

SOCIAL SUPPORT AND HEALTH OF THE FAMILY OF ORIGIN:

A PATH ANALYSIS

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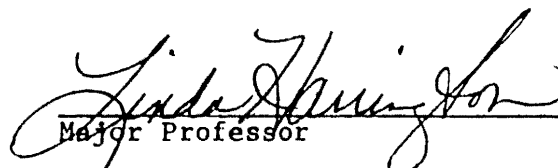
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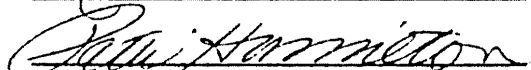
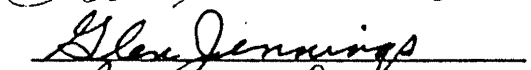
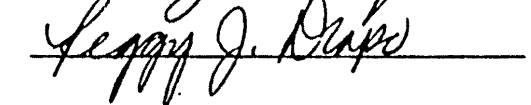
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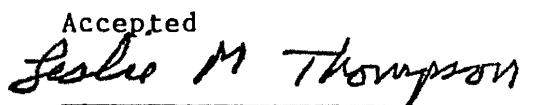
A Path Analysis

I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Nursing.


Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted

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Research

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DEDICATION

To Henrietta Clementine Mac Caslin Hawk and Abraham Lincoln Hawk,
the pioneers who moved by wagon and foot from Ohio and eastern
Tennessee, to converge in Illinois, and finally rest in Missouri.

To Mary Kathryn Hawk Orscheln and Albert Joseph Orscheln, my
parents.

To Elizabeth Ann Orscheln Sanders (Aunt Sis), a nurturer.

To Bobbie, Jenny, Judy, and Marcella, my sisters.

To Margaret and other good friends.

To Frank, my husband and best friend.

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SOCIAL SUPPORT AND HEALTH OF THE FAMILY OF ORIGIN
A PATH ANALYSIS

ABSTRACT

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The present study utilized a descriptive-correlational approach to describe the relationship between social support and health of the family of origin. The Family of Origin Scale (FOS) developed by Anderson (1980) was used to measure the health of the family in which one grew up. The Social Support Scale (SSS) (De Lorenzo, 1988b) measured social support in parents.

The study was undertaken following a pilot study to estimate the validity, reliability, and feasibility of the study. Data were collected from one mailing of 2,000 sets of questionnaires to parents of 1,000 randomly selected children in grades nine through twelve in an independent school district in north Texas. It was estimated that a total of 1,628 questionnaires reached the targeted sample. After six weeks, subjects returned 190 usable questionnaires for a return rate of 11.74%.

The data from the returned questionnaires were analyzed using SPSS^X (Norusis, 1983) statistical programs. Descriptive statistics, Pearson product moment correlation coefficients, regression coefficients, ANOVA, reliability, item, and factor analyses were computed.

The transgenerational support model proposed by De Lorenzo (1988a) was the conceptual framework upon which the study was based. The study first examined the relationship between social support and health of the family of origin; and second, examined the relationship between SSS, FOS, all subscales, and the demographic variables.

One path analysis supported FOS partially causing SSS. A second path analysis demonstrated the causal relationship between the subscales of FOS and SSS. The final path analysis consisted of certain demographic variables being antecedents of social support, and certain subscales of FOS being antecedents of the demographic variables.

To estimate construct validity, both factor and item analyses were performed. To estimate reliability, Cronbach's alphas were completed on the total scale and each of the subscales. A reliability alpha of .8841 was obtained for the SSS, and a reliability alpha of .9017 was obtained for the FOS. Factor analyses, item analyses, and Cronbach's alphas indicated that both questionnaires had adequate estimated validity and reliability for research. Finding significant relationships between FOS, SSS, and the various subscales contributed to the validation of the transgenerational support model.

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CHAPTER I

INTRODUCTION

"Relatively few people are aware of how they continue to be influenced and controlled in their behavior by unachieved goals and the unresolved problems of the parental and the grandparental generations" (Williamson, 1978, p. 94). The family that has such lasting influence in a person's life is called the family of origin, where each person has genetic, psychological, social, cultural, and spiritual beginnings. "The impact of these primordial roots is deep and pervasive and continues to play an important role in the present" (Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985, p. 287). Transgenerational theory is one attempt to explain the passage of nongenetic factors from one generation to another.

The most striking example of parental influence and control was one mother's plea to break a powerful cycle of horror (Bissell, 1988). After her 20-year-old talented son died of apparent suicidal causes, she came forth to tell how she had been an abused child, and how she had abused her son. She was aware of what she was doing, and of history repeating itself in her family, but was unable to stop. She tried to get help, but did not reveal the true extent of her abusive actions. Mrs. Bissell believed that there are caring people who can rescue anyone from the imprisonment of transgenerational chains.

This extreme case was one example of the original family's influence

in each person's life. Ability to recognize needs, to identify goals, to seek help, to accept help, and the degree to which a person is able to attain the help needed, are all functions of the health of the family that the person grew up in. Most of the help that people receive comes from informal networks of supportive people. These networks include, but are not limited to, family, friends, neighbors, and co-workers. Any help given by an informal network is called social support.

Parents, today, face great stress and enormous obstacles in raising healthy children. Besides the obvious problems of AIDS, substance abuse, and pregnancy, in 1986 there were seven million children living in single-parent homes (Verity, Ortner, & Keane, 1988). Great numbers of children live in poverty. No figures were available on the number of children living with stepparents or stepsiblings. Social support is one method of providing help to parents (Duffy, 1986; Norbeck & Scheiner, 1982; Roberts, 1984).

Since some of our informal networks of social support or helping have failed, social support has moved into the realm of the professional. "Nurses have long been aware that distress, or nonsupport, in social networks is a key variable in the use of professional services" (Roberts, 1988, p. 6). Multiple correlation studies have been conducted on social support in a variety of settings. Yet, exactly what supportive actions are, how they work, and with whom they work, still need to be answered.

Genetic makeup and environment create the disease profile of every individual (Milio, 1981). In the age of holistic nursing,

psychological, social, cultural, and spiritual factors are also accepted influences. Since these influences are accepted, then genetic makeup, psycho/socio/cultural, and spiritual factors also create a profile to be used in treating the disease process, or in problem solution.

Transgenerational theory attempts to answer questions about the cultural and social profile of each individual. If social support is to continue to be a viable nursing intervention, nurses must find out how it works. Social support might be a function of the health of the family that persons grow up in.

Problem of the Study

The problem investigated in the present study was the relationship between social support and health of the family of origin among parents. The study was conducted in one county in the southwestern United States.

The problem was researchable since there were instruments available to measure both the health of the family of origin and social support. Data collected by both of these instruments used a regression analysis to ascertain if there was a possible relationship between health of the family that a person grew up in and the person's perception of social support.

The data was collected from parents who were randomly selected from a list of all parents of children in grades nine through twelve in an independent school district. The research was feasible since both tools and parents were readily available.

Even though support is a nursing measure that is advocated in textbooks and written nursing care plans, supportive acts are usually

not specified. Support is a nursing intervention whereby resources of the nurse are added to resources of the client so that the client is enabled to initiate and successfully carry out action(s) to accomplish a desired health result (Schoenhofer, 1984).

Caplan (1974) stated that social support is the augmentation of a person's strengths to facilitate the mastery of the environment. Nursing takes place in a social matrix of cooperative action systems. Orem's self-care concept of nursing identifies support as one category of nursing action in response to a self-care deficit (Orem, 1980). Orem used the phrase "Helping others to do for themselves, or doing with others" (Orem, 1959, p. 17) as descriptive of the concept of support.

The American Nurses' Association Commission on Nursing Research (1980) identified social support as one area of needed research. Social support was seen as one path to healthy functioning. Yet, questions still persist. How do nurses help people to help themselves? What exactly is supportive help? Who asks for help? Who can accept the help given? Looking at the possible effects of transgenerational passage on social support might provide some answers to these questions. In any case, the study added new insights about the social support of individuals and families with the ultimate aim of improved nursing practice.

Purpose of the Study

The purpose of the study was to measure social support and health of the family of origin in a sample of parents, and to statistically analyze the two measures to determine the significance of the

relationship. Additionally, the study described the sample of the population that was used.

The family each person grew up in, the family of origin, has possible effects on social support. Levels of health of the family of origin might directly effect either high levels of social support if the family was healthy, or low levels of social support if the family was unhealthy.

Transgenerational issues are beginning to be studied by family therapists. The most direct study was conducted by Nadler, Kav-Venake, and Gleitman (1985). Nadler et al. studied transgenerational effects of the Holocaust, and in particular, aggression in second-generation holocaust survivors.

Only one study examined social support and transgenerational passage, although it was not referred to as social support. Haber (1987) found evidence to support family friends as resources available to the family in dealing with problems and developmental struggles from childhood to young adulthood. Some areas in which friends were beneficial to clients were the following: Bridging generation gaps, providing positive peer pressure, and providing helpful suggestions to parents based upon the friends' experiences.

No study was found in the available literature which dealt with social support and transgenerational passage. However, there were numerous studies of social support dealing with various members of the family and family issues. Research performed by Burke and Weir (1978), and Dunn, