PERCEIVED FAMILY COMPETENCE AND LATE ADOLESCENCE:
AN EXPLORATORY LOOK AT AFFECTIVE, COGNITIVE,
AND INTERPERSONAL VARIABLES

DISSERTATION

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

By

Jana L. Swart, M.A.
Denton, Texas
August, 1992
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Swart, Jana L., *Perceived Family Competence and Late Adolescence: An Exploratory Look at Affective, Cognitive, and Interpersonal Variables*. Doctor of Philosophy (Counseling Psychology), August, 1992, 90 pp., 4 tables, 1 figure, references, 77 titles.

The purpose of this study was to explore the effects of perceived family competence on late adolescent problem-solving abilities, family relationships, and affective experience. Specific areas of interest were perceived confidence in problem-solving and approach rather than avoidance of problems; intergenerational intimacy, intergenerational individuation, and personal authority in the family system as the adolescent relates to parents; and level of depression.

Subjects were 256 late adolescents whose parents were still married and living together. Results indicated that perceived family competence had an effect on the dependent variables in the expected directions. Specifically, individuals who scored high on perceived family competence were high on perceived problem-solving confidence, approached problem-solving, were high on intergenerational intimacy, intergenerational individuation, and personal authority in relation to parents, and had less depression than individuals low on perceived family competence.
Several sex differences were noted. Females had significantly higher approach to problem-solving than did males. Women reported significantly higher intergenerational intimacy with parents than did men. There was a significant interaction on personal authority such that for the high perceived family competence group, women scored higher than men. However, there were no significant differences between males and females in the low perceived family competence group.
ACKNOWLEDGEMENTS

First, thank you to my life partner and best friend, Bill, without whose unfailing love and support, I could not have accomplished this important life goal. Next, to Will and Jack, who have never known a mom who wasn't a student, for the endless source of joy and humor and constant reminder of what is really important—my family. A special thank you to "Baby Boy Swart" for not making an untimely appearance. Also, thanks to my family, especially my sister, Vanessa, my extended family, and numerous friends I wish I could name, for their love and support during the last eleven years.

Thanks to my emotional support system: my fellow graduate students and especially the Dissertation Support Group. Very special thanks go to my very special "sisters," Kay Bryant, Janet Huggins, and Phyllis Jones, each of whom was there for me countless times. Thank you to Larry Campbell and Lee Doyle for their guidance in my growth, both as a person and as a therapist.

Thanks to the numerous supervisors I’ve had throughout my clinical training. And last, I extend my appreciation to the persons who guided and supported me throughout the dissertation process, Ed Watkins, my committee, and to Joy McCreary, whose generous cooperation allowed me to complete the process before Baby.
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CHAPTER I

INTRODUCTION

Overview

The purpose of this study was to explore effects of family competence on selected interpersonal, affective, and cognitive variables in adolescents. It was hypothesized that adolescents from competent families will look quite different than those from less competent families on these variables. The developmental period of late adolescence is of particular interest, because then the individual is negotiating familial relationship issues around the tasks of psychologically separating from parents and physically leaving home.

In reviewing the literature, there appears to be a plethora of theory but a paucity of research about family competence and its impact on the development of individual family members. Lewis, Beavers, Gossett, & Phillips (1976) note that a "historic preference for research in the pathological as well as the relative ignorance of the functional is, of course, common in research processes in all health fields [with the] focus...invariably on the dysfunctional" (pp. 3-4). Olson (1988) notes that a focus on family strengths is a recent phenomenon and that "normal"
families have more often been used as control groups rather than the primary focus of research. It is the intent of this investigation to add to this small body of research by studying the effects of family competence on late adolescents.

A review of the literature indicates that competent families share some commonalities. Research suggests that in addition to possessing common qualities, optimally functioning families are different from lower functioning or clinical families (those families presenting for treatment). Such differences in family competence seemingly would have an impact on the functioning of late adolescents. But as yet late adolescents from competent families have not been specifically studied, and there appears to be a need for doing so. The remainder of this chapter will discuss the family competence model, the research that has been conducted on it, and the rationale for the use of the Beavers System Model in particular. Finally, the purpose and description of this study will be outlined in more detail.

Competent Families

The definition of a "normal" or "healthy" or "competent" family is open to interpretation. Walsh (1982) uses the Offer and Sabshin (1966) categories of mental health to discuss differing definitions of family "normality." She proposes that families can be defined
According to asymptomatic functioning, optimal functioning, average functioning, and transactional processes. Asymptomatic families have members with no psychopathology; thus, the absence of symptomatic behavior is equated with health. Optimal families evidence "ideal" or positive characteristics and fall on one end of a continuum of family health. Walsh states that these families are usually identified according to the values of the researcher's conceptual paradigm and are selected in terms of the accomplishment of certain family tasks such as the successful development of the children. Average functioning is akin to the statistical measurement of central tendency and from this perspective an optimal family is as abnormal as a severely dysfunctional family. An average family is viewed as one that "fits a pattern that is typical or prevalent in most families" (p. 5) and may not necessarily be asymptomatic. Transactional processes examine family functioning over time and view individual and family development as interdependent and requiring mutual adaptation over time.

In addition, Walsh (1982) distinguishes between functional and normative family normality. "Normative" may or may not correspond to the statistical norm or typical patterns of behaviors. Each family establishes its own norms for the regulation of behavior that may or may not conform to "societal" norms. "Functional" is an evaluation
of patterns of behavior in terms of the context and "the utility of a structural or behavioral pattern in achieving objectives" (p. 6). Walsh states that what is functional at one level (e.g., individual, family, or societal) may not be functional at another level. Price (1979) makes the same statement and expands the concept of functional to include consideration of the goal of the system, the current state of the system, and the desirability of maintaining that system. Both authors conclude that what is functional at one stage in a family's life cycle may be dysfunctional at another (Price, 1979; Walsh, 1982).

Thus, according to Walsh (1982), "the family systems orientation in general is clearly based on the perspective of normality as process, or as a transactional system operating over time" (p. 25). Within this general systemic framework, Walsh then differentiates among various models, delineating structural, strategic and behavioral models as viewing normality in a functional sense. These models see the normal family as one that does not "maintain or reinforce symptoms in any member" (p. 25). The family developmental process over time is acknowledged; however, the focus is on the current patterns of behavior in the family system. Walsh contrasts the above models with insight-oriented family approaches (psychodynamic, Bowenian, and experiential approaches), which evaluate families according to an ideal model of optimal functioning. She
notes that the various family models "are remarkably free in
general from any major contradiction or inconsistency [and
where differences occur] they reflect a more selective focus
or emphasis on a particular aspect of family functioning"
(p. 25).

Price (1979) and Barnhill (1979) discuss the concept of
healthy family systems. Price focuses on a metalevel,
stating that "how one defines healthy very much depends on
one’s values and assumptions about the nature of man"
(p.112). Culling from the views of others, Price states
that healthy may be clinically ideal, surpass the average,
ethically normal, or desirable or valuable. He adds that
what is culturally sanctioned as healthy and good mental
health may not be the same thing.

On another level is Barnhill’s analysis of what
constitutes a healthy family system (1979). He identifies
eight dimensions of healthy family functioning and groups
them into four family "themes". The first theme is Identity
Processes, which includes the dimensions of individuation
versus isolation and mutuality versus isolation. Second is
Change, which includes flexibility versus rigidity and
stability versus disorganization. Third, Information
Processing includes clear versus unclear or distorted
perception and clear versus unclear or distorted
communication. Finally, Role Structuring includes the
dimensions of role reciprocity versus unclear roles or role
conflict and clear versus diffuse or breached generational boundaries. Barnhill states that these eight dimensions are all interrelated and "can be integrated into an interlocking, mutually causal system" (p.96).

Researchers with other theoretical views also comment on the importance of family structure as it relates to competence. According to Lewis (1988) "family competence is defined as the extent to which the family structure facilitates the development of psychological health in both parents and children" (p.150). Terkelson (1980), in his discussion of what he terms family sufficiency, states that "a family is sufficient or good enough to the extent that it is matching specific elements of structure to specific needs" (p. 32). He goes on to say that a family meets the needs of its members through "interpersonal enactments" that provide the resources to meet needs and by so doing, members grow and develop.

In summary, what constitutes a competent or healthy family system can be described from many perspectives. What is most germane to this study, however, is Walsh's thesis (1982): Normality is a family process that is transactional and operates over time. While this may be a value-laden view of family competence on the one hand, it is also the most flexible and amenable to the incorporation of notions of family competence on two major levels: structure and process. These two levels will be examined in greater
detail as the discussion of family competence unfolds. Finally, many of the theories related to family health or family competence are tied to the concept of a family life cycle. While this can be a useful theoretical concept in viewing family development, this study will purposefully not adhere to a life cycle view of family functioning, because for as stated by Keith and Whitaker (1988), "individuals have life cycles, but families do not. Families are infinite" (p. 433).

Family Competence and Late Adolescence

Families expand and grow, lose members, changing in both predictable and unpredictable ways. Theorists from various "schools" of family therapy have put forth explanations for family growth and development. Family life cycle theories posit universal and predictable family transitions (Carter & McGoldrick, 1980). Psychodynamically oriented family theorists examine characteristics of individual members, such as maturity (Satir, 1967; 1972) or multigenerational transmission processes (Boszormenyi-Nagy, 1981; Bowen, 1978); structurally oriented theorists (Haley, 1979; Minuchin, 1974) focus on functional properties of families to explain family functioning. Walsh (1982) states that structural theorists view family normality as a system that does not reinforce or maintain symptoms in its members. She states that insight-oriented theorists (including
psychodynamic, Bowenian, and experiential) view normality in terms of "ideal models of optimal functioning."

Terkelson (1980) states "the purpose of the family is to provide a context that supports need attainment for all its individual members" (p.28). He posits two fundamental orders of needs: needs pertinent to survival and needs pertinent to development. Accordingly, once survival needs are met, the family unit is then "committed to creating and sustaining the sense of being valued, the sense of being cared about, the sense of being accepted "as is," and the sense of permanence of affectional ties" (p.28). The family encourages various forms of attachment-oriented interactions between and among all its members which continue over their lifetimes. Epstein, Bishop, & Baldwin (1982) concur that a primary function of the family "is to provide a setting for the development and maintenance of family members on the social, psychological, and biological levels" (p. 118). These authors state that families must deal with tasks in three basic areas in the course of fulfilling their basic function. The first task is dealing with basics such as food, shelter, and so forth. The second task is managing stages of development on both an individual and family level. The third task is handling crises that arise as a result of non-normative events. According to Epstein et al., families that cannot deal with these three tasks are at
risk to develop "clinically significant problems and/or chronic maladaptive problems" (p.118).

A basic premise of this study is that any effort to examine family competence must take on a family developmental perspective, that is, the "family undergoes development...[and] adapts to changed circumstances so as to maintain continuity and enhance the psychosocial growth of each member" (Minuchin, 1974). This view posits that development occurs within the context of the family unit and within its individual members and each influences the other. According to Walsh (1988) "role positions and reciprocal relationships, particularly relationships between parents and children, alter with the developmental changes of members" (p.29).

Part of this developmental change and growth process includes the preparation of children to leave home, both physically and psychologically. The psychological preparation begins in infancy (Mahler, Pine & Bergman, 1975) and continues throughout the lifespan (Sabatelli & Mazor, 1987). Late adolescence is a developmental period within which the individual wrestles with the interplay of psychological separation and intimacy in the family of origin; it is also a time when he or she physically departs from the family. Borrowing from Shapiro (1988), this separation-individuation process "assumes that all persons exist in relationships and that the self is interpersonally
established, maintained, developmentally modified, and reorganized through transactions in family relationships throughout the family life cycle" (p. 160).

The human infant, from the time of its birth, begins a lifelong process of either differentiating itself from others according to Mahler et al. (1975) or striving for connection with others (Stern, 1985). Stern posits that the infant seeks out objects for "intersubjective union"- not only to define the self, but to relate to others. In all likelihood, both processes come into play as the individual develops from infancy to adulthood. As Josselson (1988) has said, "because separation-individuation and relatedness [or intimacy] are two sides of the same matrix, to focus on one at the exclusion of the other distorts the understanding of the process" (p.174).

The family is the primary vessel in which the drama of the play between separation-individuation (or autonomy) and attachment (or intimacy) is contained. Psychological separation is a drive within the individual toward healthy personal adjustment that is "critically dependent on his or her ability to psychologically separate from the parents and gain a sense of identity as a separate person" (Hoffman, 1984). At the same time it must be acknowledged that this process is probably best facilitated within the context of secure attachment to the family of origin (Blos, 1962). Ackerman (1966) states that the "delicate interplay of
parallel processes of emotional joining and separation" (p. 60) forms the basic union between the individual and the family and out of that union "come individuation and new growth" (p. 60) with each stage of individuation calling for new levels of sharing and union. While separation is a lifelong process that unfolds throughout the lifespan (Sabatelli & Mazor, 1987), it appears that there are several points in the life of the individual where what is occurring in the family can either facilitate or hinder this basic developmental task. Late adolescence is perhaps the most critical period.

Josselson (1988) defines adolescence as "a period in which the child metamorphoses into an adult, that is, moves away from dependence on parents to self-sufficiency and independent life and also assumes adult expression of sexuality" (p. 170). Historically adolescence has been viewed as a time of stress and storm (Blos, 1962; Erikson, 1968). However, research (Offer, 1969; Offer, Ostrow, & Howard, 1981) has failed to bear this out as a norm. Josselson (1988), in a synthesis of several theorists' works (Fischer, 1986; Offer & Offer, 1975; Symonds & Jensen, 1961), writes that

the vast majority of adolescents maintain harmonious, loving relationships with parents throughout adolescence, that those adolescents showing the highest self-esteem and most mature
functioning tend to have the most interrelationship with their parents, that peers take on added importance but do not supercede the influence of parents in important decision making—in short, that attachment to parents continues unabated throughout adolescence and into adulthood (p. 168).

She states that "adolescents grow without detaching themselves from parents" (1988, p. 168). Josselson (1980) concludes that adolescents experiencing adjustment difficulties, rather than normally developing adolescents, may typify the traditional view of adolescence as a time to sever parental ties.

Blos (1962) contends that the individual will best negotiate the separation-individuation phase of adolescence if he or she remains in the family. This allows the adolescent to work through internal conflicts in communication with the family. If conflict is avoided due to either physical separation from the family (such as going away to college) or complete emotional disengagement with the family, developmental arrest may occur and maturation may not be achieved. Blos goes on to say that the college student in particular may experience a protracted adolescence by delaying achievement of full adulthood in the pursuit of higher education. He states that this postponement usually creates problems for the late
adolescent without specifying what those difficulties might be.

In summary, the examination of family competence and its impact on the development of the late adolescent must take into account the family developmental perspective. Within this view it is acknowledged that the family unit undergoes change as does its individual members and the influence on each (the unit and its members) is reciprocal. In particular, the interdependent processes of separating and maintaining intimacy in late adolescence must be examined within the context of the family. As stated above by Ackerman (1966), intimacy and separation form the cornerstone of the basic union between the individual and the family.

Clinical Views of Family Competence

Theorists, drawing conclusions from observations of clinical families, note certain characteristics of higher functioning families. Their theories, which were developed in the course of the treatment of dysfunctional families, will be discussed along the lines drawn by Walsh (1982; as outlined above in the section on family competence). Theories that view family normality along functional lines include the structural and strategic models. Insight-oriented theories include psychodynamic, Bowenian and experiential models.
As outlined by Walsh, insight-oriented theories view family competence in terms of optimal functioning with therapeutic goals moving beyond the amelioration of symptoms to individual and family growth in the process. Whitaker (Whitaker & Keith, 1981) characterizes the healthy family as well-integrated and flexible with separate parent and child generations. Whitaker finds that high levels of intimacy and separation go together as do autonomy and dependency. Positive and negative feelings can be expressed, although most family process is nonverbal. Emphasis in healthy families is on "becoming" over the course of the life cycle with the acknowledgement of "separating and uniting currents within subgroups...such as an adolescent's need to leave home..." (Metcoff & Whitaker, 1982, p.251). Satir (1972) focuses on process variables, observing in what she calls "vital and nurturing families" that "self-worth is high; communication is clear, direct, and honest; rules are flexible, human, appropriate, and subject to change; [and] the linking to society is open and hopeful" (p. 4). Bowen (1978) evaluates healthy family functioning according to his concept of the "differentiation of self" which implies that members are able to distinguish between thoughts and emotions, are confident that their judgments are worthy of acting upon, and can take responsibility for the outcomes of those actions. In a differentiated family, members are neither fused nor emotionally cut off from each other.
Instead members function in an autonomous and independent manner even in times of stress. The growth and health of each member are encouraged, but never at the expense of another family member.

According to Meissner (1978) the normal family strives to help children develop well-differentiated and individuated identities. He views the parents as the key to healthy family functioning and takes an object relations stance, stating that the success of the marital and parental relationships resides in what the individual parent brings from the family of origin in terms of introjects and internalized objects. If the marital relationship is organized around interactions between two well-differentiated and individuated individuals rather than around pathological projections, the couple should be successful in raising children with the same characteristics. Boszormenyi-Nagy's (1981) contextual approach also emphasizes the unconscious forces that operate in families. The more family members relate according to unconscious needs, the more unhealthy the family. Well-functioning families work toward high levels of trust which allow for autonomy in problem-solving, with members able to take into account the others' needs for growth and connection within the family. This autonomy can only occur when members are not bound by a "ledger" of unpaid intergenerational debts, either real or imagined. Lidz
(1976) also contends that structure and function are primary in the healthy family. He notes that spouses must form a parental coalition in regard to how the children will be raised regardless of other marital conflict; that spouses must form a generational boundary between themselves and the children which allows for the differentiation of children from parents; and parents must provide role models for children to emulate in their development of self-concept, self-esteem, and sex-linked role functions.

Structural and strategic models focus upon family structure and interactional patterns. Minuchin (1974), a structural theorist, states that families must have a "power hierarchy" between parents and children, with parents having more authority. The parental subsystem must operate in a complementary fashion with a boundary drawn between parental and child subsystems that also allows each access to the other across the parent-child subsystems. In well functioning families, boundaries are clear as opposed to rigid or diffuse. Minuchin states that normal families cannot be assessed by an absence of problems. He stresses that all families have problems that require compromises; however, well-functioning families possess the ability to utilize alternative modes of action when internal or external demands require change.

Strategic theorists also contend that all families, including competent families, have problems. The focus is
on how the family's problem-solving abilities maintain symptoms in family members, viewing the attempted solution as problem maintenance. Haley (1978) sees the competent family as one that can accomplish important goals while at the same time stating that there is no ideal for family normality. Each family defines normality for itself. In competent families the parents maintain a parental hierarchy and relate to each other as peers with power proportional to their roles. Dysfunction occurs when members form coalitions across hierarchies and then apply rigidly fixed patterns of behaviors in the search for symptom reduction. Structural and strategic family theories offer insight into how the parental coalition in competent families facilitates the late adolescents' strivings for intimacy and autonomy in the separation-individuation process. Haley (1979) has noted that the optimal family structure in late adolescence includes both clear interpersonal boundaries among its members and a stable marital alliance where parents, rather than forming cross-generational alliances with children, maintain appropriate hierarchical authority in the family. Minuchin and Fishman (1981) state "if there is any major dysfunction in the spouse subsystem, this will reverberate throughout the family" (p. 17); they further state that the parental subsystem must change as the needs of the children in the family change, concluding that "families with
adolescent children should negotiate differently from families with younger children" (p. 18).

**Review of the Research on Family Competence**

Family therapy, in theory and practice, has its roots in the treatment and study of troubled families. Over time, as the field of family therapy has developed, various theories have been posited about the nature of family functioning based on work with distressed families (Bowen, 1978; Haley, 1979; Minuchin, 1974; Satir, 1967, 1972). Thus, the notion of competent or healthy families is one that is often inferred from clinical populations rather than studied in its own right (Olson, 1988).

Often the assumption is that optimally functioning families share the same patterns of behavior seen among families seeking treatment (Green & Kolevzon, 1986; Walsh, 1982). Results from early empirical studies of healthy family functioning (Lewis, et al., 1976; Westley & Epstein, 1969) indicate that competent families, while differing in style, share qualities not observed in clinical families. Olson, Sprenkle, and Russell (1979) developed a circumplex model of family functioning, finding that healthy families have identifiable characteristics not found in less healthy families. Other models of optimal family functioning have been put forth (Barnhill, 1979; Epstein, Bishop, & Baldwin, 1982; Reiss, 1981); however, the empirical study of family competence is still in its infancy.
This study draws its assumptions about family competence from the Beavers Systems Model of family functioning (Beavers & Hampson, 1990) which has its original base in the Lewis et al. (1976) study of non-clinical families. This model posits that family functioning operates along a progressive continuum from healthy to severely dysfunctional families. According to Beavers and Hampson (1990), viewing family competence along a continuum allows for the assumption that all families have the potential for growth and adaptation. It is also compatible with other important and widely utilized family systems concepts such as Minuchin's structural concepts and Bowen's differentiation of the self (Beavers & Hampson, 1990).

Results from a nine year study of emotionally healthy versus non-healthy college students (Westley & Epstein, 1968) indicate that there are differences in family competence. Westley and Epstein's research question was "how does the family affect the emotional development and health of its members?" (p. 2). These authors conclude that "there are striking differences in the organization of the families of emotionally healthy and emotionally disturbed college students [and] the roots of these differences lie in the relationship between husband and wife" (pp. vi-vii). These authors identify five dimensions to the organization of the family: power, psychodynamics, roles, status, and work. Of importance to this discussion are the variables of
power and psychodynamics. They note that balance of power between spouses appears to be affected by the competence of the individuals. The category of psychodynamic organization refers to emotional relationships between members and has two main variables: problem solution and autonomy. Problem solution includes the ability to recognize and resolve emotional problems between members. Autonomy encompasses the "degree to which members of a family respect, permit, and encourage private and independent emotional lives in others. The authors state that this variable is particularly important for the growth of children.

Conclusions they draw regarding the kind of family organization that is most likely to produce emotionally healthy children include: balanced division of labor between spouses, respect of autonomy, strength in problem-solving, and spouses who accept both parental and conjugal roles.

In another extensive study of non-clinical families, Lewis et al. (1976) examined interactions among families containing at least one adolescent in order to identify optimal family functioning. Families were given a task and trained judges rated the families' videotaped behaviors along several dimensions. In addition to ratings along these dimensions, families were given a global health-pathology rating. Results showed that healthy families have a structure that is "clear and flexible, but carried lightly. Function is the greater concern" (p. 50). This
body of research identified five characteristics in healthy families that the authors consider important for the development of high functioning individuals.

The first characteristic identified is power structure and these authors found that the most successful families had a parental hierarchy with the father in the leadership position in a "viable coalition with the mother as the next most powerful person" (p. 56). Children accept this power hierarchy because they are allowed to contribute to and influence decisions in the family. The degree of family individuation was the second characteristic identified. This study found that the process of individuation is most advanced in healthy families with these families demonstrating the ability to interact in a relatively conflict-free, autonomous way and the ability to tolerate ambivalence.

The third characteristic is the acceptance of separation and loss. To quote these authors "a competent family self-destructs" (p. 67). The acceptance of separation is predicated on how well individuation has been completed. The perception of reality is the fourth characteristic. The healthy family's "myths" about itself concur with outsiders' perceptions of "reality" and there is an acceptance of the passage of time and the inevitability of change that it implies. Finally, family affect in healthy families is hopeful, warm, full of humor and
tenderness, with negative feelings expressed in a supportive fashion.

As noted in Lewis et al. (1976), family competence appears to be highly correlated with the strength of the marital dyad (Lewis, 1988; Green & Kolevzon, 1986). Research in this area supports the observations outlined above. Green and Kolevzon (1986) found significant and positive associations between individual parental maturity and family competence. Their results also indicate that the perceived quality of spousal relationships are predictive of family health. Other researchers have found that the effectiveness of the family unit in meeting the needs of its members is bound to the quality of the parental coalition (Beavers, 1977; Beavers & Hampson, 1990).

Olson (1988), in a cross-sectional study of non-clinical intact families, applied his Circumplex Model dimensions of cohesion and adaptability. Family cohesion lies on a horizontal plane and is a process variable having to do "with the degree to which an individual [is] separated from or connected to his or her family system" (p. 59). The dimension of adaptability falls on the vertical plane and focuses on the flexibility of the family system and its ability to change. He also examined communication between family members. Olson found that normal families operate in a balanced fashion, falling toward the center of the two dimensions. He stated that these families can experience
the extremes on each dimension; however, "they do not typically function at these extremes for long periods" (p. 62).

Olson stated that the Circumplex Model integrates systems theory and family development in a dynamic sense, noting that families must change as they move through normal family developmental transitions. In particular, he notes that "the theme of independence becomes more prominent as children approach adolescence" (p. 63). Olson reports that family cohesion is at its lowest when adolescents are leaving home, reflecting their attempts to differentiate themselves from their families. He found that both males and females in mid to late adolescence report significantly lower levels of cohesion than do either parent. The same is true of their view of family flexibility. Olson concludes that it may be necessary for the late adolescent to view the family as less cohesive and less flexible in order to accomplish the developmental task of differentiation from the family. Olson (1988) also examined family satisfaction and found that fathers’ satisfaction was lowest while adolescents are at home while mothers’ and both male and female adolescents’ satisfaction was lowest when adolescents are leaving home.

Epstein, Bishop, and Baldwin (1982) discussed their view of the normal family according to the McMaster Model of Family Functioning (MMFF) which evolved from studies of both
normal and clinical populations. These authors examined "structure, organization, and transactional patterns" (p. 18) in families along six dimensions: problem-solving, communication, roles, affective responsiveness, affective involvement, and behavior control. Of particular interest is the notion of problem solving. According to these authors "family problem solving refers to a family's ability to resolve problems to a level that maintains effective family functioning" (p. 19). Families deal with two types of problems: instrumental or basic survival functions and affective or emotions and feelings. These authors posit that competent families deal with both types of problems effectively, while problematic families do not. They further stated that families that cannot solve functional problems rarely solve affective ones.

The Beavers Systems Model

Beavers (1977) offers a process model of family competence based on the observation and analysis of the forms of negotiations and other family transactions initially observed in the Lewis et al. (1976) study of competent families. The Beavers Systems Model (Beavers & Hampson, 1990) has its roots in this seminal work and subsequent research comparing clinical and non-clinical families. Results from studies utilizing instruments from the model indicate that a number of variables account for the relative health of a given family and that families can
be ordered along a continuum of health-pathology. These authors found that the quality of the parental coalition is the key to the establishment of the level of family functioning. This coalition provides both family leadership and the model for how interpersonal relationships transpire. The ability of the family to communicate thoughts and feelings is also found to be of importance in identifying the level of family functioning.

The four principal characteristics of this model according to Beavers and Hampson (1990) are as follows. 
(1) Family functioning can be described as falling along a continuum, rather than falling into discrete types. 
(2) Because competence in small tasks has been shown to be closely correlated with competence with larger family tasks (Lewis, et al., 1976), this model provides for a measure of competence within an entire family. 
(3) Families have different styles of functioning that are unrelated to competence. 
(4) Finally, the model is compatible with other clinical concepts of family functioning such as Bowen’s differentiation of self and Minuchin’s structural properties of family hierarchy.

Family health/competence is globally defined by examining how well the family accomplishes the following tasks: "providing support and nurturance, establishing effective generational boundaries and leadership, promoting the developmental separation and autonomy of its offspring,
negotiating conflict, and communicating effectively" (Beavers & Hampson, 1990, p. 14). These authors have found that while there are differences among families in performance of these tasks, families are not extremely competent in one or more areas and then extremely dysfunctional in others. "Hence, the concept of a global competence rating to capture the common denominator of combined qualities of the system takes on important clinical relevance" (Beavers & Hampson, 1990, p. 14).

There are currently two forms of assessing families in the Beavers System. One utilizes a revision of the original trained observer rating scales from the 1976 Lewis et al. research. Observers utilize two instruments, the Beavers Interactional Scales: Family Competence and The Beavers Interactional Scales: Family Style. Family members are asked to negotiate a task together and trained observers rate performance on a continuum of functioning for each item. The second method to assess families is the Self-Report Family Inventory (SFI) which has been developed to tap the same underlying family interactions as measured on the observer rating scales. The SFI assesses the individual family member's view of family competence. Comparisons of the SFI and the Family Competence scale will be discussed later.

The assessment of family competence falls into five categories of continuous data. These categories are
structure of the family, mythology, goal-directed negotiation, autonomy, and family affect. Three concepts are thought to be important in examining the structure of the family: overt power, the parental coalition, and closeness. Overt power is thought to be anchored by chaos at one end and egalitarian at the other. Families ruled by chaos appear to be leaderless although often this chaos is "actually rigid and stereotyped" (Beavers & Hampson, 1990). At the egalitarian level, parents are co-leaders and make decisions through negotiation, with flexibility and adaptability more the rule.

Parental coalition is examined on a continuum from parent-child coalition through weak parental coalition to strong parental coalition on the healthy end. Where there is a strong parental coalition, the parents evidence respect for each other and operate with a unified front. Parent-child boundaries are clear and conflicts are typically handled within the spousal unit without inappropriately involving children. Closeness examines boundaries within families and is based on the assumption that in order for family members to experience intimacy, each must have a sense of personal identity and that his or her uniqueness is valued in the family. Indistinct and vague boundaries are at one end of the continuum and closeness with distinct boundaries lie at the opposite end. In competent families, distinct boundaries allow for spontaneity and a lack of
defensiveness as family members are understood and accepted as individuals.

Mythology is a concept that has to do with the family's perception of how it functions and how it appears to the outside world. Mythology is rated along a continuum from very congruent to very incongruent with raters assessing the congruence between action and description. Goal-directed negotiation is examined along a continuum of extremely efficient to extremely inefficient. How task oriented and who participates in the task are keys to this rating. In competent families negotiation or active participation in the process occurs rather than compromise, where someone invariably "gives in."

Autonomy has three dimensions: clarity of expression, responsibility, and permeability. The concept of clarity of expression involves the degree to which members are allowed to express thoughts and feelings freely, how these communications are received and how the family deals with inherent ambivalence or the expression of mixed feelings. Competent families assist each other in helping members clarify ambivalent feelings through empathic responses. Verbal communication is clear and direct and the expression of feelings is promoted. Responsibility examines the degree to which members take personal responsibility for their actions. An underlying premise is the acknowledgement by the family that individuals make mistakes and members are
not punished when acknowledging those mistakes. In competent families, personal responsibility is the rule and there is a relative absence of blaming or distortion of the facts. Permeability involves the degree to which members are receptive to statements by other members. Members in competent families acknowledge the statements of other members both verbally and nonverbally in a congruent, receptive manner.

