). Psychopathology is an interactional process that is the result of problematic relationships within a family or relevant social context. Unless the family system changes, individual dysfunction will be maintained or alternatively the dysfunction will move to other family members.

Although it is argued that family assessment should flow from solid family theory, a major problem in the family assessment area is the lack of a unified theory of family functioning (Grotevant, 1989). There is no agreed upon family diagnostic system, as with the DSM-IV for individual psychopathology, and there are many disagreements in the field about the constructs or processes that are essential to assess. Some family-oriented theorists argue that formal assessment is unnecessary for clinical practice. Although family assessment is alive and vital, the field is still in the early stages of development.
Assessment of Family Health

Given the different and multiple perspectives on family systems it is not surprising that researchers have struggled to develop reliable and valid measures of concepts from these disparate theoretical formulations. Although there is overlap in definitions of healthy family functioning, there is also diversity in these points of view. Froma Walsh (1982) provides an organizational structure for family theories and discusses four basic perspectives for defining family normality and health:

1. **Asymptomatic family functioning.** If there are no family or individual symptoms, then the family is considered normal or healthy. This comes from the medical-psychiatric perspective that defines normality as the absence of pathology. In this perspective there is no affirmative or positive definition of normal family functioning. Thus, terms such as “nonclinical” or “nonsymptomatic” are used to describe such families.

2. **Optimal family functioning.** This approach defines healthy family functioning in terms of positive or ideal characteristics. Optimally functioning families are at one end of the spectrum with average or asymptomatic families in the middle and dysfunctional families at the other end of the continuum. Specific values and models are proposed to describe healthy families. The models may define specific family structures and/or processes within families. These models and values may or may not be linked to empirical evidence on family functioning.

3. **Average family functioning.** Families are considered healthy and normal if they fit the typical pattern for families at a given time. This point of view comes from a social science perspective with definitions based on statistical norms. For example, in the 1950s divorced families were “abnormal” because they were relatively uncommon, whereas in the 1990s first-marriage families with fathers solely employed are “abnormal” because they are less common. This perspective also differentiates the concepts of health, normality, and absence of symptoms, as a normal family may have problems and symptoms if it fits within the normative group.

4. **Transactional family processes.** Universal processes are conceptualized that characterize all family systems. These basic processes promote the maintenance and growth of families for individual members and in relation to social systems. Normality and health are defined by social contexts that require adaptation over the life cycle.
In addition to these perspectives there are other issues that are important to consider in defining normal family functioning. Similar to individuals, families undergo a series of developmental changes that are referred to as the family life cycle. The family life cycle posits that families undergo predictable and unpredictable changes over time and that families face common issues throughout the life cycle stages (Carter & McGoldrick, 1980). Further, it is apparent that family relations are embedded within cultural and ethnic contexts which may impact the specific family life cycle stages and processes of certain groups of families (McGoldrick, 1982).

Building on previous work in family assessment, categories of family relationships were created to evaluate aspects of family functioning (Fisher, 1976; Grotevant, 1989). These categories provide a means to organize the multitude of concepts and factors related to family functioning.

1. **Family Status**: This includes the makeup of the family (e.g., nuclear family, divorced family, stepfamily) and membership (e.g., couple only, couple with children, single-parent family). Family status has major implications for other aspects of family functioning.

2. **Family Process**: This includes actions, behaviors, and interactions that characterize family relationships. These processes include factors such as differentiation, communication, problem solving, conflict, and control.

3. **Family Affect**: This includes emotional expression and responses among family members. Affect often sets the “tone” for other family processes and has an impact on how family members experience communications.

4. **Family Organization**: This refers to roles and rules within the family and expectations for behavior that contribute to family functioning. Aspects such as boundaries and hierarchy are included as examples of family organization.

**MEASUREMENT ISSUES IN ASSESSING FAMILY HEALTH AND DISTRESS**

A common problem with family assessment is determining the appropriate unit of analysis for study. A large portion of the research conducted on families is based on data from individual family members, rather than data from multiple sources or direct study of families (Carlson, 1989; Fisher, 1982; Fisher, Kokes, Ransom, Phillips, & Rudd, 1985; Grotevant, 1989). Are self-report measures of family functioning from individual family members representative of the
“whole” family or do they simply represent the perceptions of that individual? Is it necessary to have “whole” family assessments to evaluate family health and distress or is it sufficient to have individual perspectives? The answer to these questions depends on the purpose for the assessment and the type of data that need to be collected.

Fisher et al. (1985) provide a classification scheme of family assessment and make suggestions for methods of developing “relational” and “whole” family data. They argue that data from a single person about family relationships occur at the “individual” level of assessment and may not reflect the functioning of the entire family system. In some cases, as in the assessment of marital satisfaction or differentiation from the family of origin, this level of data is appropriate for evaluating certain aspects of the family system. However, it is not truly “family” data as such information is restricted to a single individual’s perceptions. Most surveys rely on these types of data, yet the researchers often conclude that the data represent a valid assessment of family functioning. A problem with this approach is illustrated by research on marital satisfaction and marital disruption. As frequently noted, there is often such a discrepancy between spouses that researchers have noted that there are “his and hers” marriages and divorces (Barnard, 1972; Hetherington, Cox, & Cox, 1982).

The second category of data are “relational” assessments. Individual data are collected from two or more family members and the data are then “related” to each through some methodology. These types of data represent descriptive information about the family. Individual family responses may be combined to form some composite family assessment or discrepancies between family members’ data may be used to assess agreement or satisfaction (Fisher et al., 1985). There are many new sophisticated statistical methodologies for developing relational data, such as multivariate analyses, confirmatory factor analysis, structural equation modeling, and hierarchical linear modeling (Bray, Maxwell, & Cole, 1995; Bray & Maxwell, 1985; Bryk & Raudenbush, 1987; Jöreskog & Sorbom, 1986). Data from these first two categories usually represent “insider’s” data, because they include the internal perceptions of individual family members of family functioning (Olson, 1977).

The third category of family assessment is “transactional” data. These types of data reflect an assessment of the entire family unit through some type of observation or structured interaction. It represents system interaction, rather than a sum or combination of the individual parts. These types of data represent assessments of the
family as a whole or subsystems within the family. In most cases such information also represents an “outsider’s” view of the family, as some observer or rater makes judgments about family interactions. Transactional data can be combined with relational assessments to provide multimethod, multisource measures of family functioning using multivariate statistical methods (see Hetherington & Clingempeel, 1992 for an excellent example).

Another relevant question concerns the necessity of assessing the “whole” family to determine family health (Carlson, 1989). Is it the case that certain dyads or triads within the family may provide better data for this assessment rather than an evaluation of the whole family? Family research from developmental psychology perspectives argues that various family dyads, such as parent-child interactions, may be more useful than examining the family as a whole (Cowan, 1987). The argument is that these approaches provide more valid and more powerful prediction of individual family member’s adjustment and development.

Currently, there is no definitive answer to these issues and much more research is needed to evaluate the “best” methods for assessing family health. From a systems perspective, there will probably never be “one” best method, because it is often necessary to evaluate multiple aspects of the family system. In addition, family evaluation also depends on the context, purpose, and specific aspect of family functioning being evaluated. Thus, in some cases it may be more important to evaluate individual family members’ perceptions of family process, whereas in other situations it may be necessary to evaluate the family as a unit to understand the multiple family interactions and functioning.

FAMILY FACTORS AFFECTING FAMILY HEALTH AND DISTRESS

There is no “gold standard” measure of family health and distress, such as the Minnesota Multiphasic Personality Inventory (MMPI) for psychological assessments. Given the proliferation of family theories and methodologies for evaluating families, it is not surprising that one single measure has not been developed. Some measures are based on specific family theory, whereas others are empirically developed, and still other measures are a hodge podge of constructs with no clear theoretical basis. However, research on families is beginning to identify key processes that are important to assess for family health and distress. This section discusses these factors and
reviews self-report instruments that are available for assessing these processes. A problem within the field is that researchers have given different processes and constructs similar labels or names (Grotevant & Carlson, 1989). Thus, it is sometimes difficult to understand the meaning of particular scales, which may explain why researchers may find different results when supposedly assessing similar constructs. The review of the instruments is not comprehensive and includes those instruments that have acceptable levels of reliability and validity. For more comprehensive reviews of instruments readers are referred to Grotevant and Carlson (1989) and Touliatos, Perlmutter, and Straus (1990).

Communication

Communication within families refers to how verbal and nonverbal information is exchanged among family members (Watzlawick et al., 1967). Communication entails the ability of family members to explain and clarify their needs, wants, and desires (Hetherington, Clingempeel, Eisenberg, Hagan, Vuchinich, & Chase-Landsdale, 1986). This also includes the ability to listen to others so that responses can be appropriate, and further involves solicitation of others' views to clarify their positions. Healthy communication comprises appropriate focus of attention between family members, development of shared and common meanings, and clear and direct verbal exchanges (Epstein & Bishop, 1981; Wynne, Jones, & Al-Khayyal, 1982). Dysfunctional communication is characterized by disturbances in attention between family members, lack of shared meanings, and indirect and masked verbal exchanges. Communication deviance (CD) has been associated with severe forms of psychopathology, such as schizophrenia and personality disorders (Wynne et al., 1982). Less severe forms of communication problems contribute to family conflict and ineffective problem solving, whereas good communication contributes to effective problem solving, emotional bonding, and intimacy between family members.

Measures. Several measures assess communication skills and patterns in families. These measures include assessments of dyadic and whole family communication patterns. The Family Assessment Device (FAD; Epstein, Baldwin, & Bishop, 1983) includes a Communication scale that assesses the whole family. The Parent-Adolescent Communication Scale (PAC; Barnes & Olson, 1982) provides a measure for both adults and adolescents to rate their communication between parent and child, and the Communication
scale from the Parent-Adolescent Relationship Questionnaire (PARQ; Robin, Koepke, & Moye, 1990) provides a similar measure. Other scales include the Communication scale from the Family Environment Scale (FES; Moos & Moos, 1974), the Family Communication scale from the Self-Report Family Inventory (SFI; Beavers, Hampson, & Hulgus, 1985), and the Communication scale from the Family Assessment Measure-III (FAM-III; Skinner, Steinhauer, & Santa-Barbara, 1984).

Conflict

Conflict in families ranges from mild forms of disagreement and criticism to physical altercations with significant negative affect and verbal assaults. Conflict is an interactional process that requires at least two family members engaging in a disagreement (Hetherington et al., 1986). Conflict increases as the intensity and reciprocation of the negative interactions increase; conflict tends to decrease when one or both parties attempt to de-escalate the conflict. Alexander (1973) described the escalation and de-escalation of conflict in terms of defensive and supportive communication patterns. When one member of a family makes a statement that is perceived by another member as critical, individuals tend to respond by defending themselves. This defensive response tends to be perceived as a critical statement to the original speaker and tends to invoke another defensive response from the previous speaker. As this cycle of defensive statements continues, the conflict escalates. Alexander found that when a family member responded to a perceived criticism with a supportive statement, the original speaker was more likely to respond with a non-critical, neutral, or supportive statement and conflict did not ensue. Conflict is also related to other individual and family processes, such as family stress, depression and anxiety, poor communication, and poor problem-solving skills.

Early research on family process viewed conflict as always negative and reflective of dysfunctional family relationships. However, recent research by Gottman and colleagues (Buehlman, Gottman, & Katz, 1992; Gottman & Krokoff, 1989) suggests that couples who engage in conflict and resolve the conflicts are more likely to have higher marital satisfaction in the long run than couples who avoid or "stone-wall" against conflict. This process may generalize to other family relationships as well. Conflict is associated with increased psychological and health problems in family members (Doherty & Campbell, 1988). In addition, interparental conflict is strongly
predictive of children’s behavior problems (Emery, 1982; Hetherington et al., 1982).

Measures. The Conflict Tactics Scale (CTS; Straus, 1979) is a widely used measure of family conflict. The scale measures both verbal conflict and aggression and physical violence. The FES includes a useful family conflict scale that measures verbal aspects of conflict. Other measures of family conflict include the Conflict scale from the Colorado Self-Report Measure of Family Functioning (Bloom, 1985), the Family Conflict Avoidance/Expression scale of the Structural Family Interaction Scale (SFIS; Perosa, Hansen, & Perosa, 1981), the School Conflict and Sibling Conflict scales from the PARQ, and the Conflict scale from the SFI.

Problem Solving

Effective problem-solving skills include the ability to accurately identify issues, discuss or communicate about those issues, and develop alternative solutions that resolve or help family members cope with these problems. Problem-solving skills and styles are essential for problem resolution within families. Problem solving is a family’s ability to resolve difficulties and problems in a manner that maintains effective family functioning (Epstein & Bishop, 1981). Family problems include system maintenance issues, such as money management or rules for relating, and family emotional issues, such as how families handle feelings. Effective problem solving is related to good communication and negotiating skills. Research indicates that all families encounter problems and healthy families do not necessarily have fewer problems than dysfunctional families (Epstein & Bishop, 1981), rather healthy families are better able to resolve the conflict and problems.

Measures. The FAD includes a Problem Solving scale that assesses this dimension. Other scales include the Problem Solving scale from the PARQ, the Task Accomplishment scale from the FAM-III, and the Problem Solving scale from the Family Functioning Index (FFI; Pless & Satterwhite, 1973). The FACES-II Adaptability scale assesses aspects of problem solving and the ability of families to cope with change.

Emotional Bonding

Emotional bonding and cohesion refers to the degree to which family members view themselves as emotionally close or distant from each other (Olson, McCubbin, Barnes, Larsen, Muxen, & Wilson, 1982). This dimension usually ranges from over-involvement or enmeshed to disengagement or disconnection. This factor also includes
aspects of family support, involvement, and shared interests and friends. Families that are enmeshed are believed to have diffuse family boundaries, excessive emotional responsiveness, and poorly differentiated family relationships (Minuchin, 1974). Families that are disengaged tend to have rigid family boundaries, a lack of emotional responsiveness, and lack of communication between family subsystems.

**Measures.** There are several instruments that include scales measuring emotional bonding. The most popular measure is the Cohesion scale from the Family Adaptability and Cohesion Evaluation Scales (FACES; Olson, Bell, & Portner, 1983). The latest version of this instrument is FACES-III. Other measures include the FAD Affective Involvement scale, Family Cohesion scale of the SFI, the Cohesion scale of the FES, the Cohesion scale from the PARQ, the Cohesion scale of the Colorado Self-Report Measure of Family Functioning, and the Parent-Child Cohesion/Estrangement and Enmeshment/Disengagement scales of the SFIS.

**Affect**

Family affect includes the expression of affection and reactions to affection between family members. It is similar to emotional bonding; however, it also includes affect expression and regulation, rather than just emotional connectedness (Epstein & Bishop, 1981). Family affection is also indicated by the mood or emotional tone of the family. This dimension is usually bipolar from positive to negative mood and may vary in intensity. In addition, the emotional tone may include highly expressive to overly controlled expression of affect within the family. Affect frequently changes the perceived meaning of statements and may override the verbal communication.

Strong negative emotions in families, called “expressed emotion” (EE) have been associated with relapse in families with schizophrenic and depressed patients (Brown, Birley, & Wing, 1972; Vaughn & Leff, 1976; Wynne et al., 1982). EE is critical statements, hostility, and emotional overinvolvement with an identified patient that includes significant negative affect in tone. Emotional statements are also predictive of functional and dysfunctional couple relationships. The work of Gottman and colleagues (Buehlman et al., 1992; Gottman & Krokoff, 1989) indicates that negative emotional statements carry much more weight and have stronger influence on family interactions than positive affect.

**Measures.** The FAD includes the Affective Responsiveness scale that taps these dimensions. Other scales include the FES Expressiveness
scale, the Inventory of Family Feelings (Lowman, 1973), the Affective Expression and Affective Involvement scales from the Family Assessment Measure-III (Skinner et al., 1984), and the Expressiveness scale of the Colorado Self-Report Measure of Family Functioning (Bloom, 1985). Shields, Franks, Harp, McDaniel, and Campbell (1992) recently developed the Family Emotional Involvement and Criticism Scale (FEICS), a self-report measure of expressed emotion.

Roles

Roles are expectations and repetitive patterns of interactions that fulfill family functions and needs (Epstein & Bishop, 1981). Most families have multiple roles to accommodate family needs and expectations. Epstein and colleagues (Epstein & Bishop, 1981; Epstein et al., 1983) describe five groups of roles for families. These include roles for provision of resources (e.g., food, shelter, clothing), roles for nurturance and support (e.g., emotional support, comfort), roles for life skills development (e.g., aspects that promote development and success), roles for maintenance and management of family systems (e.g., leadership, decision-making, or finances), and roles for sexual gratification of marital partners. Healthy family roles include the meeting of all family functions and needs. Dysfunctional family roles might include rigidly defined roles or unmet needs and family functions.

Measures. The FAD Roles scale provides a measure of family roles. The Adult-Adolescent Parenting Inventory (AAPI; Bavolek, 1984) provides a measure of role-reversal in parent-child relations.

Differentiation and Individuation

Individuation or differentiation of self is defined as the person's ability to function in an autonomous manner without feeling unduly responsible for or being impaired by significant others. In addition, differentiation includes the ability to distinguish and control emotional reactions with one's intellectual and cognitive capacities (Bowen, 1978). Emotional fusion is at the opposite end of the continuum with individuation. Individuation is a process by which a person differentiates within their relational contexts (Bowen, 1978; Karpel, 1976). The major relational contexts are the family of origin and nuclear family. Emotional fusion represents diminished autonomous functioning in relationships and more emotional reactivity in interactions. Further, it is the tendency to take undue responsibility for others or to avoid taking responsibility for oneself. Emotional
fusion is believed to be due to unresolved emotional attachments to the family of origin (Bowen, 1978).

Differentiation of self is a broad construct that encompasses a number of other family processes. Differentiation implies clear and effective communication, appropriate assertiveness, and control of affective moods and responsiveness. In addition, differentiated families have more effective problem-solving skills and can negotiate resolutions to conflictual situations. Families with significant emotional fusion are likely to be emotionally responsive and engage in unresolved conflicts because of poor communication and problem-solving abilities.

**Measures.** The Personal Authority in the Family System Questionnaire (PAFS-Q; Bray, 1991; Bray, Williamson, & Malone, 1984) provides two scales that measure individuation. The Intergenerational Individuation/Fusion scale measures individuation with parents, whereas the Spousal Individuation/Fusion scale measures individuation in the marital or adult dyadic relationship. The Differentiation in the Family System Scale (DIFS; Anderson & Sabatelli, 1992) provides another measure of differentiation from the family of origin. In addition, the Differentiation of Self Scale (DOSS; Kear, 1978) provides a measure of differentiation in the current family.

**Triangulation**

Triangulation is a process of dealing with anxiety and emotional fusion between two people by involving a third person to diffuse tension in the dyad via diversion, collusion, or scapegoating of the third person. Triangulation and fusion both reflect a lack of differentiation of self, although they are different processes (Bray et al., 1984). Triangulation involves three people, whereas emotional fusion occurs between two people. Although the effects of being in an emotionally fused relationship can be detrimental to an individual's functioning (e.g., increased emotional and/or physical problems), fusion is often experienced as positive. In contrast, the triangulated person is generally stressed as he/she is pulled between two others. The other two members of the triangle usually experience a decrease in anxiety and tension by the process of triangulation. Bowen (1978) views triangulation as a normal process that is used to cope with emotional fusion, whereas other family systems theorists view triangulation as a pathological process (Haley, 1976; Minuchin, 1974).

**Measures.** The PAFS-Q provides two measures of triangulation—Intergenerational Triangulation, which measures triangulated relationships between an adult-child and parents, and Nuclear Family...
Triangulation, which measures triangulation between a married couple and their children. In addition, the SFIS has a scale on Parent Coalition/Cross-Generational Triads and the PARQ includes the Coalitions scale and the Triangulation scale.

Intimacy

Intimacy is a dyadic process that includes voluntary closeness while maintaining distinct boundaries to the self (Bray et al., 1984; Williamson, 1981, 1987). Attachment and involvement in which the individuals lose their unique boundaries, is experienced as involuntary and reflects emotional fusion rather than intimacy. Intimacy includes several components including trust, love-fondness, self-disclosure, and commitment (Larzelere & Huston, 1980; Peplau, 1982). Intimate relationships embody mutual respect and freely initiated self-disclosure while individuation of the participants is maintained. At the other end of the continuum of intimacy is isolation. Intergenerational intimacy within the family of origin and intimacy with peers, particularly with one’s spouse or significant other are components of relational intimacy. Intimacy is obviously related to emotional bonding and affective expression in families. Yet, this construct measures distinct aspects of family relationships (Bray et al., 1984).

Measures. The PAFS-Q has two intimacy scales—the Intergenerational Intimacy scale, which measures intimacy between and adult-child and parents, and a Spousal Intimacy scale, which measures marital intimacy. On the Young Adult Version of the PAFS-Q there is a Peer Intimacy scale which measures intimacy between the person and their significant other.

Personal Authority in the Family System (PAFS)

PAFS is a synthesizing construct that represents the inherent tension between differentiation and intimacy within the family of origin and other important personal relationships (Williamson, 1981; Williamson & Bray, 1988). The PAFS continuum includes personal authority at one end and intergenerational intimidation at the other. PAFS is reflected by being a differentiated person, through which increased control is exercised over an individual’s life course, personal health, and well-being (Bowen, 1978; Karpel, 1976; Kerr, 1981; Williamson, 1982). PAFS includes reconnection and intimacy with members of the family of origin, while simultaneously maintaining a differentiated stance within the family of origin. This process requires termination of the intergenerational hierarchical boundary which enables a person to relate to all human
beings, including one’s parents, as peers in the basic human experience (Williamson, 1981, 1982).

Intergenerational intimidation reflects the presence of the intergenerational hierarchy between parents and their offspring and a lack of intimacy and individuation between the adults. Intergenerational intimidation develops from the dependency that children have on their parents. Intergenerational intimidation is reflected by family processes such as triangulation (Bowen, 1978) and covert loyalties (Boszormenyi-Nagy & Ulrich, 1981). Boszormenyi-Nagy and Ulrich argue that children have both conscious and unconscious loyalties to their parents that are expressed through perceived expectations and parental mandates. Children also may protect their parents by finding ways to absolve them of transgressions or failures, for example, by not embarrassing or showing them up in their life functioning (Harvey & Bray, 1991). Therefore, intergenerational intimidation constitutes an obstacle to the adult offspring’s development of autonomous and effective functioning through the life course.

Measures. The PAFS-Q has two scales, the Personal Authority in the Family System scale and the Intergenerational Intimidation scale that measure these concepts.

Family Stress

Stress is both a family process and product related to internal family functioning and the family’s transactions with the larger social context. Stress is defined as the experience of undesirable, negative life events and everyday hassles (Kanner, Coyne, Schaefer, & Lazarus, 1981; Sarason, Johnson, & Siegel, 1978). Stress is a multi-system construct that ranges from social/family interactions through physiological responses within individuals (Doherty & Campbell, 1988; Dohrenwend & Dohrenwend, 1974). Stress is generated by other family processes, such as conflict and negative emotional expressions. At the same time stress is likely to interact with other family dynamics, such as level of differentiation to produce symptomatic behaviors in family members. In addition, significant stress may interfere with family functions such as communication and emotional bonding.

Measures. Overall family stress is assessed by the Family Inventory of Life Events and Changes (FILE; McCubbin, & Patterson, 1987). The Parenting Stress Index (PSI; Abidin, 1985) measures adult’s stress due to parenting; the Life Events Survey (Sarason et al., 1978) measures an
individual’s perceived life stress; and the Hassles Scale (Kanner et al., 1981) measures daily hassles and disruptions in peoples’ lives.

FAMILY IMPACT ON MENTAL AND PHYSICAL HEALTH OF FAMILY MEMBERS

The impact of family status, process, affect, and organization on the health of family members is of increasing concern to researchers, clinicians, and policy makers (Doherty & Campbell, 1988). Researchers investigating illness-behavior interactions have begun to emphasize the role of the family and social relationships in the etiology and maintenance of an individual’s physical and emotional health (Doherty & Campbell, 1988; Henao & Grose, 1985).

Family Status

Researchers have found marital and family status are strongly related to the incidence of health problems and response to health and illness (Berkman & Syme, 1979; Bloom, Asher, & White, 1978; Chandra, Szklo, Goldberg, & Tonascia, 1983; Kiecolt-Glaser, Kennedy, Malkoff, Fisher, Speicher, & Glaser, 1988; Tcheng-Laroche & Prince, 1983). The relationship between marriage and health has been supported by a large body of research that investigated both mental and physical health outcomes, which include mortality, health care utilization, physical symptoms and overall health, immune response, psychological symptoms and distress, and suicide (Berkman & Syme, 1979; Bloom et al., 1978; Chandra et al., 1983; Gersten, Friis, & Langer, 1976; Kiecolt-Glaser et al., 1988; Weiss & Aved, 1978; Wertlieb, Budman, Demby, & Randall, 1984). The majority of evidence suggests that marriage is associated with greater health and well-being and that marital separation is a risk factor for both mental and physical health (Bloom et al., 1978; Burman & Margolin, 1992; Ross, Mirowsky, & Goldsteen, 1990).

Marital status is positively related to post-myocardial infarction survival time for men and women (Chandra et al., 1983), and husbands’ marital satisfaction was found to predict their health at a 5-year follow-up (Gersten et al., 1976). Poorer marital adjustment in married women has been associated with more ill health and less satisfaction with health (Sheldon & Hooper, 1969). Marital satisfaction was a more powerful predictor of mental health than age, race (black, white, Spanish-speaking), education, income, and adverse childhood circumstances (Gove, Hughes, & Style, 1983). Related to these findings is the equally compelling evidence from the literature on divorce and separation and health status.
3. ASSESSING FAMILY HEALTH AND DISTRESS

Separation and Divorce. Bloom et al. (1978), in their literature review, presented evidence linking separation and divorce to a variety of physical and emotional problems. Research has continued to demonstrate significant increases in medical utilization in the 6 months before and 12 months after separation as compared to a married control group (Wertlieb et al., 1984), and significantly more illness in separated and divorced persons than the married control group (Tcheng-Laroche & Prince, 1983). Kiecolt-Glaser et al. (1988) found that relative to a married control group, separated and divorced men have depressed immune functions on several functional indices of immunity. Decreased immune function is associated with greater morbidity and health problems.

Separated/divorced men were found to be more distressed and lonelier and divorced women reported significantly less life satisfaction, parenting satisfaction, and significantly more use of professional therapists than married controls (Bloom et al., 1978; Hetherington & Camara, 1984; Tcheng-Laroche & Prince, 1983). In a study of various types of marital disruption, the lowest levels of satisfaction and happiness were reported by widowed men and divorced women (Gove et al., 1983). The negative impact of divorce has been shown to be greater among older persons than younger people (Chiriboga, 1982).

Remarriage and Stepfamilies. Parental remarriage is associated with increased stress for adults and children that may persist for many years (Bray, 1988; Bray & Berger, 1994; Hetherington, 1993). In addition, children who experience a parental remarriage are at risk for developing behavioral problems, typically externalizing problems, and lowered social competency (Bray & Berger, 1993; Hetherington & Clingempeel, 1992). This places children and adolescents at risk for developing other types of psychopathology, school and learning difficulties, and other health problems (Zill & Schoenborn, 1990). Family processes within stepfamilies are also related to adult and child adjustment. However, it has been argued that there are different norms for stepfamily relationships due to the lack of accepted societal norms and expectations for stepparents (Bray & Berger, 1993).

Family Process and Affect

Family processes are also important predictors of individual health. Better parental health and better relationships between parents and their adult children and grandchildren are related to less anxiety and depression, better psychological adjustment, marital/intimate relationships, and less life stress for the adult children and
grandchildren (Bray, Harvey, & Williamson, 1987; Fine, 1988; Harvey & Bray, 1991; Harvey, Curry, & Bray, 1991; Rakowski, Barber, & Seelbach, 1983). Markides and Krause (1985) found that life satisfaction of Mexican-American grandparents was positively related to affection with grandchildren. Lack of closeness to parents has been identified consistently with risk for development of lung cancer (Kissen, 1969; LeShan, 1959; LeShan & Worthington, 1956), and related to suicide, mental illness, hypertension, coronary heart disease, and malignant tumor (Thomas & Duszynski, 1974).

In families with residential children, parents' patterns of illness behavior and health care utilization influence how children experience and respond to illness (Apley, 1967) and use health care resources (Schor, Starfield, Stidley, & Hankin, 1987). In one study 5% of families were found to account for over 12% of health care utilization (Schor et al., 1987). These relationships suggest that it is important to assess intergenerational family patterns of health and illness to better understand the functioning of families and individuals.

Stress and Social Support. There is considerable evidence converging from different sources that stress enhances vulnerability to certain diseases (Cohen & Syme, 1985; Dohrenwend & Dohrenwend, 1974). Stress appears to affect the immunosuppressive process. This evidence comes from animal studies, in vitro human studies, and studies of immune responses in populations (Dorian & Garfinkel, 1987; Kiecolt-Glaser et al., 1988). This same research also suggests that social support plays a moderating role, possibly via enhanced adaptation, buffering, mastery, or coping (Cohen & Syme, 1985; Cohen & Wills, 1985; Dorian & Garfinkel, 1987; Norbeck & Tilden, 1983). The large epidemiological study by Berkman & Syme (1979) found that for both men and women, the overall level of social support predicted risk of mortality over and above baseline physical health status, education, income, and health practices such as smoking and alcohol consumption. Marriage and family relationships are major sources of social support, and family disruption is a major source of stress (Berkman & Syme, 1979; Cohen & Wills, 1985; Hetherington & Camara, 1984).

Stress and family relationships interact to impact health and illness. Boyce et al. (1977) noted that the combination of high stress and high family routines was directly related to the severity of children's respiratory illnesses but these factors were not independently related to severity of illness. Fergusson, Horwood, Greathorn, and Shannon (1985) observed that stressful events were associated with child behavioral problems and maternal depression, but when maternal
depression was controlled, there was no correlation between stressful events and behavioral problems. In addition, several studies have found that family relationships, family process such as cohesion and adaptability, and stress predict adjustment to diabetes and diabetic control (Anderson, Miller, Auslander, & Santiago, 1981; Cedarblad, Helgesson, Larsson, & Ludvigsson, 1982; Grey, Genel, & Tamborlane, 1980; Mengel et al., 1992), and over time high stressful events are related to deterioration from good to poor diabetic control in adolescents (Koski & Kumento, 1977).

However, there is a "dark side" to social support and family interaction that may negatively impact family members' health (Coyne & Bolger, 1990; Rook, 1984). Negative family and social relationships may actually impede well-being through social strain and increased negativity in the relationship. Thus, it is important to distinguish between the positive and negative aspects of social support and its impact on health functioning.

Family Organization

A common factor in family organization is role satisfaction and validation of role performance from the environment. Googins and Burden (1987) found that workplace versus family strain was strongly associated with decreased physical and emotional well-being. The relationship cannot be explained simply by inadequate time for role demands, as women with several roles are healthier than those with fewer roles (Froberg & Gjerdingen, 1986). In one study of role burdens and physical health, dissatisfaction with roles and feelings of very great or very little time pressure were associated with poor health (Verbrugge, 1986). In the case of employed women and homemakers, better health is associated with desired, positive roles, such as marriage and married parenthood (Muller, 1986). Poorer health is associated with unwelcome role expansions such as single-parenthood, child disability, having a sick spouse, and marital dissolution. Roles change significantly after divorce and remarriage (Hetherington & Camara, 1984) and there is considerable role ambiguity for stepparents which may add to their stress and ability to adjust (Bray, 1988; Bray & Berger, 1993).

Variations Due to Family Status Differences. There are important interactions between family status, family process, and individual functioning. Hypothesized relationships among these factors may not hold in different family structures, such as families following a divorce or remarriage. Bray (1988) found that in newly remarried
stepfamilies children’s externalizing behavior problems were related to mothers’ reports of less cohesion, emotional bonding, and affective responsiveness, whereas for stepfathers’ more cohesion, affective responsiveness, and overinvolvement in family matters were associated with more behavior problems for children.

