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A Validation of the Family of Origin Scale Using Alcoholic and Mental Health Patients

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A VALIDATION OF THE FAMILY OF ORIGIN SCALE USING
ALCOHOLIC AND MENTAL HEALTH PATIENTS

by

Arthur J. Fedor

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Counselor Education
and Counseling Psychology

Western Michigan University
Kalamazoo, Michigan
August 1991

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**A validation of the Family of Origin Scale using alcoholic and
mental health patients**

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Western Michigan University, 1991

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DEDICATION

To Niki and Sam.

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CHAPTER I

INTRODUCTION

Background

The impact of individuals' family of origin experiences on their personality development has been a subject of much recent interest. Although this idea is not novel, systemic, holistic theories have revolutionized the way individual clients are seen in therapeutic settings. Bateson (1972), a founding pioneer of "systems theory," typified this emerging view when he discussed, in his Steps to an Ecology of Mind, the interdependent relationships of all members of any system (e.g., family of origin).

According to systems theory, when two individuals make contact with each other, such as in marriage, each is truly encountering the other's family of origin system. Because, as Kramer (1985) explained it, "family systems have rules which form a covert power structure of operational behavior" (p. 9). This power structure of the family of origin enhances or inhibits healthy development, implants beliefs, and forever colors the way the individual perceives the world.

From the experience of birth onward, the individual finds the world a safe and nurturing environment or a desperately dangerous and treacherous experience--or any variation of the extremes (Grof & Grof, 1990). There is an increasing realization on the part of

theorists and researchers in the mental health fields that family of origin factors not only have had a great impact on the individual's development, but also that the impact is an ongoing dynamic process continuing into adulthood (Bradshaw, 1988; Miller, 1981; Whitfield, 1987; Winnicott, 1965).

Family of origin theory sprang from its solid foundation in family systems theory. It focuses on a two-generational model, that of the individual and "the family in which a person has his/her beginnings--physically, psychically, and emotionally" (Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985, p. 287). Kegan (1982) described, in an eloquent diagrammatic way, the developmental process engendered in the family of origin experience.

Highlighting the increasingly popular perspective are the authors and theorists of the adult children of dysfunctional families treatment field (R. Ackerman, 1978; Black, 1979; Brown et al., 1984; Germak, 1984; Miller, 1983; Wegschieder, 1981; Woititz, 1983). The central message is that much of the destructive, pathological behavior of individuals can be understood through an intergenerational framework.

Therapists trained within this framework identified the powerful myths, patterns, and rules governing the families in which "identified patients" grew up (Kramer, 1985). The myths, messages, and patterns of communication are unwittingly passed on from generation to generation. The multigenerational communication patterns are what constitute reality for the individuals within any given family system (Watzlawick, 1976; Watzlawick, Weakland, & Fisch,

1974). Therefore, how one sees self and the external world is largely due to the family of origin experience.

When the power of this early, and ongoing, influence is understood, a logical premise for intervention is to address therapeutic diagnosis and treatment at the level of the family of origin system (N. J. Ackerman, 1984; R. J. Becvar & Becvar, 1982; Levant, 1984; Papero, 1983). An outgrowth of this emphasis is the development of quantifiable diagnostic measures in this field. As Mangrum (1988/1989) phrased it, "it is imperative that valid measurement techniques be developed that are consistent with family theory and interventions" (p. 4).

The Problem

A logical outgrowth from the history of family therapy theory was the pursuit of measurement of family of origin health. In this effort to develop adequate, quantifiable measures of perceived family health, the authors of the Family of Origin Scale (FOS) (Hovestadt et al., 1985) developed their scale to measure the individuals' perceptions of how well their families of origin fostered autonomy and intimacy (referred to in this text as perception of family health).

Since its inception, the FOS (Hovestadt et al., 1985) has spawned a growing number of studies focusing on its usefulness as a clinical and research instrument. A number of those studies have challenged its research value (Lee, Gordon, & O'Dell, 1989; Mangrum, 1988/1989; Mazer, Mangrum, Hovestadt, & Brashear, 1990). Although

Lee et al. (1989) charged it "may have only limited value as a research instrument" (p. 27), a number of recent researchers have found the FOS to discriminate between prisoners and college students, adult children of alcoholic parents and adult children of nonalcoholic parents, and clinical patients and nonpatients (Andrasi, 1986/1987; Lee et al., 1989; Mangrum, 1988/1989). Mazer et al., (1990), like Lee et al., found the FOS to have one major, central factor. However, Mazer et al. concluded, contrary to Lee et al., that the findings of previous research "suggest that the instrument can have a central role in applied research" (p. 423).

The Purpose

Even though the research base is growing, a paucity of those data evolves from clinical populations. More focus on clinical groups was proposed by the same researchers mentioned above. Lee et al. (1989) pointed to a number of future research directions for the FOS (Hovestadt et al., 1985). One of these directions questioned whether the FOS scores of subjects entering treatment would change after treatment.

One way of getting some insight into such questions may be to compare the FOS scores of individuals seeking treatment with those who have completed psychotherapy. A once disgruntled individual, having worked through frustration, losses, and conflicts, presumably might end treatment with a less extreme view of his or her origins. If, however, treatment has no influence on the FOS score, we may believe that the families of origin may be much as they are described, or at least that the memories of family life are stable. (Lee et al., 1989, p. 22).

Since these researchers found that there appeared to be a significant difference between patients and nonpatients in the subjects' perceptions of family of origin health as measured by the FOS (Hovestadt et al., 1985)--and since they raised the question of whether treatment had an effect on FOS scores--adequate empirical evidence is required to address this issue. To date, only one pre-post use of the FOS was addressed in the research, by Lee et al. (1989). They maintained that a part of their research addressed this issue in their second experiment. However, their method indicates that their total sample (32) of posttreatment population was derived from their original nontreatment population (100) because these subjects claimed to have had psychotherapy in the past. Consequently, the authors then placed these 32 scale results in a "posttreatment" category and compared their (the 32 "posttreatment" scales) total scores with the total scores of the clinical population (100) and the nonclinical/nontreatment population (100). Their results, then, did not reflect possible results from a true pre-post design, and their sample was a small fraction of their original populations. It was preferable to impose a true pre-post design in this instance because, as Drew (1976) put it, "the basic assumption underlying the pre-post design is that the treatment is the only influence that intervened between measurements" (p. 50). An assumption of this project, then, is that subjects will indeed be influenced by the treatment they encounter.

One purpose of this study, then, was to address the initiated question of whether the FOS would be sensitive to change as a result

of treatment, and what parts of the scale might differentiate most clearly. Collectively, the goal was to address directly both the need for research with clinical populations using the FOS and the need to assess the Family of Origin Scale's sensitivity to pre- and posttreatment measurement. Specifically, the study compared the scores obtained from individuals entering treatment with those of the same individuals after they had experienced treatment.

The following questions were addressed:

1. Is there a significant change in the individual's perception of his or her family of origin health, as measured by the FOS (Hovestadt et al., 1985), after treatment?
2. Is the difference, if any, manifested in the total score?
3. Is the difference, if any, manifested in particular individual items or subscales of the FOS (Hovestadt et al., 1985)?
4. Within this clinical population will the FOS (Hovestadt et al., 1985) accurately discriminate between those who complete treatment and those who leave against therapeutic advice?

Significance of Study

The need for empirical evidence for the usefulness of the FOS (Hovestadt et al., 1985) in assessing perception of family of origin functioning among clinical populations has been illustrated above. This study attempted to validate further the FOS as a research instrument, as well as a clinical assessment tool. The treatment field would welcome an instrument which may offer a sensitive quantitative measure of change due to treatment.

Although a number of recent studies have addressed the construct validity of the FOS (Lee et al., 1989; Mangrum, 1988/1989; Mazer et al., 1990), little has been done to address its pretreatment-post-treatment discriminatory capacity. Since the FOS was found to discriminate between clinical populations and nonclinical populations (Andrasi, 1986/1987; Latham, 1988/1989; Lee et al., 1989; Mangrum, 1988/1989; Searight, Manley, Binder, & Krohn, 1991; Settle, 1988/1989; VanFleet, 1988/1989), this study further tested the discriminatory power of the FOS.

Limitations of Study

A major and continuous problem in this undertaking was the difficulty of data collection. Since independent agencies and their staffs were enlisted to help with the collection of data, collection was dependent upon the motivation of the staffs of the agencies. Although six outpatient clinics and four residential alcoholism treatment agencies were enlisted and had agreed to participate, four of the outpatient clinics and two of the residential alcoholism treatment centers failed to follow through with the collection of data even after it was begun numerous times. This difficulty ultimately lowered sample sizes and prolonged collection efforts.

Of course, a voluntary participation study conducted in selected residential alcoholism programs, outpatient mental health clinics, and classes at a midwestern university does not allow for true randomization. Moreover, students cannot be assumed to represent the general population. However, availability necessitated their

involvement when an adult education class withdrew from the collection group. Additionally, the subjects' perceptions of their families of origin experiences are subject to distortion over time.