Family affect is comprised of four dimensions: range of feelings, mood and tone, unresolvable conflict, and empathy. Range of feelings examines the spectrum of expressed emotions with more competent families evidencing a wider range of affect. Mood and tone are characterized by both the sense optimism or pessimism and the overall mood of the family unit. In optimal families there is humor, optimism and spontaneity. Family members appear to enjoy and like each other. Unresolvable conflict acknowledges that all families experience conflict and families are rated on how well they negotiate conflict and on the impact of its style of negotiation on family functioning over time. In competent families, "when differences are incompatible or irreconcilable, they are usually viewed as individual perspectives rather than evidence of evil, chronic discontent, or mutiny" (p. 29). Finally, empathy in a family is assessed according to how well members respond to each other in a receptive and understanding way with
responses congruent to the emotional tone in which the original message is delivered.

In addition to the above scales, raters assign an overall global health-pathology rating to the family which should roughly coincide with the overall mean of the other subscales. Beavers & Hampson have found that families all have areas of greater or lesser competence, with very few families falling at either extreme (extremely optimal or dysfunctional). Families are then classified into one of five categories: optimal, adequate, midrange, borderline, and dysfunctional. These researchers conclude that optimally competent families, while the ideal, are not the norm. Other results indicate that clinical families will generally score in the low to midrange, borderline, and dysfunctional levels.

Family style is another important dimension in the Beavers Model. Borrowing from Erikson (1963), centripetal (CP) and centrifugal (CF) are systemic terms utilized to describe two distinct relational styles evidenced by all families. The boundary between the CP family and the outside world is less permeable and more containing, with the pressure on family members to look inside the family for satisfaction, "whether they find it there or not" (Beavers & Hampson, 1990, p. 35). In contrast, the CF family boundary is more tenuous and members look outside the family for satisfaction, whether they find it there or not as quoted
above. Competent families are able to shift styles according to the needs of their members. A CP style is more adaptive in families with small children where nurturance and dependence are necessary. As children reach adolescence, the competent family will shift to a mixed or CF style which allows children to be "released progressively to the outside world" (Beavers & Hampson, 1990, p. 36). A family is less competent when it maintains a rigid style, losing critical flexibility to meet individual and systemic needs. Currently, family style can only be adequately assessed by the observer rating scales. Work on the self-report measure is ongoing at present.

The SFI was developed in 1983 by Beavers and his colleagues (Beavers, Hampson, & Hulgus, 1985) in order to assess family members' views of family functioning. The majority of research studies in this area employs self-report inventories. Thus, the SFI was developed to both facilitate comparisons with other theoretical models and to contribute a measure of family competence to the field (Beavers & Hampson, 1990). In addition, as Olson (1985) has noted, "we can assume to find greater congruence across theoretical models if they use a similar methodology, i.e., self-report or behavioral tasks. Conversely, we can assume little congruence across theoretical models using different methodological approaches" (p. 204).
The SFI is based on the empirical data gathered over the years from the Beavers Interactional Scale: Family Competence. It is not a direct translation of the observer scales. Rather it was developed independently with items selected with an eye toward language family members might use to describe their family. There are five factors tapped by the SFI: health/competence, conflict, cohesion, leadership, and emotional expressiveness.

Health/competence is the primary scale and corresponds with the global competence ratings from the observational scales. "The themes addressed in this scale are those of happiness, optimism, problem-solving and negotiation skills, family love, strength of parental (or adult) coalitions without supplanting parent-child coalitions, autonomy/individuality emphasis, and minimal blaming/increased responsibility patterns" (Beavers & Hampson, 1990, p. 59). The other four scales are related to competence. Low Conflict scores are indicative of "low levels of overt unresolved conflict, fighting, blaming, and arguing, with higher levels of negotiation and acceptance of personal responsibility in solving conflicts" (Beavers & Hampson, 1990, p. 59). Cohesion measures family style with items involving "satisfaction and happiness through togetherness and emphasis on family closeness" (Beavers & Hampson, 1990, p. 59). Leadership examines adult leadership in the family with more competent families having higher
scores. Emotional Expressiveness in competent families is characterized by "perceptions of feelings of closeness, physical and verbal expressions of positive feelings, and the ease with which warmth and caring are expressed by family members" (Beavers & Hampson, 1990, p. 59).

The Beavers model has been selected as the basis for this study because it views families along a continuum of competence with the opportunities for optimal functioning, at least theoretically, available to most families. This model is a process model that also utilizes important concepts from both the clinical and empirical theories in such a way as to incorporate the most important aspects of competent families. It allows examination of family functioning along important dimensions outlined above while also allowing for the incorporation of both structural and psychodynamic tenets of other pertinent theories.

There appears to be a dearth of research in the area of family competence as a whole, i.e., what constitutes a healthy family. Likewise, there appears to be even less research about the effects that growing up in a healthy family may have on individual members. Because adolescence is a period of change and separation for all family members, this study will explore the effects of family competence on several variables as they affect the late adolescent. The model of family competence used will be based on the Beavers Systems Model of family functioning. Specifically, it is
hypothesized that family competence should have a direct impact on the late adolescent's problem-solving abilities, family relationships, and the presence or absence of depression.

Purpose of the Study

This study will examine the construct of family competence as it relates to the individual functioning of late adolescents in selected cognitive, affective, and interpersonal areas. It is hypothesized that adolescents from competent families will look quite different than adolescents from less competent families. The cognitive variable to be examined is personal problem-solving ability. The affective variable is depression, and the interpersonal variables are intergenerational intimacy, intergenerational individuation, and personal authority in the family system. Theory would suggest that late adolescents from competent families would function more competently in these areas than would individuals from less competent families. Specifically, individuals should have better problem solving skills, less depression, and greater degrees of intimacy and autonomy within their families of origin.

The ability to solve problems well affects individuals in their day-to-day functioning throughout their lives. It stands to reason that adolescents from more competent families would have better developed abilities to solve their problems and would appraise such abilities
accordingly. Heppner and Petersen (1982) identify three major components of personal problem-solving: confidence in one's problem-solving ability, either an approach or avoidance style, and personal control. These authors note that confidence in one's problem-solving ability and personal control appear to be related to Rotter's (1978) notion that the important problem-solving attitude is the expectancy that an individual has an effect on what occurs to him- or herself. In addition, their second construct of approach-avoidance style appears related to Rotter's (1978) observation that active awareness of alternatives is a functional problem-solving attitude. According to Heppner and Petersen (1982), better problem-solvers include those who express a belief in their ability to control part of their environment, systematically utilize several problem-solving behaviors rather than acting impulsively or avoiding the problem, and have "more strategies to control their behavior and seem(ed) to be more deliberate in the process" (p. 72).

Drawing from the previous literature review, the family's ability to recognize and solve problems is a crucial element associated with family competence. Individuals from competent families seemingly grow up having effective problem-solving modeled for them; because of this, they would be more apt to learn and see themselves as
possessing the abilities to solve their individual difficulties.

The affective variable of interest is depression. Depression is thought to strike from 4% to 8% of the general population at some point in their lives (Weisman & Boyd, 1983) and the effects can be debilitating. In addition, it has been estimated that approximately 25% of college students are depressed (Beck & Young, 1978). While the causes of depression in college students are probably multi-determined, research has found depression to be a symptom in students with family problems. Often at the root of difficult family relations is the fact that the adolescent is separating from family and gaining adult independence. Competent or healthy families will assist the late adolescent in this developmental task, easing the individual into the transition to young adulthood (Terkelson, 1980).

Adolescents leaving families with poor parent-child boundaries, with parent-child role-reversals or coalitions, or with marital discord are more at risk for depression (Haley, 1979; Lopez, 1986). Lopez, Campbell, and Watkins (1989) found that depressed college students report poorer marital and parental cohesion and adaptability and more marital conflict, parent-child role reversals and overinvolvement than did non-depressed subjects. These students also expressed a greater fear of separation from parents than did non-depressed students, perceiving their
attachments to their parents as conflicted. Given that competent families better accept separation and loss and that their boundaries and hierarchies are clear, it is hypothesized that individuals from competent families will score lower on depression than those individuals from less competent families where roles are less clear and leave-taking is therefore more threatening to the structure of the family.

The interpersonal variables of interest in this study are intergenerational intimacy, intergenerational individuation, and personal authority in the family. Once again these variables are related to family relationships, parental ones in particular. These constructs are taken from the work of Williamson (1981) and Bray, Williamson, and Malone (1984). Intergenerational intimacy "is viewed as the expression of mutual respect, self-disclosure, love, and commitment, while maintaining clear boundaries to the self" (Bray & Harvey, 1987, p. 3). Intergenerational individuation encompasses not only separation -individuation on the level of the individual, but the systems property of differentiation of self as defined by Bowen (1978) and discussed earlier in this chapter. Personal authority "is a synthesis of intimacy and differentiation in relationships, with the ability to relate to all other human beings, including one's parents, as peers in the fundamental experience of being human" (Bray & Harvey, 1987, pp. 2-3).
It is the contention of these authors that while personal authority cannot really be achieved in its entirety until later in life, "the developmental precursors leading to this stage begin in the individuation process of adolescence and young adulthood" (p. 3). These three concepts are intimately bound to family competency as none can be achieved in a dysfunctional family system.

In summary, this study seeks to examine how family competence affects the functioning of late adolescents in several important areas of functioning. The specific research questions are as follows:

1. Will late adolescents from more competent families have better problem-solving skills? Specifically, will they have a self-perception of problem-solving confidence?
2. Will they approach rather than avoid problems?
3. Will they score in the lower ranges on the depression inventory?
4. Will they evidence more intergenerational intimacy with parents?
5. Will they evidence more intergenerational individuation with parents?
6. Will they operate with more personal authority in relation to their parents?
CHAPTER II

METHOD

Subjects

A total of 256 undergraduate students enrolled in psychology courses at the University of North Texas were surveyed. The sample consisted of 147 females and 109 males who met the following criteria: a) were ages 17 through 21; b) were enrolled in an undergraduate psychology course; and c) whose biological parents were still married and living together. A total of 329 questionnaire packets were distributed of which 256 were usable. The mean age for the sample was 19.9 years (SD=1.104). The ethnic breakdown of subjects was as follows: Caucasian, 77%; Black, 9%; Hispanic, 5.9%; Native American, 2.3%; Asian, 3.9%; and Other, 2%.

Design

To explore the relationship of family competence to the six dependent variables, separate 2(SFI: high versus low) X 2(Gender: male versus female) ANOVAs were conducted on the following scales: Intergenerational Intimacy, Intergenerational Individuation, Personal Authority, Problem-Solving Confidence, Approach-Avoidance Style, and Beck Depression Inventory. Subjects were grouped into high
(top 50%) and low (bottom 50%) groups based on a median split according to self-perceived family competence, which was assessed by their score on the Family Health/Competence scale of the SFI. The group containing the high scorers is the high family competence group (HFC) and the group with the low scorers is the low family competence (LFC) group. A post hoc Newman Kuels was conducted on the sex by high/low family competence interaction on Personal Authority.

**Independent Variable**

**Self-Report Family Inventory** (SFI) (Beavers, Hampson, & Hulgus, 1990; see Appendix A). The SFI consists of 36 5-point Likert items that assess individuals' perceptions of their families according to 5 factors: Family Health/Competence, Conflict, Family Cohesion, Directive Leadership, and Expressiveness. The Family Health/Competence scale will be used in this study to determine the competency of the each subject's family of origin. Nineteen items load on this factor. Low scores indicate more family competence. Cronbach's Alpha has been utilized to calculate internal consistency for the SFI with reliability coefficients ranging from .84 to .88. Test-retest reliability has been assessed over 30- and 90-day periods with coefficients ranging from .84 to .87 on the Family Health scale. Criterion validity indicates that the Family Health factor on the SFI is able to distinguish between previously rated high and low functioning families.
(Beavers, Hampson, & Hulgus, 1985). Other validity data
indicate that (a) the SFI is moderately related to the
Beaver's System's observational ratings of Competence and
Style ($R = .62$) with differing correlations for different
family members, (b) that more competent families evidence a
greater variety of views than do clinical families, (c)
there is no significant relationship between social
desirability and responses to the SFI, (d) marital
satisfaction is significantly related to the factors on the
SFI, and (e) the SFI shows good convergence with other
measures of family functioning (Beavers, Hampson, & Hulgus,
1990).

**Dependent Variables**

**Personal Authority in the Family System Questionnaire—
Version C** (PAFS-QVC) (Williamson, Bray, Harvey, & Malone,
1985; see Appendix B). The PAFS-QVC is an 84-item
instrument utilizing a 5-point Likert format to measure
family processes within a two generational family system.
Seven factors have been identified: Intergenerational
Intimacy, Intergenerational Individuation, Personal
Authority, Intergenerational Intimidation, Intergenerational
Triangulation, Peer Intimacy, and Peer Individuation with
higher scores indicating higher levels of a factor. To
assess subjects' relationships to parents, this study will
examine scores on three factors: Intergenerational Intimacy
(II), Intergenerational Individuation (IIInd), and Personal
Authority (PA). Twenty-three items loaded on II, 8 on Iind and 11 on PA. For each scale, high scores indicate more of the variable. Bray and Harvey (1987) found their theoretical scales to be reliable with confirmatory factor analysis supporting these findings. Concurrent validity was established between the PAFS-QVC and seven measures of psychological adjustment and family relationships. Statistically significant correlations have been in the expected directions. The PAFS-QVC has been found to discriminate between a clinical and non-clinical sample on all but one scale (which is not pertinent to this study).

The Problem Solving Inventory (PSI) (Heppner & Anderson, 1982; see Appendix C). The PSI is a 32-item instrument utilizing a 6-point Likert format to ascertain one's self-appraisal of their personal problem-solving behaviors and attitudes. Low scores indicate self-perceptions of problem-solving confidence, personal control, and a tendency to approach (rather than avoid) personal problems. Using factor analysis, these authors have identified three constructs: problem solving confidence, approach-avoidance style, and personal control. The problem solving scale and the approach-avoidance style scale will be used in this study. Estimates of reliability range for the PSI from .72 to .90 (N= 150), indicating that the constructs are internally consistent. Test-retest reliability coefficients of .83 to .89 (N= 31) were stable over a 2-week
period (Heppner & Anderson, 1982). Validity estimates indicate that the PSI is measuring constructs that are "(a) related to general self-perceptions of problem-solving skills (Heppner & Petersen, 1982), (b) related to personality variables, most notably an internal locus of control (Heppner & Petersen, 1982), (c) related to the number of personal problems acknowledged on the Mooney Problem Checklist (Heppner, Hibel, Neal, Weinstein, & Rabinowitz, 1982), (d) related to a number of expectations, intervention strategies, attitudes, and behaviors within the problem-solving process (Heppner, et al., 1982), (e) related to the severity of short- and long-term depression (Heppner, Baumgardner, & Jackson, 1985), (f) unrelated to conceptualizing the means to solve a hypothetical problem situation (Heppner & Petersen, 1982), and (g) unrelated to intelligence or social desirability (DeClue, 1983; Heppner & Petersen, 1982)" (Heppner & Anderson, 1985, p. 418).

Beck Depression Inventory (BDI) (Beck, 1972; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; see Appendix D). The BDI is a 21 item self-report measure of depression. Higher scores are indicative of greater levels of depression. The BDI is a widely used instrument with a great number of reliability and validity estimates. Beck, Steer, & Garbin (1988) in a 25-year evaluation of the BDI report reliability and validity information for both psychiatric and nonpsychiatric populations. Unless
otherwise noted, the coefficients reported here are for nonpsychiatric populations. Reliability coefficients regarding internal consistency had a range of .73 to .92, with a mean coefficient alpha of .86. Stability coefficients are more stable for nonpsychiatric as compared to psychiatric populations with coefficients ranging from .60 to .83. Beck, Steer, and Garbin (1988) examined content, concurrent, discriminant, construct, and factorial validity. Moran and Lambert (1983) compared BDI criteria to the Diagnostic & Statistical Manual of Mental Disorders (3rd Ed., [DSM-III], 1980) and concluded that the BDI reflects six of nine criteria in the DSM-III for depression. The mean Pearson Product Moment Correlation between the BDI and five clinical ratings for nonclinical samples was .60. Research indicates that the BDI discriminates between psychiatric and nonpsychiatric populations; however, it does not discriminate well among types of depressive disorders. Construct validity has been established in several areas and factorial studies (Clark, Cavanaugh, & Gibbons, 1983; Clark, Gibbons, Fawcett, Aagesen, & Sellers, 1985; Tanaka & Huba, 1984) indicate that the BDI represents one underlying general syndrome of depression.

Procedure
Subjects were solicited from undergraduate introductory psychology classes. To best insure that this study addressed the late adolescent years, only college students
ages 17 through 21 were used as participants. Furthermore, only students from intact families (parents have never divorced) were be used. This restriction was employed to eliminate possible confounding due to alternate family structures (e.g., reconstituted families). Efforts were made to get equal numbers of males and females to participate.

The nature of the study was verbally outlined by the experimenter. Those willing to participate were given instrument packets which contained information concerning the nature of the study, a written consent form outlining their rights as participants (see Appendix E), a demographic data sheet (see Appendix F), and the SFI, PAFS-QVC, PSI, and BDI. Those who participated received extra credit for the course. To guard against any order effects, the SFI, PAFS-QVC, PSI, and BDI were randomly ordered throughout the instrument packets.

**Hypotheses**

The following six experimental hypotheses were explored:

**Hypothesis one.** High FC participants, when compared with low FC participants, will have higher self-perceptions of problem-solving confidence (as measured by scores on the Problem-Solving Confidence scale of the PSI).

**Hypothesis two.** High FC participants, when compared with low FC participants, will have approach problem-solving
styles (as measured by scores on the Approach-Avoidance Style scale of the PSI).

**Hypothesis three.** High FC participants, when compared with low FC participants, will function in a more individuated manner from their parents (as measured by the IInd scale of the PAFS-QVC).

**Hypothesis four.** High FC participants, when compared with low FC participants, will function in a more intimate manner with their parents (as measured by the II scale of the PAFS-QVC).

**Hypothesis five.** High FC participants, when compared with low FC participants, will function with more personal authority in relation to their parents (as measured by the PA scale of the PAFS-QVC).

**Hypothesis six.** High FC participants, when compared with low FC participants, will tend to be less depressed (as measured by the total score on the BDI).
One independent measure and six dependent measures were used in the present study. Separate 2(SFI: high/low) x 2(Gender: male/female) ANOVAS were computed for each dependent variable. Intercorrelations were run on the dependent variables; these are provided in Table 1. Table 2 presents the means and standard deviations for dependent measures by family competence level and sex. Table 3 presents the means and standard deviations for high and low FC groups. Table 4 presents means and standard deviations by sex. The median split procedure was employed to obtain the high and low scoring groups on family competence (median = 41.0). Median splits were then made for both males (median = 43.0) and females (median = 39.0) by FC to ensure the ratio of males to females was approximately the same in both the high and low FC groups.

Major Findings

Hypothesis one, that self-perceived HFC participants when compared with self-perceived LFC participants would have higher self-perceptions of problem-solving confidence, was supported. Specifically, the data showed that individuals in the HFC group demonstrated higher confidence
Table 1

Intercorrelations Among the Dependent Variables

<table>
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<tr>
<th>Variable</th>
<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<td>1. BDI</td>
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<td>.41*</td>
<td>-.40*</td>
<td>-.53*</td>
<td>-.38*</td>
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<td>-.32*</td>
<td>-.39*</td>
<td>-.34*</td>
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</tr>
<tr>
<td>3. AAS</td>
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<td>-.23</td>
<td>-.29</td>
<td>-.30*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. II</td>
<td>1.00</td>
<td>.68*</td>
<td>.56</td>
<td></td>
<td></td>
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<tr>
<td>5. IIND</td>
<td></td>
<td>1.00</td>
<td>.38*</td>
<td></td>
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<tr>
<td>6. PA</td>
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<td>1.00</td>
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</table>

*Note. BDI = Beck Depression Inventory; PSC = Problem-Solving Confidence; AAS = Approach Avoidance Style; II = Intergenerational Intimacy; IIND = Intergenerational Individuation; PA = Personal Authority (N = 256). *p < .01.

in problem-solving than individuals in the LFC group, $F(1, 1122.984) = 19.318, p < .001$. The main effect for sex was not significant, $F(1, 1.764) = .030, p > .05$. The sex by FC interaction was not significant, $F(1, 167.261) = 2.877, p > .05$.

Hypothesis two, that self-perceived HFC participants when compared with self-perceived LFC participants would have approach problem-solving styles, was supported. The data indicated that individuals in the HFC group had higher
Table 2

Means and SDs for the Dependent Variables by Family Competence Level and Sex

| Dependent Variables | High Family Competence | | Low Family Competence | | |
|---------------------|-------------------------|-------------------------|-------------------------|-------------------------|
|                     | M          | SD | M          | SD | M          | SD | M          | SD |
| AAS                 | 44.311     | 12.022 | 38.532     | 11.407 | 47.463     | 11.878 | 46.233     | 11.198 |
| IIIND               | 32.604     | 4.993 | 33.459     | 4.314 | 27.750     | 6.043 | 27.441     | 5.573 |
| PA                  | 43.979     | 6.651 | 49.189     | 6.852 | 40.357     | 7.139 | 41.882     | 6.056 |

Note. Score Ranges: Problem-Solving Confidence (PSC) = 11-66, low scores = more confidence; Approach Avoidance Style (AAS) = 16-96, low scores = approach style; Intergenerational Intimacy (II) = 13-115, high scores = more intimacy; Intergenerational Individual (IIIND) = 8-40, high scores = more individuation; Personal Authority (PA) = 18-63, high scores = more personal authority; Beck Depression Inventory (BDI) = 0-63, low scores = less depression.
Table 3
Means and SDs for High and Low Family Competence

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<thead>
<tr>
<th>Dependent Variable</th>
<th>High Family Competence</th>
<th>Low Family Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>PSC</td>
<td>23.280</td>
<td>6.597</td>
</tr>
<tr>
<td>AAS</td>
<td>40.963</td>
<td>11.962</td>
</tr>
<tr>
<td>II</td>
<td>99.972</td>
<td>10.530</td>
</tr>
<tr>
<td>IIND</td>
<td>33.123</td>
<td>4.592</td>
</tr>
<tr>
<td>PA</td>
<td>47.139</td>
<td>7.214</td>
</tr>
<tr>
<td>BDI</td>
<td>4.430</td>
<td>4.234</td>
</tr>
</tbody>
</table>

Note. Score Ranges: Problem-Solving Confidence (PSC) = 11-66, Low scores = more confidence; Approach Avoidance Style (AAS) = 16-96, low scores = approach style; Intergenerational Intimacy (II) = 13-115, high scores = more intimacy; Intergenerational Individuation (IIND) = 8-40, high scores = more individuation; Personal Authority (PA) = 18-63, high scores = more personal authority; Beck Depression Inventory (BDI) = 0-63, low scores = less depression.
Table 4
Means and SDs for the Dependent Variables by Sex

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Means</td>
<td>SD</td>
<td>Means</td>
<td>SD</td>
</tr>
<tr>
<td>PSC</td>
<td>25.848</td>
<td>8.067</td>
<td>25.426</td>
<td>7.888</td>
</tr>
<tr>
<td>AAS</td>
<td>46.030</td>
<td>11.987</td>
<td>42.320</td>
<td>11.903</td>
</tr>
<tr>
<td>II</td>
<td>87.232</td>
<td>14.930</td>
<td>93.541</td>
<td>15.375</td>
</tr>
<tr>
<td>IIND</td>
<td>29.741</td>
<td>6.185</td>
<td>30.558</td>
<td>5.734</td>
</tr>
<tr>
<td>PA</td>
<td>41.889</td>
<td>7.048</td>
<td>45.592</td>
<td>7.350</td>
</tr>
<tr>
<td>BDI</td>
<td>6.838</td>
<td>6.404</td>
<td>7.139</td>
<td>7.330</td>
</tr>
</tbody>
</table>

Note. Score Ranges: Problem-Solving Confidence (PSC) = 11-66, low scores = more confidence; Approach Avoidance Style (AAS) = 16-96, low scores = approach style; Intergenerational Intimacy (II) = 13-115, high scores = more intimacy; Intergenerational Individuation (IIND) = 8-40, high scores = more individuation; Personal Authority (PA) = 18-63, high scores = more personal authority; Beck Depression Inventory (BDI) = 0-63, low scores = less depression.

Individuals in the LFC group, $F(1, 1770.772) = 13.172, p < .001$. There was a significant main effect for sex, with females reporting more approach to problem-solving, $F(1, 632.312) = 4.703, p > .05$. 
The interaction was not a significant, $F(1,281.431) = 2.093$, $p > .05$.

Hypothesis three, that self-perceived HFC participants when compared to self-perceived LFC participants would function in a more individuated manner from their parents, was supported. The data showed that participants in the HFC group had more individuation from parents than participants in the LFC group, $F(1, 1872.262) = 68.451$, $p < .001$. The main effect for sex was not significant, $F(1, 3.973) = .145$, $p > .05$; the sex by FC interaction was not significant, $F(1, 20.254) = .740$, $p > .05$.

Hypothesis four, that individuals in the self-perceived HFC group when compared to the self-perceived LFC group would function in a more intimate manner with parents, was supported. Specifically, individuals in the HFC group scored higher on intimacy with parents than individuals in the LFC group, $F(1, 11533.582) = 132.55$, $p < .001$. There was a significant main effect for sex, with females reporting more intimacy with parents than males, $F(1, 680.983) = 14.39$, $p < .001$. The sex by FC interaction was not significant, $F(1, 295.041) = 2.05$, $p > .05$.

Hypothesis five, that self-perceived HFC participants when compared with self-perceived LFC participants would function with more personal authority in relation to parents, was supported. The data indicated that individuals in the HFC group showed higher personal authority in
relation to parents than individuals in the LFC group, $F(1, 2028.106) = 45.587, p < .001$. There was a significant main effect for sex with females showing more personal authority in relation to parents, $F(1, 658.812) = 14.809, p < .001$. There also was a significant interaction between FC and sex, $F(1, 202.927) = 4.561, p < .034$, (see Figure 1). A post hoc Cicchetti was conducted to determine where significant differences were between and among high and low groups. There was a significant difference ($p < .05$) for the HFC group, with females ($M = 49.19$) scoring higher than males ($M = 43.98$). In addition, both HFC males and females scored significantly higher ($p < .05$) than males ($M = 0.36$) and females ($M = 41.88$) in the LFC group. There was not a significant difference between males and females in the LFC group.

Hypothesis six, that self-perceived HFC participants when compared to self-perceived LFC participants would be less depressed, was supported. The data showed that individuals in the HFC group were less depressed than individuals in the LFC group, $F(1, 1387.760) = 33.005, p < .001$. There was no significant main effect for sex, $F(1, 17.729) = .422, p > .05$. Neither was there an interaction of sex by FC on this variable, $F(1, 8.148) = .194, p > .05$. 
Figure 1. Personal Authority Scores by Level of Family Competence and Sex.

Note. High scores = more personal authority.
CHAPTER IV

DISCUSSION

Discussion of Main Effects

The present study was designed to explore the effects of perceived family competence on certain cognitive, affective, and interpersonal variables. Variables of problem-solving, familial relationships, and lack of depression were selected because theory suggests that these are important components of competent families and, therefore, might have an effect on the functioning of late adolescents. The major finding of this study is that significant differences were found between the self-perceived high family competence (HFC) and self-perceived low family competence (LFC) groups on the six dependent variables. Results will be discussed according to theory regarding competent families outlined in the literature review above.

Results from this study indicate a significant main effect for perceived family competence on problem-solving confidence. A conclusion drawn from a previous study (Heppner & Anderson, 1985) was that for each scale of the PSI, effective problem-solvers appeared to be better psychologically adjusted. Since an underlying assumption of
this study is that competent families produce competent individuals, the following results may be interpreted with that in mind. Individuals from self-perceived competent families expressed greater perceived confidence in their problem-solving than those from self-perceived low competent families. This finding fits with the notion that competent families model good problem-solving skills (Beavers & Hampson, 1990; Epstein, Bishop, & Baldwin, 1982; Haley, 1978). In addition, competent families are optimistic, support the autonomy of members, and model the acceptance of responsibility for decisions (Beavers & Hampson, 1990), characteristics which might also contribute to confidence in problem-solving. If one has learned how to solve problems in the family of origin, then it should follow that one would express confidence in the ability to solve problems. A possibility to consider is that individuals from high competent families may have had an opportunity not afforded those from low competent families: the chance to observe proficiency in problem-solving modeled in the family on an ongoing basis. Support for this conjecture may be found in the Heppner et al. (1982) study that persons with high problem-solving skills are more likely to learn those skills by observing others.

The finding that individuals from self-perceived HFC families were high on intergenerational individuation also fits with theory. Intergenerational individuation
encompasses both the individual task of psychological separation from parents and the family systems property of separation, where members are neither emotionally fused nor emotionally cut-off from one another. Competent families acknowledge that separation from parents is a goal of child-rearing and there is an emphasis on autonomy and individuality in these families (Beavers & Hampson, 1990; Lewis et al., 1976). It is possible that these qualities in self-perceived high competent families afford those adolescents the opportunity to develop their sense of individuality, an opportunity which may not exist in self-perceived low competent families. It is likely that the acknowledgement of separation and encouragement of autonomy in HFC families has an important influence on the development of the ability to successfully leave home. In addition, according to Bray and Harvey, (1987), individuals high on intergenerational individuation possess a sense of autonomy that enables them engage in relationships by choice and accept responsibility for themselves within those relationships. It is possible that the emphasis on development of autonomy in HFC families allows individuals to acquire the characteristic of intergenerational individuation.

A significant main effect was also found for perceived family competence on the variable of depression. Previous research has indicated that late adolescents from families
with poor parent-child boundaries and/or marital discord are more at risk for depression (Lopez, 1986; Lopez, Campbell, & Watkins, 1989; Haley, 1979). Competent families are characterized by appropriate parent-child boundaries (Beavers & Hampson, 1990; Haley, 1978; Minuchin, 1976), minimal blaming (Beavers & Hampson, 1990), and assisting children in leaving home (Beavers & Hampson, 1990; Lewis et al., 1976). Perhaps, these are characteristics in self-perceived high competent families which may create a buffer against the development of depression. It could be that these adolescents are better prepared to cope with life experiences and thus, are at less risk for depression. With regard to parent-child boundaries, it may be that the inverse of the link between depression and poor parent-child boundaries noted above holds. Specifically, competent families are characterized by appropriate boundaries between parent and child which may partially account for the finding that HFC individuals had less depression than LFC individuals.

A significant main effect for perceived family competence was found for perceived approach-avoidance problem-solving style. As with perceived problem-solving confidence, it would seem that these characteristics of competent families—the opportunity to observe the family of origin model 1) good problem-solving skills, 2) the acceptance of responsibility for one’s decisions, and 3)
autonomous functioning within an optimistic family environment (Beavers & Hampson, 1990), would engender the ability to approach one's problems. Again, it may be these are characteristics of self-perceived HFC families not found in self-perceived LFC families that make a difference for late adolescents in their perceptions of approach problem-solving style.

A significant main effect was found on intergenerational intimacy for HFC individuals. Intergenerational intimacy is described as "voluntary closeness with distinct boundaries to the self" (Bray & Harvey, 1987). As mentioned above, competent families are characterized by appropriate boundaries, they nurture and support each other, and are distinguished by happiness and family love (Beavers & Hampson, 1990) which may account for the significant main effect for intimacy with parents. It could be that adolescents from self-perceived HFC families have more opportunities to observe these characteristics and incorporate them into their sense of identity than do individuals from self-perceived LFC families. Thus, the experience of nurturance in HFC families may engender this sense of closeness.

A significant main effect for sex was found on intergenerational intimacy with females reporting more intimacy with parents than males. This finding follows female developmental theory in that women develop in
relation to others more so than do men (Gilligan, 1982; Josselson, 1988). Josselson specifically states that intimacy for women is part of identity and that intimacy is found "in the development, differentiation, and mastery of ways of being with others" (p. 99). Adolescent women, more so than adolescent men, tend to value interrelatedness with family members, affectional ties, and family commitments (McDermott, Robillard, Char, Hsu, Tseng, & Ashton, 1983). Rice (1992) found that relationships with parents are consistently correlated to satisfactory social and emotional well-being for women. Therefore, an explanation of this significant difference between males and females on intimacy with parents can be viewed as a developmental difference between the sexes, with a more affiliative role for females fostered in the family.

A significant main effect for sex was found for perceived approach problem-solving style. Women tended to approach problem-solving more so than men. This result is surprising as it is inconsistent with both the research on problem-solving and sex-role theory as outlined above. Previous research utilizing the PSI has found no gender differences (Heppner, 1988; Larson, Piersel, Imao, & Allen, 1990). In addition, an examination of items on this scale reveal that most items concern thinking about solutions to problems, with more thought indicating more approach to problem-solving. Heppner et al. (1982) found that men
reported thinking as the most frequent strategy for solving intrapersonal problems, while women reported talking to be the most frequent strategy. This finding would lead to the assumption that for this scale of the PSI, men might approach problem-solving more than women. A final thought is that this finding is sample-specific and would not generalize to the general population.

Finally, a significant interaction for level of FC by sex was found such that self-perceived HFC females had significantly higher scores on personal authority than self-perceived HFC males. This finding may be the result of how much the scale is weighted by items pertaining to intimacy, an area where women would be expected to score higher. As stated above, according to the authors of this measure (Bray & Harvey, 1987), personal authority is, in part, a synthesis of intimacy and individuation. While there are no overlapping items on the Intergenerational Intimacy and Personal Authority scales, it could be that items on Personal Authority that relate to intimacy tap the same dimension found on the Intergenerational Intimacy scale. Another possibility to consider is that, in keeping with the sex difference for women on intergenerational intimacy, women scored significantly higher here simply because intimacy is a component of personal authority. It could be that the additional connectedness women have with parents
fosters the ability to have a more peer-like relationship with them.

The finding of a non-significant sex difference for LFC individuals is unexpected and requires more cautious interpretation. However, there is a possibility to consider. It could be that personal authority is an ability that can only attain personal significance for HFC individuals. It may be that it is only in HFC families that the environment exists that would foster the ability to maintain intimacy and autonomy in relation to parents and thus a more peer-like relationship with them. In regard to LFC families, it would seem unlikely that individuals from these families would have had consistent opportunities to learn how to balance intimacy and autonomy nor would the attainment of a peer-like relationship with parents be expected.

Summary

Results from this study indicate that self-perceived family competence as reported by late adolescents appears to have an impact on variables of affect, relationships with parents, and perception of problem-solving abilities. These results fit with both theory and research in the area of family competence. As hypothesized, participants from self-perceived HFC families appear to fare better as individuals in the areas tapped by this study. These late adolescents see themselves as possessing an approach to and confidence
in their abilities for problem resolution. They appear able to manage their leaving-taking from their families of origin in such a way as to maintain a connection with their parents while furthering their sense of independence and autonomy. Importantly, they appear to experience less depression in the process. Additionally, the significant findings related to sex differences on several variables seem to fit with theory and research regarding gender differences in how men and women balance intimacy and autonomy in this culture.

A conclusion that might be drawn from this study is that growing up in a competent family helps create competent individuals, at least in the areas explored here. Individuals who perceived their families as high in competence also appeared to possess certain characteristics that bode well for success in life. These individuals reported less depression, the perception that they possessed good problem-solving skills, and relationships with parents that are characterized by autonomy, intimacy, and personal authority. It could be argued that late adolescents with these characteristics stand a better chance of becoming productive and well-adjusted adults, more so than individuals from families that are low in competence.

Limitations and Suggestions for Further Study

Several limitations need to be mentioned. First, the subjects in this study were from intact families; therefore, the results are not generalizable to late adolescents from
single parent or reconstituted families. Second, the participants were students at a large Southwestern university and these findings may not apply to students in other geographic areas. Third, the age range of 17 through 21 was chosen to encompass the developmental time period of late adolescence. A wider age span encompassing more of the early twenties would not have been out of line with theory and may have produced different results. Fourth, the majority of participants in this study were Caucasian; therefore, conclusions cannot be drawn from these data regarding family competence in other ethnic groups. Fifth, self-perceived and actual family competence may be different in reality and this study focused only on self-perceived family competence (cf Hampson, Beavers, & Hulgus, 1989).

Future research in this area could address some of these limitations. First, additional studies need to continue to address possible discrepancies between self-perceived and observer-rated family competence. Perhaps, as suggested by Hampson et al. (1989), a self-report measuring a collective family view may have more validity than a one member self-report of family competence. Consistent with other limitations cited above, additional studies may wish to examine family competence differences between intact families and other kinds of families (such as single parent or remarried families), across geographic locations, across different age groups, and across ethnic groups. Neither
birth order and number of siblings in the family of origin nor marital status of participants was examined. Differences in evaluation of family competence could be affected by these variables.
SELF-REPORT FAMILY INVENTORY: VERSION II

For each question, mark the answer that best fits how you see your family now. If you feel that your answer is between two of the labeled numbers (the odd numbers), then choose the even number that is between them.

<table>
<thead>
<tr>
<th></th>
<th>YES: Fits our family very well</th>
<th>SOME: Fits our family some</th>
<th>NO: Does not fit our family</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Family members pay attention to each other's feelings.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Our family would rather do things together than with other people.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. We all have a say in family plans.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The grownups in this family understand and agree on family decisions.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Grownups in the family compete and fight with each other.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. There is closeness in my family but each person is allowed to be special and different.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. We accept each other's friends.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. There is confusion in our family because there is no leader.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Our family members touch and hug each other.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Family members put each other down.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. We speak our minds, no matter what.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. In our home, we feel loved.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Even when we feel close, our family is embarrassed to admit it.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. We argue a lot and never solve problems.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Our happiest times are at home.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. The grownups in this family are strong leaders.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. The future looks good to our family.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. We usually blame one person in our family when things aren't going right.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Family members go their own way most of the time.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Our family is proud of being close.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Our family is good at solving problems together.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Family members easily express warmth and caring towards each other.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. It's okay to fight and yell in our family.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. One of the adults in this family has a favorite child.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. When things go wrong we blame each other.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. We say what we think and feel.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Our family members would rather do things with other people than together.</td>
<td>1 2 3 4 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Family members pay attention to each other and listen to what is said.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>29.</td>
<td>We worry about hurting each other's feelings.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>30.</td>
<td>The mood in my family is usually sad and blue.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>31.</td>
<td>We argue a lot.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>32.</td>
<td>One person controls and leads our family.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>33.</td>
<td>My family is happy most of the time.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>34.</td>
<td>Each person takes responsibility for his/her behavior.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>35.</td>
<td>On a scale of 1 to 5, I would rate my family as:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>My family functions very well together.</td>
<td>My family does not function well together at all. We really need help.</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>36.</td>
<td>On a scale of 1 to 5, I would rate the independence in my family as:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(No one is independent.)</td>
<td>(Sometimes independent.)</td>
<td>(Family members usually go their own way. Disagreements are open. Family members look outside of the family for satisfaction.)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Family Members rely on each other for satisfaction rather than on outsiders.</td>
<td>Family Members find satisfaction both within and outside the family.</td>
<td>Family Members find satisfaction both within and outside the family.</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B

PERSONAL AUTHORITY IN THE FAMILY SYSTEM

QUESTIONNAIRE-VERSION C
PERSONAL AUTHORITY IN THE FAMILY SYSTEM QUESTIONNAIRE-
VERSION C (PAFS-QVC)

Permission was obtained in writing to use the PAFS-QVC in this study. However, the request was made that the instrument not be included in the appendix. Rather, readers interested in obtaining a copy of this instrument are requested to contact James H. Bray, Ph.D. at the following address or telephone number:

Baylor College of Medicine
Department of Family Medicine
5510 Greenbriar
Houston, TX 77005
713/798-7751
The Problem Solving Inventory

FORM B

P. Paul Heppner, Ph.D.

Name ____________________________ Date ____________________________

Sex _______ Age _______ Grade or class (if you are a student) __________

Directions

People respond to personal problems in different ways. The statements on this inventory deal with how people react to personal difficulties and problems in their day-to-day life. The term "problems" refers to personal problems that everyone experiences at times, such as depression, inability to get along with friends, choosing a vocation, or deciding whether to get a divorce. Please respond to the items as honestly as possible so as to most accurately portray how you handle such personal problems. Your responses should reflect what you actually do to solve problems, not how you think you should solve them. When you read an item, ask yourself: Do I ever behave this way? Please answer every item.

Read each statement and indicate the extent to which you agree or disagree with that statement, using the scale provided. Mark your responses by circling the number to the right of each statement.

<table>
<thead>
<tr>
<th></th>
<th>Strongly</th>
<th>Moderately</th>
<th>Slightly</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Agree</td>
<td>Agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. When a solution to a problem has failed, I do not examine why it didn't work..........................1 2 3 4 5 6
2. When I am confronted with a complex problem, I don't take the time to develop a strategy for collecting information that will help define the nature of the problem..........................1 2 3 4 5 6
3. When my first efforts to solve a problem fail, I become uneasy about my ability to handle the situation .................................................................1 2 3 4 5 6
4. After I solve a problem, I do not analyze what went right and what went wrong.........................1 2 3 4 5 6
5. I am usually able to think of creative and effective alternatives to my problems..........................1 2 3 4 5 6
6. After following a course of action to solve a problem, I compare the actual outcome with the one I had anticipated..................................................1 2 3 4 5 6
7. When I have a problem, I think of as many possible ways to handle it as I can until I can't come up with any more ideas .........................................................1 2 3 4 5 6
8. When confronted with a problem, I consistently examine my feelings to find out what is going on in a problem situation .........................................................1 2 3 4 5 6
9. When confused about a problem, I don't clarify vague ideas or feelings by thinking of them in concrete terms ...........................................................................1 2 3 4 5 6
10. I have the ability to solve most problems even though initially no solution is immediately apparent ..............................................................1 2 3 4 5 6
11. Many of the problems I face are too complex for me to solve ......................................................1 2 3 4 5 6
12. When solving a problem, I make decisions that I am happy with later .............................................1 2 3 4 5 6
Read each statement and indicate the extent to which you agree or disagree with that statement, using the scale provided. Mark your responses by circling the number to the right of each statement.

1. When confronted with a problem, I tend to do the first thing that I can think of to solve it .................................................. 1 2 3 4 5 6
2. Sometimes I do not stop and take time to deal with my problems, but just kind of muddle ahead .................................................. 1 2 3 4 5 6
3. When considering solutions to a problem, I do not take the time to assess the potential success of each alternative .................................................. 1 2 3 4 5 6
4. When confronted with a problem, I stop and think about it before deciding on a next step .................................................. 1 2 3 4 5 6
5. I generally act on the first idea that comes to mind in solving a problem .................................................. 1 2 3 4 5 6
6. When making a decision, I compare alternatives and weigh the consequences of one against the other .................................................. 1 2 3 4 5 6
7. When I make plans to solve a problem, I am almost certain that I can make them work .................................................. 1 2 3 4 5 6
8. I try to predict the result of a particular course of action .................................................. 1 2 3 4 5 6
9. When I try to think of possible solutions to a problem, I do not come up with very many alternatives .................................................. 1 2 3 4 5 6
10. When trying to solve a problem, one strategy I often use is to think of past problems that have been similar .................................................. 1 2 3 4 5 6
11. Given enough time and effort, I believe I can solve most problems that confront me .................................................. 1 2 3 4 5 6
12. When faced with a novel situation, I have confidence that I can handle problems that may arise .................................................. 1 2 3 4 5 6
13. Even though I work on a problem, sometimes I feel like I'm groping or wandering and not getting down to the real issue .................................................. 1 2 3 4 5 6
14. I make snap judgments and later regret them .................................................. 1 2 3 4 5 6
15. I trust my ability to solve new and difficult problems .................................................. 1 2 3 4 5 6
16. I use a systematic method to compare alternatives and make decisions .................................................. 1 2 3 4 5 6
17. When thinking of ways to handle a problem, I seldom combine ideas from various alternatives to arrive at a workable solution .................................................. 1 2 3 4 5 6
18. When faced with a problem, I seldom assess the external forces that may be contributing to the problem .................................................. 1 2 3 4 5 6
19. When confronted with a problem, I usually first survey the situation to determine the relevant information .................................................. 1 2 3 4 5 6
20. There are times when I become so emotionally charged that I can no longer see the alternatives for solving a particular problem .................................................. 1 2 3 4 5 6
21. After making a decision, the actual outcome is usually similar to what I had anticipated .................................................. 1 2 3 4 5 6
22. When confronted with a problem, I am unsure of whether I can handle the situation .................................................. 1 2 3 4 5 6
23. When I become aware of a problem, one of the first things I do is try to find out exactly what the problem is .................................................. 1 2 3 4 5 6

CON AA PC Total
BDI

Please circle the number next to the sentence which best describes your symptoms for the past seven days. Choose only one sentence under each letter.

A. 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.

B. 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.

C. 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 failure.
   3 I feel I am a complete failure as a person.

D. 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 dissatisfied or bored with everything.

E. 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.

F. 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.

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

H. 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.

I. 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.

J. 0 I don’t cry anymore 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.
<p>| | | |</p>
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<thead>
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<tbody>
<tr>
<td>K.</td>
<td>0</td>
<td>I am no more irritated now than I ever am.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I get annoyed or irritated more easily than I used to.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I feel irritated all the time now.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I don't get irritated at all by the things that used to irritate me.</td>
</tr>
<tr>
<td>L.</td>
<td>0</td>
<td>I have not lost interest in other people.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I am less interested in other people than I used to.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I have lost most of my interest in other people.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I have lost all of my interest in other people.</td>
</tr>
<tr>
<td>M.</td>
<td>0</td>
<td>I make decisions about as well as I ever could.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I put off making decisions at all anymore.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I have greater difficulty in making decisions than before.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I can't make decisions at all anymore.</td>
</tr>
<tr>
<td>N.</td>
<td>0</td>
<td>I don't feel I look any worse than I used to.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I am worried that I am looking old or unattractive.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I feel that there are permanent changes in my appearance that make me look unattractive.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I believe that I look ugly.</td>
</tr>
<tr>
<td>O.</td>
<td>0</td>
<td>I can work about as well as before.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>It takes an extra effort to get started at doing something.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I have to push myself very hard to do anything.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I can't do any work at all.</td>
</tr>
<tr>
<td>P.</td>
<td>0</td>
<td>I can sleep as well as usual.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I don't sleep as well as I used to.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I wake up several hours earlier than I used to and cannot get back to sleep.</td>
</tr>
<tr>
<td>Q.</td>
<td>0</td>
<td>I don't get more tired than usual.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I get tired more easily than I used to.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I get tired from doing almost anything.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I am too tired to do anything.</td>
</tr>
<tr>
<td>R.</td>
<td>0</td>
<td>My appetite is not worse than usual.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>My appetite is not as good as it used to be.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>My appetite is much worse now.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I have no appetite at all anymore.</td>
</tr>
<tr>
<td>S.</td>
<td>0</td>
<td>I haven't lost much weight, if any, lately.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I have lost more than 5 pounds.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I have lost more than 10 pounds.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I have lost more than 15 pounds.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I am purposely trying to lose weight by eating less. Yes _ No _ .</td>
</tr>
<tr>
<td>T.</td>
<td>0</td>
<td>I am no more worried about my health than usual.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I am worried about physical problems such as aches and pains; or upset stomach; or constipation.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I am worried about physical problems - it's hard to think of much else.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I am so worried about my physical problems, that I cannot think about anything else.</td>
</tr>
<tr>
<td>U.</td>
<td>0</td>
<td>I have not noticed any recent change in my interest in sex.</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>I am less interested in sex than I used to be.</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>I am much less interested in sex now.</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I have lost interest in sex completely.</td>
</tr>
</tbody>
</table>
APPENDIX E

CONSENT FORM
Dear Student:

We are conducting research on the personality characteristics of college students. Participation in this research is strictly voluntary. Your course instructor may award you extra credit for participation; however, refusal to participate or withdrawal from this project will in no way affect your standing in this course.

The total amount of time required to complete the questionnaires will be approximately 45 minutes. PLEASE COMPLETE THE ENTIRE TEST PACKET IN ONE SITTING. Please choose a block of time that will allow you to complete testing without interruption. Please read the instructions for each questionnaire before you begin. NOTE: one questionnaire must be completed on both sides. Be as frank and candid as possible in answering each questionnaire. YOUR RESPONSES WILL REMAIN COMPLETELY CONFIDENTIAL.

Sometimes filling out questionnaires may cause one stress or distress. Should this prove the case, the experimenter would be willing to talk with you. You may contact her at 214-824-1922.

Your prompt completion and return of these materials is greatly appreciated. Should you have any questions regarding this packet, you may contact us at the Psychology Department at 565-2671.

Thank you for participating in this project.

Sincerely,

Jana L. Swart, M. A. 
Ph.D.
Doctoral Candidate

C. Edward Watkins, Jr.,
Associate Professor

______________________________
Student's Name (PRINT)

______________________________
Student's Signature (SIGNED)
APPENDIX F

DEMOGRAPHIC DATA SHEET
PERSONAL DATA QUESTIONNAIRE

DIRECTIONS: Please enter your age in the space provided. Then, on the multiple choice items below, please circle the number that best describes you or your current situation. CIRCLE ONLY ONE NUMBER.

A.) AGE ______.

B.) ETHNICITY

1. Caucasian
2. Black
3. Hispanic
4. Native American
5. Asian
6. Other

C.) SEX

1. male
2. female

D.) CLASS

1. freshman
2. sophomore
3. junior
4. senior
5. graduate student
6. other

E.) WHICH OF THE FOLLOWING IS CURRENTLY TRUE OF YOUR BIOLOGICAL PARENTS?

1. married, living together
2. married, living separately
3. divorced
4. one or both parents deceased
REFERENCES


Bray, J. H., & Harvey, D. M. (1987). Intimacy and individuation in young adults: Development of the college student version of the personal authority in the family systems questionnaire. Unpublished manuscript, Department of Family Medicine, Baylor College of Medicine, Houston.


Green, R. G., & Kolevzon, M. F. (1986). The correlates of healthy family functioning: The role of consensus and conflict in the practice of family therapy. *Journal of Marital and Family Therapy, 12*(1), 75-84.


concept of adolescence: Differences between adolescent boys and girls in the context of their families.


Terkelson, K. G. (1980). Toward a theory of the family life cycle. In E. A. Carter & M. McGoldrick (Eds.), *The