Variations Due to Ethnic and Racial Differences. Most of the models of family relationships are based on White, middle-class families and do not necessarily include variations that may occur for families from different cultural and ethnic backgrounds. In addition, most of the family measures are based on these models and have not been validated with families from diverse ethnic backgrounds. Morris (1990) found that the Family Assessment Device appeared to make appropriate assessments of Hawaiian-American families, while providing inappropriate assessments of Japanese-American families. Hampson, Beavers, and Hulgus (1990) found no differences in global competence or family style between Anglo, African-American, and Mexican-American families. However, specific family style differences between the ethnic groups were noted in ratings that were consistent with theoretical and cultural expectations. This is clearly an area that needs further study and researchers and clinicians are cautioned in using measures and instruments developed on one ethnic group to assess the health and dysfunction of families from other ethnic and cultural backgrounds.

INTERGENERATIONAL SYSTEMS MODEL OF FAMILY HEALTH AND DISTRESS

How does family structure, process, and organization impact the health of individual family members? Our research has drawn on intergenerational family systems theories (Bowen, 1978; Kerr, 1981; Williamson & Bray, 1985, 1988) to explain the relationships between family functioning and individual health and distress. The family of origin is viewed as the major social group that impacts individuals’ development. This influence is presumed to persist whether or not the person continues to interact with the family (Boszormenyi-Nagy & Ulrich, 1981; Bowen, 1978; Williamson, 1981). The influence is constituted by the individual’s current perceptions of his/her family relationships (Williamson & Bray, 1988). The important family processes considered by intergenerational family systems theory include intimacy, individuation, triangulation, personal authority, and intimidation. As previously noted, other family processes, such as communication and problem solving, are subsumed in these broader
concepts. We have conducted a series of studies to evaluate the relationship between intergenerational family relationships and individual psychological and physical health and adjustment.

Bray, Harvey, and Williamson (1987) conducted two studies that investigated intergenerational family processes, as measured by the PAFS-Q, and their relationship to life stress and health distress. In the first study, self-reports of relationships in the family of origin and current nuclear family were used to predict health/illness in an adult clinical sample. Over half (53%) of the variance in health distress was accounted for by family process variables. Family of origin relationships continued to predict health distress, even after controlling for nuclear family relationships. In the second study, self-reports of family of origin and peer relationships and life stress were used to predict health/illness in a nonclinical college-aged sample. Family processes were significant predictors of health distress over and above life stress.

Based on the previous studies and a re-examination of intergenerational family theory, a more complex model was developed that includes explicit causal relationships among multigenerational family relationships. Intergenerational family theory hypothesizes that relational patterns are transmitted and reproduced from generation to generation (Bowen, 1978). We speculate that these patterns are transmitted via social learning with parents and grandparents (Williamson & Bray, 1988) and maintained out of loyalty to the previous generations (Boszormenyi-Nagy & Ulrich, 1981). Thus, it is expected that patterns of differentiation and individuation in intimate relationships with peers (e.g., spouses, significant others) are similar to patterns with the parents. This hypothesis is specified in Figure 1 as the influences of intergenerational intimacy/individuation and intergenerational intimidation/fusion on peer intimacy/individuation. Circles enclose the theoretical constructs and unidirectional arrows indicate the hypothesized causal directions. The model represents only interfactor causal relationships; the causal influences of each factor on the same factor at a different time period are also included in the model but are not shown.

Bowen (1978) hypothesizes that experiencing stress or anxiety stimulates emotional fusion between family members which increases the probability of symptom development in one or more family members. The symptoms may be expressed as marital conflict, dysfunction (physical, psychological, and/or social) within self or a significant other, and/or dysfunction within children in the family.
More individuated people are less likely to develop symptoms during stressful periods and recover more quickly following the period of stress.

Bowen (1978) and Williamson and Bray (1985) proposed that a person's level of individuation and personal authority in the family of origin are directly related to that person's psychological and physical health. Individuals who experience more individuation in their family and peer relationships are more likely to take personal responsibility for their well-being, engage in health-enhancing behaviors, cope effectively with life's difficulties, and less likely to experience negative reactions due to stress (Harvey & Bray, 1991). Positive family relationships and social support are expected to contribute to positive expectations and self-statements, perceiving fewer negative situations, and experiencing enhanced self-competency. In contrast, psychological distress is expected to be caused by emotional fusion and intergenerational intimidation created through emotional reactivity, unresolved emotional attachments to family members, and diminished levels of social support for individuals. Thus, higher levels of health-enhancing behaviors and lower levels of psychological distress, life stress, and health distress are expected to relate to intergenerational intimacy/individuation and peer intimacy/individuation. Individuation and personal authority are reflected by...
increasing freedom of choice regarding parental expectations, with an associated enhancement of coping and self-esteem (Harvey & Bray, 1991). Thus, psychological distress, life stress, and health distress are expected to relate to more intergenerational intimidation/fusion.

Reciprocal influences between health, stress, and individuation are expected. However, this model predicts that the current levels of intimacy/individuation and intergenerational intimidation/fusion are the principal and prominent influences on an individual’s ability to cope with stresses and changes encountered throughout the life cycle (Williamson & Bray, 1985, 1988). Current perceptions of relational patterns are considered central influences on stress, illness, and distress, rather than historical perceptions and events (Williamson & Bray, 1988). The intergenerational perspective considers both the current interactional patterns of family relationships and the construction of the meanings of these relational patterns by individual family members (Harvey & Bray, 1991).