The common problem of "practice effect" exists in a pre-post design when the same instrument is given twice within a relatively short period of time (Anastasi, 1982). Familiarity and memory might tempt individuals to respond exactly as they did the first time, or it might tempt some to show a difference deliberately. Carmines and Zeller (1979) discussed this "reactivity" by clarifying that reactivity refers to the fact that sometimes a change in a phenomenon can be induced simply by measuring that phenomenon.

Although it would have been ideal to collect the posttreatment scales as much as a year or more after the pretreatment measure was given to outpatient clients, for those clients who remained in treatment that long, the difficulties of collection mentioned above dictated a more restricted time frame between the initial administration of the scale and the posttreatment administration.

In an attempt to control for possible inconsistencies of therapeutic interventions, this study collected much of its data from inpatient alcoholism centers which have structured treatment programs of consistent length and content.

As stated, ideally, repeated measures taken from an outpatient sample might be collected a year or more after the initial pretreatment administration. At least, then, scores might reflect more true and lasting change, especially if therapeutic change would be more recognizable after patients have had time to assimilate the effects

of therapy.

Finally, a large number of participants in this study ($n = 55$) were alcoholics. This group is historically notorious for having low motivation for change, having been typically forced into treatment by courts, families, or employers. Results of self-reports must be interpreted with this in mind.

Definition of Terms

Family of origin theory: This theoretical framework is an intergenerational view, which postulates that the individual's current perceptions and current levels of functioning are directly related to the perceptions the individual developed in systemic interaction with, and relationship to, those with which he or she grew up.

Family of origin therapy: Family of origin therapy then takes its cue from its theory base. Cognizant of the myths, binds, and messages of the client's family of origin, the therapist endeavors to promote systemic change in the family and not simply individual insight or self-esteem enhancement.

Residential alcoholism treatment program: A treatment facility in which patients suffering from alcoholism are housed for the duration of a treatment program. After a possible detoxification process, the individual begins individual and group therapy to enhance emotional and psychological recovery and build a solid support system for sobriety; is educated regarding alcoholism; and is offered vocational guidance and referrals.

Adult children of alcoholics (ACA): A phrase used for those adults who as children were raised in a family of origin which had at least one alcoholic parent.

Summary

Family of origin theory and its influence have gained wide acceptance in the mental health fields. Still, a need exists for quantifiable measures of subjects' perceived family of origin experiences. These measures or instruments offer empirical evidence to support, strengthen, and stretch the theory base.

This study was proposed as an adjunct to the above goal through an attempt to broaden the validation base of the Family of Origin Scale (FOS) (Hovestadt et al., 1985) by applying it to a clinical population sample. Specifically, this study examined the sensitivity of the instrument to detect differences in individuals' perceptions of family of origin experiences after treatment. The questions to be answered have been listed in the purpose section of this chapter.

CHAPTER II

REVIEW OF LITERATURE

Importance of Family of Origin in the Development of the Individual

Theorists such as Erikson (1963) and Lidz (1976) have long heralded the importance of the family of origin environment on the development of the child. Family systems theorists such as Lewis, Beavers, Gossett, and Phillips (1976) have furthered the notion of the powerful effect of the quality and nature of family nurturance on the emotional, physical, and psychological health of the child. Glick and Kessler (1974) outlined the primary tasks of the family in arriving at a healthy, functioning level. They, too, identified many myths that dysfunctional families live by and pass on.

Miller (1986), in her book, Pictures of a Childhood, offered a description of the aspects necessary in the environment of a child's family of origin that would instill healthy psychological growth: "For their development, children need the respect and protection of adults who take them seriously, love them, and honestly help them to become oriented in the world" (Miller, 1986, p. 159).

As Miller (1990) championed the new awareness of the depth and breadth of the "hidden" child abuse in this culture, she pointed out that recent exposes pour out of literature today, written by adult children of abusive family of origin experiences. They reflect,

according to Miller, a necessary recognition growing in the public at large of the truth about child abuse today. She eloquently supported two major contentions: (1) that in order for deep and lasting therapeutic change to occur, the patient must first acknowledge what his or her experience of his or her family of origin really was; and (2) that a mourning process (grieving) must accompany that realization in order that healing commences (Miller, 1984).

Object-relations theorists such as Fairbairn (1952) have supported the contention that it is the necessary reactions to the "objects" (parents or others) around the child which can determine the psychological health of the individual as an adult. Further supporting Miller's (1984) contentions, Fairbairn pointed out that the child does not have a choice of acceptance or rejection of narcissistically damaging parental behavior. As Fairbairn (1952) explained, "they force themselves upon him; and he cannot resist them because they have power over him" (p. 67).

Family systems theory incorporates much of personality development theory with general systems theory, recognizing the powerful dynamic process of the family as a whole. Rather than focusing on the individual, family systems theory views the family as a functioning, living organism, much as the individual has been viewed in the past. In fact, Bertalanffy (1966) succinctly defined a system as referring to any group of individuals if change in the behavior of one of those individuals is a function of the behavior of all the other members of that group. N. J. Ackerman (1984) extended this by saying that behavioral change in any individual impacts all the

other people of the group in a meaningful way.

To take this direction of thought to its logical end, R. J. Becvar and Becvar (1982) simply stated, "it makes no sense to analyze any person independently" (p. 48). All are seen as in relation to the other. The actions of all members of the family have effects on all other members of that system.

The individual may move geographically, but he or she never completely leaves the family in which he or she grew up: "One hypothesis is that members of the marital dyad are attracted to each other on the basis of perceived compatibility of the rule system each brings from his or her family of origin" (R. J. Becvar & Becvar, 1982, p. 49). The family system, then, is a complex organism with many variables contributing to the healthy or unhealthy functioning of the whole.

Lewis et al. (1976) found no single quality which could be seen as responsible for the health in a family. Equally, no lack of a single quality could be seen as cause for an unhealthy family. The differences between healthy and unhealthy families appeared to be related more to degrees of the presence of certain qualities.

It has, therefore, been the goal of family systems theorists to construct views and definitions of families based upon systems theory. Lewis et al. (1976) explained that a family system, as a whole, is greater than the sum of its parts. To family of origin therapists, this translates into the use of the family system as a much more powerful avenue or mechanism of change than the individual's intrapsychic insights. This is especially true when that

individual typically has to return after therapy to struggle with the same powerful family system dynamics to which he or she has grown so accustomed. Unlike therapists trained in the traditional theories of individual psychodynamics, the family systems therapist is, according to Boszormenyi-Nagy (1965), "compelled to realize that the level on which pathology exists and therapy takes place is that of a system which is more than the sum total of pathologies of the individual members as discrete entities" (p. 59).

Boszormenyi-Nagy (1965) continued in the same vein by heralding, "The practical implication of this viewpoint is likely to produce a radical departure from the traditional individual-based nosologic orientations of psychiatry, to one that is system-based" (p. 59). Finally, he offered the question, "How can the concepts of the dialectical [systemic interaction] model be applied to the description of family health and pathology?" (Boszormenyi-Nagy, 1965, p. 59).

In apparent answer to this question, Bowen (1978) developed an intergenerational systemic family model, incorporating a multigenerational view of the individual with a theory of how dysfunction develops and what the individual needs to do to become more "differentiated." Bowen, in his model, elucidated the major tasks of healthy maturation, intimacy and autonomy. And, again, in apparent answer to Boszormenyi-Nagy (1965), Bowen (1978) and N. J. Ackerman (1984) posited the concept of triangulation as a major stumbling block to healthy intimacy and autonomy. N. J. Ackerman (1984) explained triangulation this way, "two persons relating through a

third in such a way as to freeze their own relationship and prevent both insulation from one another and fusion with a third party" (p. 22).

Family of origin therapy grew out of the above theoretical perspectives. The shift in view from the more traditional individual, intrapsychic therapy to family of origin therapy, involves a dynamic shift from the individual as focus to the family system as focus (Fine & Hovestadt, 1987). In fact, Framo (1976) extended this position to the point of essentially insisting his couples therapy clients bring in their families of origin to the therapy session.

Kaslow (1982) offered an historical overview of the evolution of the family therapy movement from its formal beginnings as espoused by such pioneers as Bell (1967), Jackson and Satir (1961), and Bowen (1978) to present-day family systems theorists. Gurman and Kniskern (1981) followed suit illustrating the depth and breadth of family therapy today by offering outlines of the many faces of this field. A few examples of the identified approaches are psychoanalytic and object-relations, behavioral, systems theory, and intergenerational (of which family of origin therapy is the backbone). With the many approaches of family therapy in practice a growing need for empirical research surfaced.

Family of origin research had, as one of its early proponents, Framo (1982), who reported his own early frustration in the field of psychological research. At the time, according to Framo, "practically all the studies done by social psychologists had been with ad hoc groups of strangers" (p. 3), instead of intimately related

people. The family of origin system constituted a very different group. As the focus turned to family of origin research, the necessity of new measurement tools emerged.

Measurement of the Perception of Family of Origin

Since research of the past had centered on measuring changes in the individual's behavior and psychological make up, little was done until the past two decades to address the measurement of perception of the family system. The importance of the development of an empirical base was too often ignored. As Piercy and Sprenkle (1986) put it, "our field has too often been dominated by charismatic clinician/teachers whose ideas have rarely been empirically tested with anything approaching scientific rigor" (p. 32). Even so, the family and marital inventories developed present a unique problem. As Fredman and Sherman (1987) put it, "The body to be studied is not the individual or even the group; it is the system and the relationships" (p. 7). This realization turned researchers towards the creation of new measurement tools.

The Family of Origin Scale (FOS) (Hovestadt et al., 1985) was developed with the above realization in mind. And its focus was to be on measuring the perceived experience of the family of origin by each individual. To date a growing number of researchers are utilizing this instrument in a variety of research and clinical settings (Latham, 1988/1989; Manley, Searight, Binder, & Russo, 1990; Searight et al., 1991; Settle, 1988/1989). And as mentioned previously, it has been shown to have discriminatory power in measuring

differences between populations (Andrasi, 1986/1987, Lee et al., 1989; Mangrum, 1988/1989).

Pre-Post Changes in Perception

Rogers (1961) gave a fine description, albeit tentative, of the changes one might find in the individual after successful treatment. He identified the following changes in the patient after treatment: an increasing openness to experience, increasingly existential living, an increasing trust in his or her organism, and an increasing ability to function more creatively and fully all life.

However, possible changes in the perception one has towards his or her family of origin experience went largely without measure until very recently (Hovestadt et al., 1985). It would be pure speculation to guess whether a "more fully functioning" person (Rogers, 1961) would exhibit a more negative view of his or her family of origin after treatment or whether he or she would recollect his or her family of origin experiences in a more favorable light.

Until recently very little instrumentation was available that adequately measured the individual's perception of his or her family of origin experience (Hovestadt et al., 1985). The family of origin therapy field had embraced many new theories and interventions, all without broad empirical validation (Hovestadt et al., 1985). The door has been opened to explore the breadth of possible uses of scales such as the FOS in both clinical and research settings.

The question of whether therapeutic intervention alters the way people recall their families of origin is a question not well grounded empirically. Lee et al. (1989) brought this question to light in regard to the use of the FOS (Hovestadt et al., 1985), by utilizing a small sample of their research population's scale scores to compare those scores with their clinical and nonclinical subjects' scale scores. Lee's et al. study was a first and only pre-treatment-posttreatment application of the FOS, in terms of measuring for changes in perception of family of origin experience after treatment. This study utilized a more formal pre-post design in that it derived its results from pretreatment and posttreatment scores of the same individuals.

Summary

Family of origin theory has its roots in early systems theory and in clinical family therapy practice. The Family of Origin Scale (Hovestadt et al., 1985) owes its development to this history. It utilizes this theory to assess individuals' perceptions of their families' health.

A number of recent studies (Andrasi, 1986/1987; Latham, 1988/1989; Mazer et al., 1990) have addressed the FOS's usefulness as a research instrument. Mazer et al. (1990), Mangrum (1988/1989), and Lee et al. (1989) found the FOS to measure one major salient factor, challenging the construct validity of the scale. Still its research value was upheld by Mazer et al. As Mazer et al. put it, "since the FOS has been shown to differentiate among clinical

populations such as addicts, children of alcoholics, the mentally ill, and the incarcerated, implications for the utility of the FOS in applied research are apparent" (p. 426).

It was the intent of this study to further validate the FOS's role in applied research and clinical usefulness.

CHAPTER III

METHOD

Population and Sample

Population

The population for this study was adult patients of southwestern Michigan residential alcoholism treatment programs and of outpatient mental health clinics in treatment in 1990 and 1991. Additionally, a comparison group was derived from college students enrolled at a midwestern university.

Sample

The sample was selected by contacting four residential alcoholism treatment centers in the southwestern Michigan area, by contacting six outpatient mental health clinics in the same area, and by contacting the appropriate university professors of the participating university. Willingness of the administrations and staffs of these organizations determined the actual population studied. Although four alcoholism centers and six outpatient mental health centers agreed to participate in the study, two of the alcoholism treatment centers and four of the outpatient mental health centers dropped out of the study. The final collection was confined to two major alcoholism treatment centers and two outpatient mental health

clinics. Subjects' participation was strictly voluntary in all cases. This was communicated verbally by the staffs of the organizations and in writing by the researcher prior to administering the instrument. Selection illustrated an attempt to represent, as accurately as possible, the "typical" populations commonly found in these organizations. The posttreatment scales for the experimental group were collected from the pretreatment group upon their completion of a designated treatment program; the "post"-scales were collected from the comparison group after a comparable "no treatment" time interval.

Characteristics of the Sample

Each subject was given a personal information questionnaire covering various demographic items, such as, age, sex, marital status, and birth order. Additional questions were asked in regard to death of either mother or father (if applicable), age when parents separated (if applicable), and whether or not he or she had previous treatment.

Instrument

The Family of Origin Scale (FOS) was initially developed by Anderson (cited in Hovestadt et al., 1985) and revised in 1985 by Hovestadt et al. The scale was designed to measure the individual's perception of levels of health in his or her family of origin. The family of origin, as described by Hovestadt et al. (1985), is the family unit in which the individual has his or her emotional,

psychological, and physiological beginnings. The FOS is a 40-item, 5-point Likert scale. Scores can range from 40 to 200. Two hundred would represent the highest or most positive view of the family's health, while 40 would represent the lowest or most negative view of the family's health.

The test-retest reliability coefficient for this instrument is .97 (Hovestadt et al., 1985). Construct validity studies have been developed by Mangrum (1988/1989) and Lee et al. (1989). Both research groups found that the FOS (Hovestadt et al., 1985) measured only one dominant factor "of any importance" (Lee et al., 1989, p. 25). However, this major factor is in line with the FOS authors' general intent in measuring a basic freedom on the part of family members to express themselves in the family. Mangrum (1988/1989) also found some support of the original authors' contention that the FOS measured a number of constructs of perceived family health. Indeed, "the factor analysis on the college data yielded seven interpretable factors" (Mangrum, 1988/1989, p. 55). Since Mangrum's (1988/1989) study, Mazer (1991) used further factor analysis in developing a revised FOS in order to add a more solid empirical base to the intention of the scale. These studies all address the construct validity of the FOS. In other words they "target the extent to which the scale measures what it was designed to measure" (Pinsoff, 1981, p. 736).

Additionally, studies have shown the FOS (Hovestadt et al., 1985) to have discriminatory capability in separating criminals from college students, adult children of alcoholic parents from adult

children from nonalcoholic parents, and men in alcohol distressed marriages from men in marriages which are not alcohol distressed (Andrasi, 1986/1987; Holter, 1982; Mangrum, 1988/1989).

To date, only one pre-post use of the FOS (Hovestadt et al., 1985) has been completed (Lee et al., 1989). However the sample used by Lee et al. was very small (32) and the study was an after-thought wherein the researchers simply compared the one score result from each of the 32 subjects who had previously "had psychotherapy," with the score results of the rest of their sample of 100 current patients and 100 nonpatients and referred to this as a pre-post design. In a strict pre-post design, the same subjects would be expected to take the scale previous to, and after, treatment.

Procedures and Statistical Analyses

A proposal describing the study was submitted to, and accepted by, the Western Michigan University (Kalamazoo) Human Subjects Institutional Review Board. A series of proposals was then submitted to the various agencies expected to be involved in the study. After approval from the agencies was received, numerous instructional meetings were held to train or educate staff, or clarify procedures. Although six outpatient clinics and four alcoholism treatment centers agreed to participate, originally, only two outpatient clinics and two alcoholism treatment centers followed through with a usable collection of data.

The data were collected on mark sense sheets and read electronically into a data file at the Western Michigan University Testing

Services, Kalamazoo. The statistics were calculated using the Statistical Package for the Social Sciences-Expanded (SPSSX) software (SPSS, Inc., 1986).

To test the sensitivity of the instrument, the project used a quasi-experimental design to validate the FOS's sensitivity to change. It was assumed from the beginning that it would be a descriptive study. Rather than on efficacy of treatment, the emphasis was on validation of the instrument through an examination of the FOS's sensitivity to subjects' personality change following treatment. Therefore, it was also assumed from the beginning that the treatment the clinical group underwent would elicit changes in personality. The focus addressed whether or not the FOS would measure those changes.

The quasi-experimental design attempted to approximate, as closely as possible, a true experiment in a setting which did not allow for the usual control of variables (Isaac & Michael, 1981). The treatment offered the experimental group was completely outside the control of the researcher.

Procedure

The researcher contacted the original four residential alcoholism treatment agencies in the area and six of the private mental health clinics in this same region. The researcher also contacted the instructors of the university classes selected to be involved in the study. Selection of the agencies and classes was determined by cooperation of the agencies' staffs and the classes' professors.

The researcher distributed the instruments to the clients directly when possible, or to the staff members of the appropriate agencies who offered research assistance. Each staff member of each agency involved in the study was schooled on verbal instructions to be given subjects. Additionally, written instructions were given to each subject which explained how to complete the survey.

Statistical Hypotheses

The research questions for this study were derived from queries raised by previous researchers (Lee et al., 1989). This previous study begged the question: Do subjects' perceptions of their families of origin change after treatment? The null hypothesis was assumed: The clinical group's perceptions of their families' health would not be evidenced by changes in FOS scores following treatment.

Hypothesis 1: Family of Origin Scale (Hovestadt et al., 1985) scores of clinical subjects will exhibit no significant difference between pretreatment and posttreatment measures.

Hypothesis 2: There will be no significant difference in perceptions of family of origin experiences, as measured by the Family of Origin Scale (Hovestadt et al., 1985), between those who complete treatment and those who leave treatment early.

Previous research supported the FOS's ability to discriminate between clinical and nonclinical groups: Two of those studies (Andrasi, 1986/1987; Mangrum, 1988/1989) suggest that adult children of alcoholic parents and criminals score lower on the FOS than non-adult children and noncriminals, respectively. Therefore, it was

assumed that alcoholics and other clinical subjects, as a group, would have a lower score than a comparison group of nonclinical college students. However, the FOS (Hovestadt et al., 1985) had not yet been empirically supported to be an instrument which could identify changes in subjects' perceptions of family of origin health either by total score results or by subscales or individual item scores. The sensitivity of FOS scores as a possible barometer of change due to treatment had not been tested.

Statistical Analyses

A two-tailed t test was used to evaluate for possible differences in means of total scores on the FOS (Hovestadt et al., 1985) between pretest data and posttest results. Similarly the same tests were used to evaluate for possible differences between individual item means and concept (Autonomy and Intimacy) means on the FOS, of pre and post results. And, finally, t tests were used to evaluate possible differences on the FOS between those subjects who completed treatment (stayers) and those who left against therapeutic advice (leavers). The minimum acceptable level of significance for these analyses was set at $p < .05$. These statistical procedures were chosen for their appropriateness for the study according to generally accepted statistical theory (Bartz, 1976; Bruning & Kintz, 1968; Edwards, 1955).

Summary

This study was undertaken to explore the clinical sensitivity range and research usefulness of the Family of Origin Scale (Hovestadt et al., 1985), in terms of possible after treatment change in clinical subjects' perceptions of their families' of origin health. It also addressed the possible differences of subjects' perception of family of origin health between "leavers" and "stayers" in the experimental group.

The experimental subjects were patients in regional residential alcoholism treatment programs and outpatient mental health clinics. The comparison group subjects were undergraduate college students at a Midwestern university.

Two-tailed t tests were used to evaluate possible differences in means of perceived family of origin health in total scores, subscale scores, and individual item scores--between pretest and post-test results.

Two-tailed t tests were also used to evaluate possible differences in perceived health of family of origin between those who completed treatment and those who left treatment early.

CHAPTER IV

RESULTS

The major hypotheses of this study are examined in this chapter. The twofold purpose of this study should be recalled: to assess the FOS's discriminatory (differential) validity between pretreatment and posttreatment scale scores and to determine if changes occur in subjects' perceptions of the health of their families of origin. Results of data analyses are explored to determine if the original hypotheses are supported.

Hypothesis 1

Family of Origin Scale (Hovestadt et al., 1985) scores of clinical subjects will exhibit no significant difference between pretreatment and posttreatment measures.

Two-tailed t tests were employed to determine mean differences of total scores and concept (Intimacy and Autonomy) scores. Additionally, in keeping with the purpose of assessing the FOS's discriminatory validity, a detailed item analysis was performed to determine which items would be most sensitive to change (see Appendix A for full item descriptions). The results of these analyses are shown in Tables 1, 2, and 3, respectively.

For the experimental group, results of all data analyses proved to be nonsignificant ($p < .05$) with the exception of that of the

Autonomy concept. As displayed in Table 2, a pre-post comparison of Autonomy concept means resulted in a significant difference at the $p < .01$ level.

Table 1
Two-Tailed t -Test Results of Mean FOS Total Scores
for Clinical Group

	Pre		Post		t value	p
	Mean	<u>SD</u>	Mean	<u>SD</u>		
Total	122.35	34.68	120.36	34.92	1.15	.254

Table 2
Two-Tailed t -Test Results of Mean Concept Scores
for the Clinical Group

	Pre		Post		t value	p
	Mean	<u>SD</u>	Mean	<u>SD</u>		
Intimacy	60.92	18.67	61.26	18.10	-0.40	.691
Autonomy	63.03	17.81	58.85	18.26	3.81	.000*

*Denotes statistical significance ($p < .05$).

Items 4, 5, 6, 9, 10, 11, 14, 15, 16, 18, 19, 20, 23, 24, 25, 34, 36, 37, 38 make up the item configuration of the Autonomy concept. As the reader can see on Table 3, separate items do not discriminate between pre- and posttreatment scores. Collectively,

Table 3

Two-Tailed t -Test Analysis by Item Between Pretreatment
and Posttreatment Scores of the Clinical Group

Item	Pre		Post		\underline{t} value	\underline{p}
	Mean	<u>SD</u>	Mean	<u>SD</u>		
1	3.17	1.39	3.26	1.29	-0.61	.544
2	3.31	1.35	3.23	1.38	-0.64	.521
3	3.16	1.29	3.26	1.22	-0.65	.517
4	2.98	1.26	3.12	1.31	-0.97	.337
5	2.78	1.34	2.76	1.27	0.18	.859
6	3.07	1.34	3.14	1.26	-0.42	.676
7	2.95	1.40	3.05	1.31	-0.59	.559
8	3.63	1.12	3.56	1.13	0.55	.584
9	3.14	1.36	3.00	1.33	0.91	.368
10	3.33	1.34	3.01	1.30	1.99	.050*
11	2.79	1.39	2.72	1.36	0.43	.669
12	2.56	1.37	2.68	1.21	-0.83	.409
13	2.60	1.32	2.65	1.17	-0.29	.773
14	2.86	1.30	2.78	1.15	0.46	.644
15	3.05	1.36	2.99	1.32	0.36	.720
16	2.55	1.29	2.54	1.21	0.07	.946
17	2.81	1.42	2.81	1.48	0.00	1.000
18	3.05	1.20	3.01	1.28	0.28	.782
19	3.10	1.37	2.98	1.34	1.05	.295
20	3.30	1.30	3.13	1.30	1.32	.192

Table 3--Continued

Item	Pre		Post		$\frac{t}{\text{value}}$	p
	Mean	<u>SD</u>	Mean	<u>SD</u>		
21	2.39	1.25	2.60	1.19	-1.85	.068
22	3.31	1.39	3.26	1.34	0.41	.683
23	3.04	1.33	2.94	1.26	0.79	.432
24	3.20	1.21	3.04	1.03	1.44	.155
25	3.20	1.21	2.95	1.25	1.59	.117
26	3.11	1.25	3.05	1.25	0.42	.676
27	2.73	1.32	2.81	1.33	-0.61	.541
28	2.95	1.46	2.81	1.40	0.82	.417
29	3.15	1.30	3.18	1.40	-0.20	.843
30	3.65	1.31	3.54	1.18	0.94	.349
31	3.02	1.27	3.06	1.22	-0.30	.767
32	3.04	1.45	2.91	1.36	0.91	.365
33	3.27	1.26	3.22	1.23	0.40	.689
34	3.00	1.36	2.81	1.34	1.38	.171
35	3.25	1.26	3.10	1.32	1.28	.203
36	2.93	1.10	2.86	1.05	0.51	.615
37	3.09	1.28	3.13	1.34	-0.29	.776
38	3.43	1.17	3.25	1.21	1.55	.125
39	3.44	1.41	3.23	1.40	1.69	.094
40	3.28	1.35	3.28	1.41	0.00	1.000

*Denotes statistical significance ($p < .05$).

however, the mean totals of all the items which make up the Autonomy concept do exhibit evidence of significant difference between pretreatment and posttreatment scores. Analysis of Autonomy concept scores of the comparison group yielded no similar significant difference (see Table 5).

For the FOS Autonomy concept alone, the null hypothesis was rejected. It was concluded that the Autonomy concept differentiates significantly between the clinical group's pretreatment results and its posttreatment results.

The findings of the analysis of mean item scores (see Table 3) showed only one item, 10, exhibited a significant difference ($p < .05$) from pretreatment to posttreatment in the experimental group scores. One item of a 40-item scale would be expected, at the $p < .05$ level, to be found by chance. The null hypothesis would not be rejected for the experimental group on total means and item means scores.

For the experimental group, then, the null hypothesis was not rejected for total scores and items. It was rejected for the Autonomy concept. Only the Autonomy concept exhibited a significant difference between pretreatment and posttreatment scores.

To test whether the passage of time affects scores, a comparison group was utilized. An unanticipated finding for the comparison group was a significant difference ($p = .047$) that was found on total score means between pre-no-treatment and post-no-treatment results (see Table 4). Seven individual items also exhibited

significant differences ($p < .05$) between pre- and post- scores in the comparison group (see Tables 4, 5, and 6).

Table 4
Two-Tailed t -Test Results of Mean FOS Total Scores for Comparison Group

	Pre		Post		t value	p
	Mean	<u>SD</u>	Mean	<u>SD</u>		
Total	142.64	32.98	146.61	33.41	-2.03	.047

Table 5
Two-Tailed t -Test Results of Mean Concept Scores for the Comparison Group

	Pre		Post		t value	p
	Mean	<u>SD</u>	Mean	<u>SD</u>		
Intimacy	73.87	16.69	75.97	16.99	-1.81	.075
Autonomy	73.10	17.05	71.77	16.46	1.24	.218

This result is consistent with the total score difference found in the scores of the comparison group. Items 7, 8, 10, 12, 20, 34, and 36 were found to differentiate significantly ($p < .05$) between pre-time-interval and post-time-interval item means scores.

Table 6

Two-Tailed t -Test Analysis by Item Between Pre-"No-Treatment"
and Post-"No-Treatment" Scores of the Comparison Group

Item	Pre		Post		t value	p
	Mean	<u>SD</u>	Mean	<u>SD</u>		
1	3.98	1.11	3.95	1.02	0.26	.795
2	4.13	1.07	4.32	0.90	-1.80	.077
3	3.85	1.14	4.02	1.06	-1.86	.067
4	3.79	1.13	3.90	1.20	-0.77	.447
5	3.27	1.27	3.35	1.21	-0.66	.512
6	3.67	1.19	3.81	1.19	-1.24	.219
7	3.57	1.20	3.87	1.04	-2.04	.045*
8	3.62	1.17	3.90	0.93	-2.94	.005*
9	3.59	1.14	3.73	1.06	-0.89	.375
10	3.08	1.37	3.50	1.26	-3.53	.001*
11	3.22	1.23	3.31	1.23	-0.61	.544
12	2.88	1.30	3.36	1.24	-3.24	.002*
13	2.91	1.19	3.09	1.22	-1.27	.208
14	3.13	1.10	3.33	1.14	-1.63	.107
15	3.69	1.25	3.69	1.13	0.00	1.000
16	3.34	1.10	3.48	1.08	-1.03	.309
17	3.59	1.19	3.77	1.23	-1.84	.070
18	3.63	1.12	3.63	1.13	0.00	1.000
19	3.88	1.13	3.70	1.20	1.44	.154
20	3.39	1.26	3.66	1.13	-2.17	.034*

Table 6--Continued

Item	Pre		Post		<u>t</u> value	<u>p</u>
	Mean	<u>SD</u>	Mean	<u>SD</u>		
21	3.36	1.15	3.33	1.14	0.22	.825
22	4.25	1.13	4.33	0.99	-0.74	.460
23	3.53	1.15	3.63	1.09	-0.70	.484
24	3.31	1.08	3.44	1.08	-0.82	.414
25	3.52	1.16	3.59	1.07	-0.56	.576
26	3.69	1.18	3.63	1.25	0.48	.631
27	3.33	1.22	3.36	1.25	-0.20	.840
28	3.55	1.33	3.47	1.41	0.41	.683
29	3.72	1.09	3.66	1.25	0.42	.673
30	4.21	1.15	4.21	1.05	0.00	1.000
31	3.52	1.16	3.67	1.16	-1.30	.199
32	3.66	1.26	3.69	1.36	-0.30	.766
33	3.61	1.20	3.77	1.12	-1.09	.279
34	3.45	1.22	3.66	1.17	-2.42	.018*
35	3.52	1.07	3.61	1.24	-0.74	.465
36	3.10	1.10	3.44	1.06	-2.82	.007*
37	3.58	1.25	3.60	1.27	-0.11	.909
38	3.52	1.16	3.67	1.02	-1.86	.067
39	4.09	1.24	4.09	1.19	0.00	1.000
40	4.11	1.20	4.03	1.22	1.22	.228

*Denotes statistical significance ($p < .05$).

Hypothesis 2

There will be no significant difference in perceptions of family of origin, as measured by the Family of Origin Scale (Hovestadt et al., 1985), between those subjects who complete treatment (stayers) and those subjects who leave treatment early (leavers). A two-tailed t test was employed to determine if mean differences occurred between the two groups on the pretreatment FOS total and item results. The results of these analyses appear in Tables 7 and 8. Findings of the analysis were nonsignificant ($p < .05$). Scores of subjects who leave treatment before completion ($n = 27$) do not differ significantly on mean FOS total or item scores from scores of subjects who complete treatment ($n = 81$). The null hypothesis was not rejected.

Table 7

Two-Tailed t-Test Results of Mean Total Scores
for Leavers and Stayers

	Leavers		Stayers		<u>t</u> value	<u>p</u>
	Mean	<u>SD</u>	Mean	<u>SD</u>		
Total	115.96	36.21	122.35	34.67	-0.80	.427

Additional Analyses

Since previous studies (Andrasi, 1986/1987; Mangrum 1988/1989) reported significant differences on FOS scores between clinical and

Table 8
Item Mean Ratings for Leavers and Stayers

Item	Leavers		Stayers		t value	p
	Mean	SD	Mean	SD		
1	3.19	1.57	3.17	1.39	0.04	.971
2	2.93	1.38	3.31	1.35	-1.25	.217
3	3.37	1.24	3.16	1.29	0.75	.456
4	2.81	1.44	2.98	1.25	-0.53	.598
5	2.81	1.36	2.81	1.35	-0.01	.994
6	3.52	1.45	3.07	1.34	1.40	.168
7	2.70	1.38	2.96	1.39	-0.84	.404
8	3.37	1.36	3.63	1.11	-0.89	.377
9	2.67	1.49	3.18	1.36	-1.56	.125
10	3.15	1.59	3.33	1.34	-0.53	.598
11	2.70	1.41	2.79	1.38	-0.28	.783
12	2.96	1.26	2.54	1.37	1.47	.148
13	2.69	1.46	2.60	1.32	0.27	.788
14	2.89	1.34	2.88	1.30	0.05	.963
15	3.26	1.29	3.05	1.36	0.72	.473
16	2.63	1.50	2.55	1.29	0.25	.806
17	2.92	1.44	2.81	1.42	0.33	.739
18	2.92	1.52	3.05	1.20	-0.39	.702
19	2.77	1.42	3.10	1.37	-1.04	.306
20	2.81	1.55	3.28	1.31	-1.38	.174

Table 8--Continued

Item	Leavers		Stayers		t value	p
	Mean	SD	Mean	SD		
21	2.88	1.58	2.39	1.25	1.46	.153
22	3.54	1.50	3.31	1.39	0.68	.502
23	3.04	1.54	3.05	1.32	-0.03	.978
24	3.12	1.20	3.20	1.21	-0.28	.780
25	3.12	1.54	3.20	1.21	-0.23	.819
26	3.08	1.44	3.11	1.25	-0.10	.920
27	3.08	1.38	2.73	1.32	1.12	.268
28	2.72	1.43	2.95	1.46	-0.70	.487
29	3.50	1.29	3.19	1.30	1.05	.300
30	3.80	1.38	3.65	1.31	0.47	.644
31	3.40	1.19	3.02	1.26	1.36	.182
32	2.92	1.44	3.05	1.44	-0.39	.697
33	3.00	1.35	3.27	1.26	-0.89	.378
34	2.80	1.53	3.00	1.36	-0.59	.561
35	3.04	1.40	3.25	1.26	-0.65	.523
36	3.20	1.35	2.93	1.10	0.92	.362
37	2.84	1.40	3.09	1.27	-0.79	.437
38	3.29	1.37	3.43	1.17	-0.46	.651
39	3.04	1.37	3.44	1.41	-1.28	.207
40	3.38	1.50	3.28	1.35	0.27	.791

nonclinical populations, a t test was administered in a between-group data analysis. As would be predicted by those two studies, the mean total FOS scores of the clinical subjects differed significantly ($p < .001$) from the mean FOS total scores of the nonclinical sample. The significant difference ($p < .01$) held for both the pretreatment scores and the posttreatment scores on Intimacy and Autonomy and most individual items.

Although not included in the hypotheses of the study, some secondary analyses of data warrant a brief acknowledgment. When FOS results were analyzed by gender using t tests to evaluate for possible differences in FOS results between men and women, a significant difference ($p = .046$) was found; women (111.34) exhibited lower FOS total pretreatment scores than men (128.48). When the same statistic was applied to the posttreatment results, the level of significance increased ($p = .003$), with women's total FOS scores (104.31) at greater variance with men's total FOS posttreatment scores (129.31). However, there was no significant difference between pretreatment and posttreatment scores for women or men. This finding is in keeping with the results of analyses of the first two hypotheses of this study: no significant difference between pretreatment and posttreatment scores. No difference was found in the comparison group between men and women.

Another secondary analysis of demographic variables involved an examination of data to determine if subjects raised in a home where the parents separated or one died before the subject was 16 (parent-lost) would differ on FOS scores from those raised in a home where

the parents remained together until the subject was at least 15 (parents-remained). A t-test statistical procedure was applied to the data to examine for possible differences in mean total scores and mean item scores. No significant difference was found in the clinical group between those who came from a parent-lost home and those who came from a parents-remained home.

In the comparison group, there was no significant difference on total scores, but six items (3, 6, 12, 14, 19, and 37) on the pre-test and five items (3, 6, 15, 36, and 37) on the posttest, exhibited significant difference ($p < .05$) between subjects who grew up in parent-lost homes and those who grew up in parents-remained homes.

Finally, the test-retest reliability (.97) matched that of the original authors of the FOS (Hovestadt et al., 1985).

Summary

Both the discriminatory power of the FOS and effects of treatment on perceptions of family of origin health were examined in this project. The results of this study suggest that only the Autonomy concept produced evidence of change of subjects' perceived family of origin health after treatment. FOS total score means, item score means, and Intimacy subscale score means did not show discriminatory sensitivity to change following treatment.

No difference was found on FOS scores between subjects who leave treatment early and those who complete treatment. However, an unexpected finding arose when a statistically significant difference was found in the comparison group between pre- and post- results

with a "no treatment" time interval between administrations.

The discriminating power of the FOS was again supported. The experimental (clinical) group differed significantly from the comparison group on mean total, mean subscales, and mean item scores.

A number of findings were reported with respect to demographic variables. In the clinical group women's total scores differed from those of men at the $p < .05$ level. The results of comparing women's ($n = 29$) total scores with men's ($n = 52$) total scores on the pretest showed means of 111.34 for women and 128.48 for men, with a t value of 2.05 at $p = .046$. On the posttest women had a mean of 104.31, while men had a mean of 129.31, resulting in a t value of 3.16 at $p = .003$. Thirteen items on the pretest and 22 on the posttest differentiated significantly ($p < .05$) between men's and women's scores.

Although no difference was found in pre- to post- measures between men and women, a difference between men and women was found in both administrations, with women of the clinical group showing significantly less positive views of their families' of origin health. No difference between women and men was found in the comparison group.

An analysis of score differences between those who grew up in a parent-lost home and those who had a parents-remained home for most of their childhood resulted in nonsignificance in the clinical group. Those who grew up in a parent-lost home scored essentially the same as those who grew up in parents-remained homes.

The mean total scores for those who came from parent-lost homes and those who came from parents-remained homes of the clinical or comparison groups were not significantly different on either the pretest or posttest administrations of the FOS.

CHAPTER V

DISCUSSION, RECOMMENDATIONS, AND SUMMARY

Discussion

The field of family of origin theory and therapy is said to have moved from its infancy stage to its childhood. Its youth brings with it problems of credibility and of inadequate empirical research in support of theory. Wynne (1988) summarized, "a new wave of family therapy research has begun to emerge" (p. 264). This new research must respond to these problems.

The new emphasis on research has subsequently led to a clamor for empirically based measurement tools. One of the most recent of these tools to be constructed was the Family of Origin Scale (FOS) (Hovestadt et al., 1985), which offers clinician-researchers quantifiable measures of abstract concepts in the family of origin therapy field. It was in this vein that the present study pursued the possibility of broadening the research and clinical applications of the FOS.

Lee et al. (1989) first begged the question of a pre-post design application of the FOS. Although their study found no significance in its pre-post results, their study lacked a true pre-post format in that it used different samples for "pre" and "post" measures. Essentially, then, the Lee et al. study was "cross-sectional" in focus, not pre-post. It was an attempt of the present study to

apply a more strict pre-post design, in an attempt to support further the possible uses of the FOS by demonstrating its effectiveness as a measure of change.

Gurman and Kniskern (cited in Raffa, Sypek, & Vogel, 1990) identified a number of general guidelines in their overview of family therapy research which apply to this study as well. Among them, a need for comparison or control groups, a need to report statistics in text, and a need for the use of instruments which have proven validity and reliability were highlighted. It was an attempt of this study to adhere to those guidelines while addressing the question raised by Lee et al. (1989).

In the present study, the FOS's Autonomy subscale scores were most useful in measuring change in clinical populations from pre-treatment to posttreatment. Total scores and item scores showed no significance. Limitations in sample sizes encountered during the study could account for some of the nonsignificance. Although the FOS again was found to discriminate clearly between demographically different populations, the results in the present pre-post comparison identified only the Autonomy concept (20 items) as yielding significance from pre- to postmeasures of the clinical group. Possible reasons for these findings will be discussed in this chapter along with the discussion of the results.

The first hypothesis of this study was formulated to determine if the FOS were a sensitive instrument for measuring change due to treatment. Correspondingly, the question was addressed of whether or not subjects' perceptions changed regarding the health of their

families of origin. Data analysis results bore no evidence to reject the null hypothesis in mean item or total scores. The null hypothesis was rejected, however, by pre-post comparison of the FOS Autonomy concept mean scores. The Autonomy concept of the FOS, although under challenge of its construct validity by two studies (Lee et al., 1989; Mangrum, 1988/1989), was found in this study to differentiate between clinical subjects' pretreatment and posttreatment results. These results do not necessarily challenge Lee's et al. (1989) or Mangrum's (1988/1989) findings, in which they determined the FOS to be essentially unidimensional. They reported a single salient factor accounted for approximately 40% of the "commonality of variance" (Mangrum, 1988/1989, p. 35). Of the items which comprise the Autonomy concept, 7 are found in the 14 which comprised Mangrum's "central" factor, and 8 are found in Lee's et al. 13 which comprised their "central" factor.

The Autonomy concept contains the five subscales: clarity of expression, responsibility, respect for others, openness to others, and acceptance of separation and loss. Hovestadt et al. (1985) had hoped that the Autonomy concept in their FOS encapsulated, for the most part, the self-differentiation process referred to by Bowen (cited in Hovestadt et al., 1985). The authors contended that the healthy family fostered autonomy "by emphasizing clarity of expression, responsibility, respect for others, openness to others, and acceptance of separation and loss" (Hovestadt et al., 1985, p. 290).

With the findings of Lee et al. (1989), Mangrum (1988/1989), and Mazer et al. (1990), however, there is some question of the original instrument's (FOS) construct validity. These studies suggest that the FOS may not measure exactly what the original authors intended. In fact, Lee et al. (1989) suggested that all items be seen as having essentially the same psychological content. Mazer et al. (1990) reported general agreement with Lee et al. Both studies found a single salient factor which accounted for much of the total variance of test scores.

Mazer et al. (1990), however, suggested, "with respect to item content, the factor is partially congruent with the Autonomy concept hypothesized for the test authors" (p. 425). Additionally, Mazer et al. concluded:

The facility to express one's views, opinions, and feelings, even though they may differ from those of parents and other family members, is the psychological construct which appears to underlie the organization of the dominant factor in all analyses on the FOS that have been reported. (p. 426).

The results of the present study would seem to fall clearly in line with Mazer's et al. conclusions.

Only one item (10) of this study exhibited evidence of change from pretreatment to posttreatment in a by-item statistical analysis. None of the individual items which comprise the Autonomy concept was found to evidence significance.

Some limitations of the study might have influenced these findings, however. One problem was the fact that a much smaller group of outpatient mental health subjects was collected than was

anticipated. This limitation was due to a reported lack of motivation on the part of agency staffs to follow through with the investment of time and energy needed for a pre-post design study. The majority of the experimental group ($n = 55$), then, were alcoholics in residential alcoholism centers. Alcoholics, as a group, have notoriously low internal motivation for change.

Additionally, one could reasonably guess that changes in the views of the family of origin health might manifest in a group of subjects undergoing family therapy, but might not manifest in a group of inpatient alcoholics and other outpatient mental health clients undergoing other therapeutic treatment modalities. For this reason one of the agencies originally enlisted as part of this study was a family therapy clinic. Unfortunately, the agency was also one of the four outpatient clinics to withdraw from the study.

In addressing the issue of change due to treatment, it is entirely possible that change could occur without it manifesting itself positively on the FOS. Indeed, as Fairbairn (1952) had explained, therapeutic change could well involve the emergence of formerly repressed, negative memories of childhood. An individual could, then, conceivably leave "successful" treatment with a more negative view of his or her family of origin.

