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Comparing Family Functioning Levels in Individuals Using the MMPI-2

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Abstract

Previous research has demonstrated a relationship between poor family functioning (i.e. poor communication, a lack of bonding and cohesion, and family conflict) and problems within individual areas (i.e. juvenile delinquency, social adjustment, substance abuse, and bipolar disorder) in adolescents. The current study examines the relationship between family functioning, as measured by the Family Functioning Scale (FFS), and scale scores on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). Participants were 1,109 students from a Midwestern university (449 Men and 660 Women) ranging in age from 18 to 53 (mean age = 19.47). All participants completed a computer-administered version of the MMPI-2 and FFS, as part of a larger study. Zero-order correlations were calculated between the FFS total score and MMPI-2 scales. Results indicated that poor family functioning is most highly correlated with the MMPI-2 Content Scale Family Problems; however, poor family functioning was also related to scores on Content Scales, Depression scale and Low Self Esteem scale, as well as Supplementary Scales, College Maladjustment scale, and Post-Traumatic Stress Disorder-Keane scale on the MMPI-2. The research suggests that individuals with poor family functioning are more likely to have problems with depression and low self-esteem and may also be more likely to deal with symptoms related to PTSD. Treatment implications are also discussed.

Comparing Family Functioning Levels in Individuals Using the MMPI-2

Introduction

Although family functioning is a particularly complex entity that can be assessed in many different ways, it generally refers to the quality of family life at the systemic level, such as wellness, strengths, weaknesses, and competence of a family (Shek, 2005). When attempting to measure family functioning, there are many important family constructs that must be considered, such as communication, bonding and cohesion, and conflict within families (Bray, 1995). Problems in the area of communication are among the most common problems identified in dysfunctional families. Healthy communication includes a family's ability to give appropriate attention among family members, evolution of shared and common meanings, and clear and direct verbal exchanges (Epstein & Bishop, 1981). Dysfunctional communication is characterized by disruptions in attention between family members, lack of shared meaning, and indirect and masked verbal exchanges.

Along these lines, Dickstein (2002) conducted a study on family routines and rituals and the importance of family functioning. This study conducted observational assessments of mealtime in order to obtain naturalistic information about routine family functioning. By doing this, the study was able to observe patterns of communication, problem solving, behavioral expectations, and role negotiations. Four control styles were found, which included chaotic, laissez-faire, rigid, and flexible control styles. A chaotic control style was found to be least effective and consisted of a random shifting among control styles so that there was confusion about standards of behavior. The laissez-faire style was found to have no standards, with total latitude given to family members. In the rigid control style there was little room for negotiation, and in the flexible control style, which was found to be most effective, there were reasonable standards for family members with room for negotiation depending on circumstances. This study

found that the manner in which families behave together is important to the functioning of the family as a whole and to the development of individual family members. Also, it was determined that family functioning assessed during routine mealtime is associated with early childhood social-emotional and behavioral competence.

Bonding and Cohesion is another construct that is important when measuring family functioning. Bonding and cohesion refer to the level to which family members view themselves as emotionally close or distant to other members of the family (Bray, 1995). This dimension ranges from over-involvement or enmeshed to disengagement or disconnection. Enmeshed families are believed to have diffuse family boundaries, excessive emotional responsiveness, and poorly differentiated family relationships. Disengaged families tend to have rigid family boundaries, a lack of emotional responsiveness, and lack of communication between family subsystems. Problems with emotional bonding and cohesion have been found to be associated with higher levels of conflict in the family. In addition, cohesion operates differently in different types of family structures. For example, during early remarriage, boys' adjustment is related to more cohesion and emotional bonding in the stepfamily, whereas girls' adjustment is related to less cohesiveness and less involvement in the stepfamily (Bray & Berger, 1993).

Cashwell & Vacc (1996) conducted a study to examine how family relationships relate to self-reported delinquency among adolescents. While this study found that being involved with deviant peers was the strongest direct predictor of adolescent delinquent behavior, the study also found that family cohesion provided the strongest overall familial influence on delinquent behavior. These findings suggest that family cohesion is most influential on delinquent behavior as it influences peer-group choice. The study concluded that living in a cohesive family reduces the likelihood of becoming involved with deviant peers.

Compared to communication and bonding and cohesion, the area that has received the predominant amount of attention from the research literature is familial conflict. Conflict within families is one of the most consistent predictors of various types of individual marital and family dysfunction (Bray, 1995). Family conflict ranges from mild forms of disagreement and criticism to physical altercations with significant negative affect and verbal assaults. Conflict is also related to other individual and family processes, such as family stress, depression and anxiety, poor communication, and poor problem-solving skills. It has also been found that family conflict is associated with increased psychological and health problems for family members (Doherty & Campbell, 1988).

Bradford, Vaughn and Barber (2007) conducted a study evaluating what effect interparental conflict, both overt and covert, and parent-child conflict has on youth problem behaviors. It was found that overt interparental conflict was positively associated with antisocial behavior in youths, and covert interparental conflict was positively associated with depression and antisocial behavior in youths. This same study also found significant direct associations between covert conflict and depression and overt conflict and antisocial behavior through increased parent-child conflict. If interparental conflict and parent-child conflict affects youth problem behaviors then it can be reasonably predicted that there will be continuity and family functioning will affect adulthood in many of the same ways.

Familial conflict, such as physical abuse, has been found to have dramatic affects on adolescent adjustment (Salzinger, Feldman, & Hammer, 1993). Salzinger et al.'s study had many significant findings including that abused children had lower peer status and they were rated by peers as more aggressive and less cooperative and by parents and teachers as more disturbed. The abused children were found to be significantly less socially adjusted compared to other

children the same age. This study found that abused children were at a much higher risk to have negative social status, meaning that they tend to be rejected by their peers. This has been found to be associated with mental health problems, school withdrawal, delinquency, and adult criminality. One of the strongest predictors of school dropout and delinquency has been peer rejection, which has been found to be significantly higher in abused children than in controls. According to Parker and Asher (1987) children that have deviant socialization experiences and lack normal social opportunities have a much greater chance of having a maladjusted outcome.

Regardless of the type of family dysfunction (i.e., communication problems, problems regarding bonding and cohesion, or conflict within families), there have been studies that have demonstrated that higher levels of family dysfunction overall are associated with a variety of different problems in regards to psychological well being and problem behaviors in adolescents, such as delinquent behavior and substance abuse (Clark et al., 1998). A study conducted by Clark et al. (1998) found that the families of adolescents with alcohol use disorders functioned less well than did families of normal adolescents. This study found that parents of children with anxiety disorders have been shown to report higher levels of family dysfunction compared with control families. Several studies have supported a relationship between low bonding with family and problematic alcohol and substance use among adolescents (Hawkins, Catalano, & Miller, 1992). Improved family functioning has also been shown to be associated with a decrease in substance abuse in treated adolescents (Stewart & Brown, 1993).

A study conducted by Hughes, Hedtke, & Kendall (2008) examined maternal and paternal reports of family functioning in families of children with anxiety disorders compared with families of children with no psychological disorders. The study found that maternal and paternal reports of poor family functioning was significantly associated with worse child

outcomes on the basis of child, parent, and clinician measures, including child anxiety disorder severity, higher child anxiety, and worse child global functioning. It was found that paternal as well as maternal anxiety and depression were shown to predict poor family functioning. This study also found that child anxiety and depression were significantly associated with family functioning but were not predictive of family functioning when parental anxiety and depression were taken into account.

Another study conducted by Du Rocher Schudlich, Youngstrom, Calabrese, & Findling (2008) investigated the association between family functioning and conflict and their links with mood disorder in parents and with children's risk for bipolar disorder. The results suggested that there was an indirect pathway from parental bipolar and unipolar disorder to family conflict via impaired family functioning. Increased family conflict in turn was predictive of child bipolar disorder. This suggests that conflict is not entirely a direct result of parents being diagnosed with a mood disorder, but rather that it develops out of a negative family climate, including deficits in problem solving and communication.

Self Report Measures

Although there are different ways to asses family functioning, such as projective tests, clinical interviews, performance on experimental tasks, and observations, self report instruments have most commonly been used to assess family functioning (Shek, 2005). One criticism that self report measures face when measuring family functioning is that self report measures only represent the perceptions of one individual and not of the whole family (Bray, 1995). The question arises whether or not is it necessary to have complete family assessments from all family members to evaluate family functioning or if it is sufficient to have individual

perspectives from only part of the family. However, if one is attempting to assess at least the impact of perceived family function/ dysfunction, an individual's opinion can be very useful.

While self report measures for family functioning have been criticized, they also have many strengths. First, there has been a great deal of empirical work carried out in order to develop and test measures of family functioning, (e.g. the Family Functioning Scale (Tavitian et al., 1987) and the Family Problems scale and Familial Discord subscale on the MMPI (Graham, 2006)) and link them to clinical intervention. Second, the psychometric properties for self report measures of family functioning can be vigorously evaluated using statistical analyses (Shek, 2005). Third, because of the ease in administering self report measures, they can be easily utilized in clinical and research contexts.

Family Functioning Scale

Tavitian et al., (1987) developed the Family Functioning Scale to measure general family functioning, and it was designed to be an inexpensive, comprehensive, reliable, and externally valid self-report measure of family functioning. In order to develop the scale, the sequential method of scale development proposed by Jackson (1970) was used. Five potentially meaningful dimensions of family functioning were included in the scale, which includes Positive Family Affect, Family Communication, Family Conflicts, Family Worries, and Family Rituals/Supports. The component that accounted for the greatest proportion of variance is the Positive Family Affect component, and this finding is consistent with other similar studies (Lowman, 1980).