Tests of the Model

An evaluation of this causal model was conducted by Harvey and Bray (1991) in a short-term, two-wave, longitudinal study of young adults (see Figure 2). Results for the first administration indicated that the degree of individuation/intimacy in intergenerational and peer relationships directly influenced subjects’ health-related behaviors. These factors accounted for 30% of the variance in health-enhancing behaviors. Intergenerational intimidation/fusion directly influenced the level of health distress and the complete model accounted for 35% of the variance in health distress. The degree of intimacy/individuation in peer relationships was found to directly influence subjects’ level of psychological distress. The intergenerational family factors were found to directly influence life stress, but these factors had separate direct effects on health distress over and above life stress. The complete model accounted for 73% of the variance in psychological distress.

In a third paper, Harvey et al. (1991) extended and replicated the findings of the previous studies by simultaneously evaluating this theory using structural equation analysis in a sample of middle-aged adults and their college-aged offspring. This study directly examined intergenerational relationships and the transmission hypothesis between two generations of family members. Differences in family relationship patterns were noted between mothers and their children and fathers and their children (see Figures 3 and 4). For both mothers
and fathers, levels of individuation and intimacy were significant predictors of their own health distress and psychological distress. Parents' patterns of individuation and intimacy directly and indirectly influenced their offspring's family relationship patterns of individuation and intimidation providing partial support for the intergenerational transmission of family patterns. Fathers' intergenerational patterns operated through nuclear and marital relationships to influence their college-aged children's family patterns, whereas mothers' patterns had both direct and indirect influences on their college-aged children's family patterns, via nuclear family relationships. Overall, mothers' intergenerational and nuclear family relationships had stronger influences on their children's relationships and adjustment than did fathers' relationships.

Taken together these studies provide empirical support for an intergenerational family systems model and its influence on health and dysfunction. These studies highlight the importance of assessing family relationships in multiple generations to understand the impact of stress and social/family influences on health and well-being.
Figure 3. Intergenerational (ITGL) Model of Mothers and Children (From Harvey, Curry, & Bray, *Journal of Family Psychology*, 5, 204-236, Copyright 1991 by the American Psychological Association. Reprinted by permission.)

Figure 4. Intergenerational (ITGL) Model of Fathers and Children (From Harvey, Curry, & Bray, *Journal of Family Psychology*, 5, 204-236, Copyright 1991 by the American Psychological Association. Reprinted by permission.)
Family Health Influences on Individual Health

A central question raised by this line of research is how do social interactions impact physiological and cellular functioning and dysfunction? Although a complete review of these relationships is beyond the scope of this chapter, a brief discussion addresses this relatively new and quickly developing area of science. Family systems theorists view the family as an emotional unit that not only develops relational patterns that foster adaptation, but also regulates emotional and affective responsiveness of its members (Bowen, 1978; Kerr, 1981; Epstein & Bishop, 1981; Mengel et al., 1992; Minuchin, Rosman, & Baker, 1978; Ramsey, 1989). Recent developments in our understanding of physiology-behavior relationships provide answers to how family interaction and behavior relates to individual physiological responsiveness and functioning (Mengel et al., 1992). There is considerable evidence that interactions within the family system have reciprocal influences with the nervous system, immune system, and endocrine system that result in physiologic functioning and play an important role in health and illness (Ramsey, 1989). Within the nervous system the limbic system is believed to have control of emotions and also originates signals that manifest as stress responses (Asterita, 1985). Thus, emotional states may cause stress responses, which in turn impact other physiologic responses. Therefore, emotional and affective responses in the family can be transmitted to an individual's body via the limbic system and impact the health and well-being of that individual (Smith & DeVito, 1984; Stebbens & Smith, 1964). Further, other emotional reactions generated by family interactions and process are also related to the nervous system and endocrine system. Depression is related to activation of the pituitary and adrenal cortical system, whereas anger, hostility, and active coping are related to activation of the sympathetic adrenomedulary system (Eckman, 1984; Henry & Stephens, 1977). As discussed previously, stress created by changes in family status, family relationships, and other environmental changes are also related to decreased immune functioning which is related to increased risk for illness (Kiecolt-Glaser et al., 1984, 1988). A recent study found that increased stress was directly related to susceptibility to viral infections, such as the common cold, and the ability of the immune system to destroy viral infections (Cohen, Tyrrell, & Smith, 1991). Thus, family

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1 I wish to acknowledge the consultation of Mark B. Mengel, M.D. for his help in preparation of this section.
systems functioning can impact an individual's emotional responsiveness and stress and can impact the body and influence the development of disease states.

FUTURE DIRECTIONS

It is clear that we have made significant progress in the development of family assessment tools and towards understanding family health and distress; however, there continues to be much to learn. Research is needed to further identify key family processes that contribute to family health and well-being and to clearly specify how to measure them. In addition, we need to increase our understanding of how family interaction and process contributes to individual family members' physical and mental health. Although overall measures of family functioning are useful, they do not capture the multiple levels of systems within systems that are considered in performing a family assessment. As Gottman (1989) poignantly stated, "The hallmark of this work is and must be precision. Global measures of family functioning are limited in that one does not really know what is being measured" (p. 213). Cultural and ethnic variations also must be considered, as well as the social context in which the changing American family resides. Most of our models of the family, and therefore our assessment instruments, do not consider these structural, cultural, and ethnic variations in families, or the massive and evolving changes in family demographics.

REFERENCES


3. ASSESSING FAMILY HEALTH AND DISTRESS


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