At the beginning of their study, Lee et al. (1989) asked as the focus of their second experiment: "Does the FOS score indicate unhealthy families that produce future patients? Or do individuals with negative views of their family find their way into treatment?" (p. 22). The authors suggested a pre-post design to gain insight to

these questions. The present study took direction from Lee et al. (1989) and utilized a formal pre-post comparison group design.

Lee et al. (1989) found FOS mean total scores of past patients (117.97, SD 32.33) to be very close to the scores of subjects entering treatment (114.55, SD 29.80). Similarly, the results of this research showed pretreatment subjects' FOS mean total scores (122.35, SD 34.68) to be extremely close to posttreatment scores (120.36, SD 34.92).

Finally, Lee et al. (1989) concluded, "This finding may lend some credence to the notion that the FOS actually describes the family of origin as it was. People who have been through psychological treatment continue to describe their families in a very negative way" (p. 22). Indeed, if part of the process of therapy brings to the surface repressed material from the patient's past (Fairbairn, 1952; Miller, 1981; Winnicott, 1965), it may well be that a negative view of the health of the family of origin is quite refractory, and doesn't lend itself readily to change. Put simply, treatment subjects could very well change while leaving their view of the health of their families of origin in tact; or view them even more negatively as was apparently exhibited by the pre-post Autonomy scores results. It may be that focus on painful past experiences evoked in treatment tends to manifest itself in less favorable perceptions of subjects' families of origin, at least with respect to those areas measured by the FOS Autonomy concept.

The results of this study then did not support the FOS's items or total scores as sensitive to possible therapeutic change. They

did, however, highlight the Autonomy concept as having that sensitivity. Although one item (10) was found to show a significant difference ($p < .05$) from pretreatment to posttreatment in the experimental group, one item would be expected to be found by chance at the $p < .05$ level. Therefore, the null hypothesis was not rejected in the case of FOS mean total and item scores, but was rejected by the Autonomy concept scores.

An unanticipated result of analysis was mentioned in Chapter IV--a significant difference was found in the comparison group mean FOS scores after a no-treatment time interval ($p = .047$). This difference may be an artifact. Since the time interval between pre- and post- administration of the FOS was comparable to the treatment time periods for the experimental group (30 days), it would not be expected that such possible intervening variables as maturation would have much effect. One purely speculative guess might be that college students who already have a positive view of their families of origin (142.64) might, after having their attention brought to it, be tempted to show an even more positive view (146.61). However, the level of significance was slight.

The second hypothesis addressed whether a difference could be found between scores of subjects who completed treatment and those of subjects who left early. The null hypothesis was not rejected. There was no significant difference on FOS scores between "stayers" and "leavers." How one views one's family of origin may simply have little or nothing to do with whether or not one stays or leaves treatment early.

To sum the findings on the two major hypotheses of this study, the null hypothesis was not rejected in review of total and by-item results. The null hypothesis was rejected, however, by results of Autonomy concept pre-post analysis.

The findings of this study do not completely support the Lee et al. (1989) conclusions wherein those researchers found no posttreatment change on the FOS. However, the report of their results suggests that the authors did a one-way analysis of variance on total score means only.

Finally, in some apparent agreement with the above authors' speculations, the findings of the Autonomy concept analysis suggest that the view of the family of origin, at least that part covered by the Autonomy concept, may become less positive after treatment. It may be, as those authors speculated, "This finding may lend some credence to the notion that the FOS actually describes the family of origin as it was. People who have been through psychological treatment continue to describe their families in a very negative way" (Lee et al., 1989, p. 22). The Family of Origin Scale may or may not be sensitive to the kind of change occurring as a result of treatment. However, a question remains as to how much change, if any, truly occurred due to treatment of the clinical subjects in this study.

Some ancillary findings of the statistical results may merit mention. As in previous studies (Andrasi, 1986/1987; Lee et al., 1989; Mangrum, 1988/1989), the FOS's ability to discriminate between clinical and nonclinical groups was again demonstrated. Mangrum

(1988/1989), Lee et al. (1989), and Mazer et al. (1990) all reported that the FOS essentially offers a measure of the quality of acceptance and support in interpersonal communication felt by individuals in their families of origin. Its usefulness as a diagnostic tool, then, was again supported.

Although the sample of women was small (29) compared to men (52) in the clinical group, a significant difference between these two subgroups was found on both the pretreatment total FOS scores ($p = .046$) and on the posttreatment measure ($p = .003$). The mean totals on the pretest were 111.34 with an SD of 38.77 for women, and 128.48 with an SD of 30.88 for men. On the posttest the mean total scores were 104.31 with an SD of 35.40 and 129.31 with an SD of 31.57, respectively. The t values were 2.05 for the pretest and 3.16 for the posttest. The women had significantly less positive views of their families of origin than did men, and their views differed more significantly after treatment. Although the difference from pretreatment to posttreatment for women was not significant, their posttreatment mean scores did suggest movement towards an even less positive view of their families of origin.

Interestingly, Bonnington (1989) compared FOS results on men and women college students and found no significant difference. This author also found no significant difference within the college student comparison group. Bonnington postulated, "It may be that these respondents were too close to the age of leaving home for a difference to appear and that differences may appear as individuals become more independent of their families of origin" (p. 813).

The significant differences found between men and women in the clinical group may have something to do with Bonnington's (1989) premise. The clinical women fall in the age range of 30-45 years old described by Bray and Williamson (1987) as the time when "individuals resolve the inherent tension between differentiation and intimacy in the biological family and in other significant relationships" (p. 34). Perhaps differences are beginning to show in the subjects' lives. However, 18 of the 29 women in the study were among the outpatient mental health population, leaving only 11 women in the residential alcohol treatment population ($n = 63$). The numbers are simply too small to offer generalizable findings or speculations.

When the clinical group data were separated into groups of those ($n = 43$) who came from parent-lost homes (parents separated or one died before subject was 16) and those ($n = 38$) who came from parents-remained homes (parents remained together until subject was over 16), no significant difference ($p < .05$) was found in the FOS scores. The mean totals were 122.53 and 122.13, respectively. The standard deviations were 37.53 and 31.64, with a t value of $-.05$ and probability of $.96$. Similarly, the results of this analysis in the comparison group data were nonsignificant.

Recommendations

Sampling difficulties and other limitations rendered the results of this study rather inconclusive. However, the results of this study should not preclude further research with the FOS, which

may be warranted under appropriate circumstances. The field of family of origin theory continues its need for empirical support. To date, the FOS has made contributions to both research and clinical settings (Andrasi, 1986/1987; Manley et al., 1990; Mazer, 1991).

Since the principal significant finding was discovered in the pre-to-post results in the mean Autonomy concept scores, it is suggested that further investigation focus on this concept. Further investigation warrants greater adherence to experimental design with control over data collection and a matched or randomized control group. Additionally, a longer time interval between pre- and post-administrations of the FOS might result in a measure of more lasting change, and could control for the possibility for change after subjects have had time to "process" their therapy experiences. The extra time could also allow for measure of longer-term outpatient mental health treatment. A larger sample of outpatient mental health clients might offer clearer results. Additionally, the focus of such a pre-post study might be on programs offering only family therapy. This application of the FOS to family therapy settings fits well with two more of Gurman and Kniskern's (cited in Raffa et al., 1990) guidelines for family therapy research: having treatment needs adhere to theory and having treatment well defined for quality control.

In addition to the further use of the FOS to illuminate treatment effects, it might be advisable to incorporate the use of another well-validated instrument which has been shown to be sensitive to change due to treatment.

Further investigation might also be warranted around the issue of possible differences of perception of family of origin health between men and women in treatment.

A point of curiosity in a finding of this study is that in the two cases where significant pre-post difference was found (Autonomy concept and men/women in the clinical population), the direction of change was towards a less positive view of the family of origin after treatment. This of course brings to question what change is good change in regards to therapy outcome. A less favorable expressed view of the family of origin does not necessarily suggest unsuccessful treatment (Miller, 1990).

The continuation of relevant research applications of the FOS may be warranted. An instrument requires a long period of time and numerous applications in a variety of settings to establish supported psychometric validity (Kinston, Loader, & Miller, 1987).

Summary

The pitfalls found during the course of this study highlight the difficulty of research in the field of family of origin theory and therapy in general. Control over data collection, treatment quality, and theory adherence is a major challenge. But if this challenge is not met, then research may be conducted only on that which is easily controlled and measured. Ryder (1988) warned against pursuing studies with only easily measured outcomes because those outcomes can be demonstrated more readily. Such research might avoid difficult-to-measure outcomes, but at what cost? What

could result, Ryder has admonished, is the tail wagging the dog in the building of theory and subsequent treatment paradigms in the family of origin field. The present study has illuminated some of the inherent problems of field research with the FOS and, subsequently, underscores the importance of Ryder's admonition.

APPENDICES

Appendix A
Family of Origin Scale

Family of Origin Scale

Directions: The family of origin is the family with which you spent most or all of your childhood years. This scale is designed to help you recall how your family of origin functioned. Each family is unique and has its own way of doing things. Thus, there are no right or wrong choices in this scale. What is important is that you respond as honestly as you can. In reading the following statements, apply them to your family of origin as you remember it. Using the following scale, fill in the appropriate circle in the row at the end of each statement. Disregard the numbers on the left of the grid. Please respond to each statement.

Key:

- 5 = (SA) = STRONGLY AGREE that it describes my family of origin.
 4 = (A) = AGREE that it describes my family of origin.
 3 = (N) = NEUTRAL.
 2 = (D) = DISAGREE that it describes my family of origin.
 1 = (SD) = STRONGLY DISAGREE that it describes my family of origin.

(5 = SA, 4 = A, 3 = N, 2 = D, 1 = SD)

1. In my family, it was normal to show both positive and negative feelings.
2. The atmosphere in my family usually was unpleasant.
3. In my family, we encouraged one another to develop new friendships.
4. Differences of opinion in my family were discouraged.
5. People in my family often made excuses for their mistakes.

(5 = SA, 4 = A, 3 = N, 2 = D, 1 = SD)

6. My parents encouraged family members to listen to one another.
7. Conflicts in my family never got resolved.
8. My family taught me that people were basically good.
9. I found it difficult to understand what other family members said or how they felt.
10. We talked about our sadness when a relative or family friend died.
11. My parents openly admitted it when they were wrong.
12. In my family, I expressed just about any feeling I had.
13. Resolving conflicts in my family was a very stressful experience.
14. My family was receptive to the different ways various family members viewed life.
15. My parents encouraged me to express my views openly.
16. I often had to guess at what other family members thought or how they felt.
17. My attitudes and my feelings were frequently ignored or criticized in my family.
18. My family members rarely expressed responsibility for their actions.
19. In my family, I felt free to express my own opinion.
20. We never talked about our grief when a relative or family friend died.
21. Sometimes in my family, I did not have to say anything, but felt understood.
22. The atmosphere in my family was cold and negative.
23. The members of my family were not very receptive to one another's views.
24. I found it easy to understand what other family members said and how they felt.

(5 = SA, 4 = A, 3 = N, 2 = D, 1 = SD)

25. If a family friend moved away, we never discussed our feelings of sadness.
26. In my family, I learned to be suspicious of others.
27. In my family, I felt that I could talk things out and settle conflicts.
28. I found it difficult to express my own opinion in my family.
29. Mealtimes in my home usually were friendly and pleasant.
30. In my family, no one cared about the feelings of other family members.
31. We usually were able to work out conflicts in my family.
32. In my family, certain feelings were not allowed to be expressed.
33. My family believed that people usually took advantage of you.
34. I found it easy in my family to express what I thought and how I felt.
35. My family members usually were sensitive to one another's feelings.
36. When someone important to us moved away, our family discussed our feelings of loss.
37. My parents discouraged us from expressing views different from theirs.
38. In my family, people took responsibility for what they did.
39. My family had an unwritten rule: Don't express your feelings.
40. I remember my family as being warm and supportive.

Source. "A Family of Origin Scale" by A. Hovestadt, W. Anderson, F. Piercy, S. Cochran, and M. Fine, 1985, Journal of Marital and Family Therapy, 2, pp. 287-297. Reprinted by permission.

Appendix B

Paradigm for the Family of Origin Scale

Paradigm for Family of Origin Scale

Construct	Meaning in a healthy family	Positive scale items	Negative scale items
Autonomy concept			
A. Clarity of expression	Thoughts and feelings are clear in the family	24, 34	9, 16
B. Responsibility	Family members claim responsibility for their own actions	11, 38	5, 18
C. Respect for others	Family members are allowed to speak for themselves	15, 19	4, 28
D. Openness to others	Family members are receptive to one another	6, 14	23, 37
E. Acceptance of separation and loss	Separation and loss are dealt with openly in the family	10, 36	20, 25
Intimacy concept			
A. Range of feelings	Family members express a wide range of feelings	1, 12	32, 39
B. Mood and tone	Warm, positive atmosphere exists in the family	29, 40	2, 22
C. Conflict resolution	Normal conflicts are resolved without undue stress	27, 31	7, 13
D. Empathy	Family members are sensitive to one another	21, 35	17, 30
E. Trust	The family sees human nature as basically good	3, 8	26, 33

Source. "A Family of Origin Scale" by A. Hovestadt, W. Anderson, F. Piercy, S. Cochran, and M. Fine, 1985, Journal of Marital and Family Therapy, 2, pp. 287-297. Reprinted by permission.

Appendix C
Information Sheet

Information Sheet

Directions: Please complete the following information sheet by filling in the circle which corresponds to the answer you select for each question. Be sure to enter your answer in the row at the end of each question. Disregard the numbers on the left of the grid.

1. Age

(1) under 18	(2) 18-21	(3) 22-25	(4) 26-30
(5) 31-35	(6) 36-40	(7) 41-50	(8) 51+

2. Race/Ethnic

(1) White	(2) Black	(3) Native American	(4) Hispanic
(5) Asian	(6) Oriental	(7) Other	

3. Sex

(1) male	(2) female
----------	------------

4. Marital status

(1) married	(2) single	(3) divorced	(4) widowed
(5) cohabitating			

5. Birth order

(1) oldest	(2) next to the oldest	(3) next to the youngest	
(4) youngest	(5) only child	(6) other	

6. Education level

(1) junior high school	(2) high school	(3) 2 years of college	(4) bachelor's degree
(5) master's degree	(6) specialist's degree	(7) doctorate	

7. Employment

(1) full-time	(2) part-time	(3) laid off	(4) retired
(5) fired	(6) homemaker	(7) disabled	

8. Your age when your parents separated

(1) under 1 yr	(2) 1-3 yrs	(3) 4-6 yrs	(4) 7-10 yrs
(5) 11-15 yrs	(6) 16-18 yrs	(7) 18+ yrs	
(8) not applicable			

9. Your age when your mother died

(1) under 1 yr	(2) 1-3 yrs	(3) 4-6 yrs	(4) 7-10 yrs
(5) 11-15 yrs	(6) 16-18 yrs	(7) 18+ yrs	
(8) not applicable			

10. Your age when your father died

(1) under 1 yr	(2) 1-3 yrs	(3) 4-6 yrs	(4) 7-10 yrs
(5) 11-15 yrs	(6) 16-18 yrs	(7) 18+ yrs	
(8) not applicable			

11. Have you ever received counseling or psychotherapy?
(1) yes (2) no

12. Have you ever received help for a substance abuse problem?
(1) yes (2) no

Appendix D

Human Subjects Institutional Review Board Approval Letter

Human Subjects Institutional Review Board



Kalamazoo Michigan 49008-3859

 WESTERN MICHIGAN UNIVERSITY

Date: June 15, 1990

To: Arthur J. Fedor

From: Mary Anne Bunda, Chair *Mary Anne Bunda*

This letter will serve as confirmation that your research protocol, "A Validation of the Family of Origin Scale Using Alcoholic and Mental Health Patients: An Analysis of Clinical Data Pre-Posttreatment", has been approved under the exempt category of review by the HSIRB.

The Board decided that you need to ask your colleagues to destroy the Master List of code numbers to names after the retest.

The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the approval application.

You must seek reapproval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date.

The Board wishes you success in the pursuit of your research goals.

xc: G. Mazer, CECP

HSIRB Project Number 90-05-06Approval Termination June 15, 1991

Appendix E
Instruction Sheets

Instruction Sheet for Students

One of my colleagues, Mr. Fedor, has asked if we would be willing to help him with a research project by completing the Family of Origin Scale. The self-report Family of Origin Scale surveys your views of your family during your childhood and teen years. The survey does not ask sensitive questions.

The survey takes only about 15 minutes to complete. Participation is voluntary. If you choose not to participate, it will have no bearing on your grade and you will remain anonymous. Since we might ask you to take the same questionnaire again, your test number will be recorded next to your name. This is for research purposes only. Furthermore, the researcher, Mr. Fedor, will not know who took which questionnaire, and he will not tell the scores to me. In this way the confidentiality will be protected. I feel this is an important study which will help us in counseling families and I hope you will be willing to participate.

Instruction Sheet for Clients

One of my colleagues, Mr. Art Fedor, has asked if we would be willing to help him with a research project by completing the Family of Origin Scale. The self-report Family of Origin Scale surveys your views of your family during your childhood and teen years. The survey does not ask sensitive questions.

The survey takes only about 15 minutes to complete. Participation is voluntary. If you choose not to participate, it will have no bearing on your treatment status or progress, and you will remain anonymous. Since you might be asked to take the same questionnaire again, your test number will be recorded next to your name at the agency. This is for research purposes only. I have no interest in individual results. Furthermore, the researcher, Mr. Fedor, will not know who took which questionnaire, and he will not tell me your scores. In this way confidentiality will be protected.

I feel this is an important study which will help us in counseling families and I hope you will be willing to participate.

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