Minnesota Multiphasic Personality Inventory

Previous studies have demonstrated the effects of problems within individual areas, such as juvenile delinquency, social adjustment, substance abuse, and bipolar disorder, and only with adolescents. Although the effects of family functioning on adolescents has been greatly

examined, the ways in which family functioning affects people later in life has gone relatively unstudied. What is needed is a more robust approach along with an examination of older individuals. The MMPI-2 affords both opportunities. The Minnesota Multiphasic Personality Inventory – 2 (MMPI-2; Butcher et al. 2001) is a 567 item, true or false, self report inventory that assesses an individual's functioning across several different domains, such as personality, psychopathology, social, and behavioral. The MMPI-2 consists of several sets of scales, including Validity, Clinical, Content, Restructured Clinical, Psychopathology-Five (PSY-5), and a variety of Supplementary scales.

The MMPI-2 contains numerous validity scales in order to attempt to determine a test-taker's approach to the measure. There are two overall approaches which might invalidate (i.e., provide non-interpretable) MMPI-2 results. These approaches are Content Non-Responsive (CNR) and Content Responsive Faking (CRF) approaches (McNulty et al., 2003). CNR responses look for high scores on the MMPI-2 Cannot Say (CNS), Variable Response Inconsistency (VRIN), and True Response Inconsistency (TRIN) scales. The CNS scale is simply a count of the number of items that were not answered or were answered both true and false. The TRIN scale helps to identify individuals who responded to the items inconsistently true (acquiescence) or inconsistently false (nonacquiescence), and the VRIN scale helps to identify test-takers who respond to the items randomly. If any of these scales is elevated, the protocol should be considered invalid and not interpreted. The CRF invalidating response approach is used to indicate whether the test-taker is attempting to portray himself or herself as having little or no distress (i.e., "faking good" or defensive, Scales Lie (L) and Correction (K)) or exaggerate or claim to have symptoms of severe psychopathology (i.e., "faking bad" or malingering, Scales Infrequency (F), Infrequency-Back (Fb), and Infrequency-

Psychopathology(Fp)). High CRF scores should be examined to determine whether the elevations result from severe psychopathology after TRIN and VRIN scores have been ruled out as the source of elevation.

The ten Clinical Scales include scale 1 (Hypochondriasis), 2 (Depression), 3 (Hysteria), 4 (Psychopathic Deviate), 5 (Masculinity-Femininity), 6 (Paranoia), 7 (Psychasthenia), 8 (Schizophrenia), 9 (Hypomania), and 0 (Social Introversion). People with high scores on these scales tend to have symptoms reflective of the title of the scale (e.g. the depression scale indicate persons who display depressive symptoms; psychopathic deviate scale may have difficulty incorporating the values and standards of society; etc.) However, due to extensive heterogeneity in the MMPI-2 Clinical scales, the MMPI-2 also contains many different subscales which are entitled the Harris-Lingoes subscales (Graham, 2006). These scales were developed in order to clarify the meaning of parent clinical scale elevations by creating scales that were more homogenous compared to their parent clinical scales. Harris and Lingoes (1955, 1968) constructed subscales for 6 of the 10 standard clinical scales. The subscales generally should not be interpreted unless their parent scales are significantly elevated (i.e. $T \geq 65$) and interpretation should be limited to trying to understand why high scores have been obtained on the parent scales.

The 15 Content Scales include scales that assess specific problems including Anxiety (ANX), Fears (FRS), Obsessiveness (OBS), Depression (DEP), Health Concerns (HEA), Bizarre Mentation (BIZ), Anger (ANG), Cynicism (CYN), Antisocial Practices (ASP), Type A Behavior (TPA), Low Self-Esteem (LSE), Social Discomfort (SOD), Family Problems (FAM), Work Interference (WRK), and Negative Treatment Indicators (TRT) (Graham, 2006). High scores on these scales are indicative of problems related to the scale title (e.g. family problems scales are

indicative of persons who describe considerable problems in their current families and/ or families of origin). As with the clinical scales, there are also subscales for the content scales, the Content Component Scales (Graham, 2006). Similar to the Harris Lingoes scales, the Content Component Scales were designed to clarify the meanings of elevated Content Scale scores.

The nine Restructured Clinical scales (RC; Tellegen et al., 2003) of the MMPI-2 were developed to measure the core constructs of the original MMPI Clinical scales by removing demoralization, which is hypothesized to adversely affect these scales. Tellegen's goal in developing the scales was to preserve the valuable predictive features of the existing Clinical scales while attempting to improve their distinctiveness. The RC scales consist of nine scales; Demoralization (RCd), Somatic Complaints (RC1), Low Positive Emotions (RC2), Cynicism (RC3), Antisocial Behavior (RC4), Ideas of Persecution (RC6), Dysfunctional Negative Emotions (RC7), Aberrant Experiences (RC8), and Hypomanic Activation (RC 9).

The MMPI-2 also contains the Personality Psychopathology Five (PSY-5) which is a dimensional model of personality psychopathology (Quilty & Bagby, 2007). The five domains that make up the PSY-5 include: Aggressiveness (AGGR), Disconstraint (DISC), Introversion/ Low Positive Emotionality (INTR), Negative Emotionality/ Neuroticism (NEGE), and Psychoticism (PSYC). AGGR represents antagonism, grandiosity, and desire for power; DISC represents impulsiveness, sensation-seeking, and antisociality; INTR represents social withdrawal, low levels of energy or positive affect; NEGE represents a wide range of negative affect; and PSYC represents the capacity to maintain accurate and useful models of the objective world. Harkness, McNulty, and Ben-Porath (1995) subsequently developed scales from the MMPI-2 to assess these personality domains. The MMPI-2 PSY-5 scales have demonstrated evidence of internal consistency and various forms of construct validity, such as structural

invariance, and concurrent and discriminant validity (Bagby, Ryder, Ben-Dat, Bacchiochi, & Parker, 2002)

In addition to the utilization in the construction of the standard validity and clinical scales, the MMPI item pool was used to develop numerous other scales by variously recombining the items using item-analytic, factor-analytic, and intuitive procedures (Graham, 2006). These scales are referred to as the supplementary scales. While a number of supplementary scales exist (some officially recognized, and some not), the most common utilized supplementary scales include the Anxiety (A) scale, the Repression (R) scale, the MacAndrew Alcoholism scale-Revised (MAC-R), the Addiction Acknowledgment Scale (AAS), the Addiction Potential Scale (APS), the Hostility (Ho) scale, and the College Maladjustment (Mt) scale. People who score high on the A scale may be anxious and uncomfortable or depressed, and people who score high on the R scale may be passive, submissive, or introverted. High scores on the MAC-R scale indicate people who may be socially extroverted, enjoy competition and risk taking, or have histories of behavior problems in school or with the law. High scores on the AAS scale typically indicate a person who reports utilizing alcohol or illicit substances, while high scores on the APS scale suggests a potential for or vulnerability to substance abuse, whether or not that abuse is currently taking place. High scores on the Ho scale may indicate a person that experiences higher levels of anger or may be more likely to display overt hostile behavior. High scores on the Mt scale may indicate people who are ineffectual, pessimistic, or procrastinate.

Hypothesis

Based on findings from the adolescent literature, the present study hypothesized that low family functioning (as measured by the Family Function Scale, (Tavitian et al., 1987)) will correlate with higher scores on MMPI-2 scales that measure depression, anxiety, and antisocial

behaviors. However, it should also be noted that due to the lack of literature on the impact of family functioning in a college aged population, the current study is exploratory in nature and hopes to develop a more in depth understanding of possible ways family functioning levels may affect college aged individuals, thus correlates with all MMPI-2 scale scores that measure clinically relevant behavior will be explored. In addition, due to the tendency for men and women to generate different scale correlates, the results for the current study will be presented separately by gender.

Method

Participants

Potential participants for the current study consisted of 1,109 (Men, N = 449; Women, N = 660) undergraduate students from a Midwestern university. Participants were primarily Caucasians (88.0%; N = 976), with a smaller proportion of African-Americans (7.2%; N = 80) or individuals either reporting as having another or an unidentified ethnicity (4.8%; N = 53). The age range of the participants was 18 to 53 (Mean = 19.47; SD = 3.083).

Participants were excluded from the current study if they produced an invalid MMPI-2 or Family Functioning Scale (FFS) profile. For the current study, MMPI-2 profile invalidity was defined as having a Cannot Say (CNS) raw score $\geq$ 30, a T Score $\geq$ 80 on True Response Inconsistency (TRIN), Variable Response Inconsistency (VRIN), Lie (L), or Correction (K), and/or a T Score $\geq$ 100 on Infrequency (F), Infrequency-Back (FB) or Infrequency-Psychopathology (Fp). In addition, FFS scores were considered invalid if an individual did not respond to 10% or more of the items. Based on these criteria, a total of 172 (15.5%) individuals produced an invalid MMPI-2 and/or FFS. No difference was found between those who produced valid and invalid test results profiles in terms of age; however, significant differences were found

on gender ($x^2 = 5.891$, $p \leq .015$, df = 1) and ethnicity ($x^2 = 23.553$, $p \leq .001$, df = 2), as a result of a larger proportion of men and non-Caucasians producing invalid MMPI-2 profiles and/or FFS scores.

The final group of participants consisted of 937 individuals (Men, N = 365; Women, N = 577). Of the final participants, 843 (90.0%) were Caucasians, 54 (5.8%) were African-Americans, and 40 (4.3%) either had another ethnicity, or did not report their ethnicity. The mean age of the final group of participants was 19.53 (SD = 3.204, range 18 to 53).

Measures

Minnesota Multiphasic Personality Inventory-2 (MMPI-2). The MMPI-2 (Butcher et al. 2001) is a 567 item, true or false, self report inventory that assesses an individual's functioning across several different domains, such as personality, psychopathology, social, and behavioral. The MMPI-2 consists of several sets of scales, including Validity, Clinical, Content, Restructured Clinical, Psychopathology-Five (PSY-5), and a variety of Supplementary scales.

Family Functioning Scale. The Family Functioning Scale (FFS, Tavitian et al., 1987) is a self- report measure of general family functioning. It consists of 40 items (7 point Likert scale, 1 = Never; 2 = Almost Never; 3 = Rarely; 4 = Sometimes; 5 = Frequently; 6 = Almost Always; 7 = Always) that measures five dimensions of family functioning, including Positive Family Affect, Family Communication, Family Conflicts, Family Worries, and Family Rituals/Supports. For the current study, only the total score on FFS was utilized.

Procedure

All participants were tested as part of a larger project that consisted of two testing sessions, exactly 7 days apart. All participants completed a computer-administered version of the MMPI-2 during either the first or second testing session (depending upon their assignment in the

larger study) and one of two sets of criterion measures (which included the FFS) during each of the two testing session. The measures in each criterion set were counterbalanced, as was the administration order of the criterion sets. All participants completed the FFS (in addition to additional criterion measures) by the end of the second testing session. All participants received credit in their Introduction to Psychology course in exchange for participation.

Results

In the current study, zero-order correlations were used. However, given the large sample sizes of both men and women, relatively small correlations were statistically significant, so rather than using statistical significance in reporting correlations, only correlations of .40 (which is a midpoint between a medium and large correlation effect size, based on Cohen, 1988) or larger will be reported. It should also be noted that negative correlations on the total FFS score represent poor family functioning. Results are presented separately by gender, due to previous findings that MMPI-2 correlates tend to vary by gender (Graham, 2006).

For men, the study found that the total FFS score was most highly correlated with MMPI-2 content scale FAM (r = -.55). MMPI-2 clinical scales 7 and 8 were also moderately correlated (r = -.40 and -.45, respectively) with the total FFS score for men. MMPI-2 content scale Depression (DEP) (r = -.42), Low Self Esteem (LSE) (r = -.40), and Negative Treatment Indicators (TRT) (-.43) also moderately correlated with the total FFS score for males. MMPI-2 supplementary scale College Maladjustment (Mt) (r = -.41) and Post-Traumatic Stress Disorder–Keane PK (r = -.41) were also moderately correlated with total FFS score for men.

For women, the FAM content scale on the MMPI-2 was highly correlated with the total FFS score (r = -.64). The supplementary PK scale was also highly correlated with the total FFS score (r = -.51). Also for women, the MMPI-2 clinical scales 4 (r = -.47), 7 (r = -.45), and 8 (r = -

.48) were moderately correlated with the total FFS score. The total FFS score also moderately correlated with the MMPI-2 content scales of Anxiety (ANX) (r= -.47), DEP (r = -.48), LSE (r = -.43), Work Interference (WRK) (r = -.43), and TRT (r = -.43) for women. The total FFS score and MMPI-2 RC scales of Demoralization (RCd) (r = -.47) and Dysfunctional Negative Emotions (RC7) (r = -.42) were moderately correlated. For women, the Psy-5 scale Negative Emotionality (NEGE) moderately correlated with the total FFS score (r = -.43), and the supplementary scales of Mt (r = -.49) and A (r = -.49) moderately correlated with the total FFS score.

With regard to the subscales on the FFS, Table 1 presents the correlates of the Family Conflict Scale (FFS) for men, and Table 2 reports the results for women. Overall, FFS was highly correlated with the MMPI-2 Content Scale FAM for men (r = .50) and for women (r = .52). The positive family affect subscale on the FFS moderately correlated with the FAM scale for men (r = -.48) and highly correlated with the FAM scale for women (r = -.60). For women, the positive family affect subscale also moderately correlated with the PK supplementary scale (r = -.42), clinical scales 4 (r = -.42), 8 (r = -.42), and DEP content scale (r = -.41). The family rituals subscale was moderately correlated with the FAM content scale for women (r = -.41), and the family worries subscale on the FFS was moderately correlated with the PT clinical scale for women (r = .41) and ANX content scale for women (r = .40).

Discussion

The current study examined the relationship between family functioning, as measured by the Family Functioning Scale (FFS), and various measures of behavioral, psychological, and social dysfunction in adults, as measured by the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). The purpose of the study was to examine how family functioning effects the

psychological well being of people later in life, primarily in their college aged years. Previous research with adolescents found that low family functioning was related to depression, anxiety, and antisocial behaviors. For men results indicated the total FFS score was most highly correlated with MMPI-2 content scale FAM on the MMPI-2 (as would be expected given the nature of the scale) and was moderately correlated with clinical scale 8, content scales DEP, LSE, and TRT, and supplementary scales Mt and PK. For women results indicated the total FFS score was highly correlated with FAM content scale (again, as would be expected) and supplementary PK scale. Also for women, the total FFS score was moderately correlated with MMPI-2 clinical scales 4, 7, and 8, content scales of ANX, DEP, LSE, TRT, and WRK, RC scales of RCd and RC7, Psy-5 scale of NEGE, and the supplementary scales of A, Mt, and PK. Overall, results suggest that, compared to adolescents, adults who report high levels of family problems are more likely to experience problems related to internalizing disorders, such as depression and anxiety, accompanied by intrusive ideation.

Based on the results of the current study, both men and women who report low levels of family functioning tend to have increased problems related to depression and low self-esteem during their college aged years. People who experience problems with depression and low self-esteem may have few or no friends, difficult interpersonal relationships, a very poor self-concept, compare themselves unfavorably with others, experience passiveness in relationships, and have difficulty making decisions. These problems may lead to further trouble forming relationships with friends and significant others which may only reinforce the negative thoughts of the individual.

Results suggest that both men and women with low family functioning tend to have high scores on the PK supplementary scale. High scores on this scale indicate that the individual is

likely manifesting many of the symptoms and behaviors typically associated with PTSD, which is related to persons who are reporting intense emotional distress, feel guilty and depressed, and may feel misunderstood and mistreated. People who come from families with low levels of functioning may experiences problems throughout their lives due to the family problems they had growing up. Also, the correlation with the TRT scale for both men and women may suggest that individuals with poor family functioning have a more difficult time establishing trusting relationships with their therapist, and thus may terminate treatment prematurely, feel that no one can understand them, and give up easily when problems are encountered. Further, the problems that have been linked to low family functioning in this study are often the type of problems that are related to a person's ability to form sound and lasting relationships. Previous studies have found that this may in turn possibly have a cyclic effect where individuals who experienced low family functioning growing up have trouble forming healthy relationships and then have children who experience similar levels of low family functioning.

Limitations in the current study include a lack of ethnic diversity in the sample, possibility of underrepresentation of poor family functioning and psychological problems in a college population compared to the general population, and the FFS is not time delimited (i.e. could infer if scores on the FFS were due to the current or past family situation). Also, because the current study is correlational in nature, it is not clear whether poor family functioning effects psychological problems or whether the psychological problems are affecting family functioning. Finally, an exploration of the subscales of the FFS revealed little additional information in terms of the impact on psychological, behavioral, and social functioning of various forms of family difficulties. It is possible that the current measure was not sensitive enough to detect fine tuned differences in family difficulties.

Future research should utilize a more diverse population and utilize a measure of family functioning that identifies current and past family function problems, as well as that may potentially further differentiate the types of family difficulties being experienced. Also a longitudinal study would be useful in order to determine whether poor family functioning or psychological problems come first. In addition, different types of counseling need to be examined in order to find a treatment that will help individuals who experience problems related to poor family functioning. One possibility for this would be to examine group counseling aimed at individuals who have experienced poor family functioning in order to determine if being able to relate to the other members in group help the individuals to stick around longer and not prematurely end treatment. This may also help with learning to form healthy relationships, and being able to relate to the experiences of the other members of the group may help to relieve feelings of depression and guilt for the way their family was growing up.

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Table 1

Selected MMPI-2 Scales Correlated with FFS Scores for Men (N = 365)

MMPI-2 Scales	Total FFS Score	Positive Family Affect	Family Communication	Family Conflict	Family Rituals/ Supports	Family Worries
Clinical Scales						
1 (HS)	-.33	-.29	-.09	.24	-.18	.24
2 (D)	-.24	-.23	-.08	.10	-.21	.14
3 (HY)	-.11	-.15	.00	.07	-.09	.06
4 (PD)	-.38	-.34	-.15	.30	-.29	.11
5 (MF)	-.23	-.21	-.01	.16	-.21	.15
6 (PA)	-.19	-.17	.01	.17	-.11	.20
7 (PT)	**-.40**	-.31	-.06	.34	-.21	.36
8 (SC)	**-.45**	-.34	-.12	.37	-.28	.29
9 (MA)	-.18	-.12	-.00	.32	-.04	.10
0 (SI)	-.32	-.25	-.19	.14	-.21	.19
Content Scales						
ANX	-.32	-.25	-.05	.27	-.13	.33
FRS	-.16	-.16	.03	.10	-.05	.22
OBS	-.27	-.18	-.00	.30	-.06	.35
DEP	**-.42**	-.32	-.16	.30	-.29	.23
HEA	-.30	-.25	-.04	.23	-.13	.26
BIZ	-.27	-.22	.00	.31	-.08	.27
ANG	-.29	-.24	.00	.31	-.11	.28
CYN	-.25	-.15	-.10	.27	-.08	.16
ASP	-.24	-.16	-.13	.26	-.10	.05

(table continues)

Table 1 (continued)

MMPI-2 Scales	Total FFS Score	Positive Family Affect	Family Communication	Family Conflict	Family Rituals/ Supports	Family Worries
Content Scales (continued)						
TPA	-.18	-.19	-.02	.34	-.10	.24
LSE	**-.40**	-.33	-.15	.28	-.23	.25
SOD	-.20	-.15	-.17	.02	-.16	.10
FAM	**-.55**	**-.48**	-.16	**.50**	-.39	.17
WRK	-.36	-.29	-.08	.31	-.19	.29
TRT	**-.43**	-.33	-.20	.30	-.27	.22
RC Scales						
RCd	-.38	-.30	-.13	.27	-.26	.25
RC1	-.31	-.27	-.08	.20	-.15	.24
RC2	-.23	-.22	-.14	.01	-.20	.10
RC3	-.26	-.16	-.15	.24	-.14	.08
RC4	-.31	-.26	-.07	.29	-.25	.08
RC6	-.24	-.23	.01	.27	-.09	.21
RC7	-.37	-.27	-.07	.31	-.14	.38
RC8	-.26	-.21	-.01	.29	-.07	.26
RC9	-.20	-.13	.06	.29	-.01	.22

(table continues)

Table 1 (continued)

MMPI-2 Scales	Total FFS Score	Positive Family Affect	Family Communication	Family Conflict	Family Rituals/ Supports	Family Worries
PSY-5 Scales						
AGGR	-.07	-.03	.11	.22	.02	.08
PSYC	-.29	-.24	-.04	.31	-.10	.25
DISC	-.11	-.06	-.05	.15	-.09	-.06
NEGE	-.33	-.23	-.01	.30	-.13	.36
INTR	-.20	-.19	-.18	-.03	-.25	-.01
Supplementary Scales						
A	-.38	-.28	-.10	.30	-.19	.32
R	.12	.19	-.03	-.22	.00	-.12
Es	.34	.28	.05	-.31	.14	-.30
HO	-.32	-.23	-.11	.31	-.13	.20
OH	.21	.16	.13	-.16	.06	-.14
Do	.25	.19	.03	-.21	.14	-.19
Re	.25	.18	-.04	-.29	.12	-.19
Mt	**-.41**	-.32	-.11	.33	-.25	.29
GM	.32	.28	.04	-.24	.16	-.29
GF	.06	.03	.01	-.15	.00	.03
PK	**-.41**	-.31	-.16	.32	-.24	.30
MACR	-.06	-.04	.10	.21	.01	.07
APS	-.11	-.01	.10	.16	-.06	.26
AAS	-.23	-.20	-.06	.19	-.16	.09

Note: See Appendix for Scale Names

Table 2

Selected MMPI-2 Scales Correlated with FFS Scores for Women (N = 577)

MMPI-2 Scales	Total FFS Score	Positive Family Affect	Family Communication	Family Conflict	Family Rituals/ Supports	Family Worries
Clinical Scales						
1 (HS)	-.35	-.28	-.14	.28	-.14	.33
2 (D)	-.30	-.26	-.18	.15	-.16	.23
3 (HY)	-.13	-.14	-.10	.01	-.07	.10
4 (PD)	**-.47**	**-.42**	-.27	.34	-.29	.22
5 (MF)	-.02	-.03	.01	-.02	.02	.09
6 (PA)	-.32	-.27	-.17	.18	-.18	.23
7 (PT)	**-.45**	-.34	-.24	.34	-.17	**.41**
8 (SC)	**-.48**	**-.42**	-.24	.39	-.24	.34
9 (MA)	-.26	-.20	-.06	.30	-.07	.24
0 (SI)	-.32	-.26	-.23	.20	-.15	.20
Content Scales						
ANX	**-.47**	-.36	-.23	.36	-.21	**.40**
FRS	-.05	.02	.11	.16	.13	.31
OBS	-.39	-.28	-.19	.34	-.11	.37
DEP	**-.48**	**-.41**	-.30	.28	-.25	.33
HEA	-.31	-.27	-.11	.26	-.11	.31
BIZ	-.35	-.28	-.13	.31	-.14	.28
ANG	-.34	-.24	-.10	.34	-.17	.28
CYN	-.30	-.23	-.08	.34	-.12	.27
ASP	-.24	-.16	-.11	.28	-.10	.16

(table continues)

Table 2 (continued)

MMPI-2 Scales	Total FFS Score	Positive Family Affect	Family Communication	Family Conflict	Family Rituals/ Supports	Family Worries
Content Scales (continued)						
TPA	-.30	-.18	-.10	.28	-.16	.27
LSE	**-.43**	-.35	-.25	.30	-.16	.33
SOD	-.19	-.15	-.22	.04	-.15	.04
FAM	**-.64**	**-.60**	-.32	**.52**	**-.41**	.25
WRK	**-.43**	-.33	-.24	.34	-.17	.36
TRT	**-.45**	-.36	-.27	.30	-.20	.32
RC Scales						
RCd	**-.47**	-.39	-.29	.30	-.24	.34
RC1	-.33	-.29	-.14	.25	-.14	.30
RC2	-.32	-.31	-.28	.11	-.20	.12
RC3	-.30	-.25	-.09	.33	-.15	.25
RC4	-.33	-.34	-.18	.31	-.22	.08
RC6	-.30	-.25	-.02	.30	-.12	.22
RC7	**-.42**	-.30	-.20	.34	-.15	.39
RC8	-.34	-.28	-.15	.27	-.17	.26
RC9	-.22	-.15	-.03	.28	-.07	.24

(table continues)

Table 2 (continued)

MMPI-2 Scales	Total FFS Score	Positive Family Affect	Family Communication	Family Conflict	Family Rituals/ Supports	Family Worries
PSY-5 Scales						
AGGR	-.03	-.07	.14	.16	-.01	.05
PSYC	-.36	-.25	-.13	-.33	-.13	.32
DISC	-.12	-.11	-.11	.11	-.18	-.10
NEGE	**-.43**	-.30	-.21	.35	-.17	.38
INTR	-.24	-.25	-.24	.04	-.19	.02
Supplementary Scales						
A	**-.49**	-.38	-.26	.36	-.21	.39
R	.16	.11	-.03	.36	-.21	.39
Es	.35	.29	.10	-.28	.04	-.20
HO	-.38	-.28	-.12	.40	-.18	.31
OH	.28	.19	.20	-.20	.16	-.14
Do	.29	.18	.16	-.24	.10	-.28
Re	.24	.17	.09	-.28	.10	-.20
Mt	**-.49**	-.37	-.25	.38	-.23	.38
GM	.24	.14	07	-.24	-.01	-.38
GF	.20	.16	.16	-.14	.20	.00
PK	**-.51**	**-.42**	-.27	.37	-.24	.39
MACR	-.12	-.11	-.01	.13	-.07	.08
APS	-.21	-.10	-.09	.20	-.05	.22
AAS	-.24	-.22	-.16	.17	-.14	.07

Note: See Appendix for Scale Names

Appendix

Clinical Scales

1 Hs - Hypochondriasis

2 D - Depression

3 Hy - Hysteria

4 Pd - Psychopathic Deviate

5 Mf - Masculinity–Femininity

6 Pa - Paranoia

7 Pt - Psychasthenia

8 Sc - Schizophrenia

9 Ma - Hypomania

0 Si - Social Introversion

Restructured Clinical (RC) Scales

RCd - dem - Demoralization

RC1 - som - Somatic Complaints

RC2 - lpe - Low Positive Emotions

RC3 - cyn - Cynicism

RC4 - asb - Antisocial Behavior

RC6 - per - Ideas of Persecution

RC7 - dne - Dysfunctional Negative Emotions

RC8 - abx - Aberrant Experiences

RC9 - hpm - Hypomanic Activation

Content Scales

ANX - Anxiety

FRS - Fears

OBS - Obsessiveness

DEP - Depression

HEA - Health Concerns

BIZ - Bizarre Mentation

ANG - Anger

CYN - Cynicism

ASP - Antisocial Practices

TPA - Type A

LSE - Low Self-Esteem

SOD - Social Discomfort

FAM - Family Problems

WRK - Work Interference

TRT - Negative Treatment Indicators

Personality Psychopathology Five Scales (PSY-5)

AGGR - Aggressiveness

PSYC - Psychoticism

DISC - Disconstraint

NEGE - Negative Emotionality/Neuroticism

INTR - Introversion/Low Positive Emotionality

Supplementary Scales

A - Anxiety

R - Repression

Es - Ego Strength

Ho – Hostility

O-H - Overcontrolled Hostility

Do - Dominance

Re - Social Responsibility

Generalized Emotional Distress

Mt - College Maladjustment

GM - Gender Role – Masculine

GF - Gender Role – Feminine

PK - Post-Traumatic Stress Disorder–Keane

MAC-R - MacAndrew–Revised

AAS - Addiction Admission

APS - Addiction Potential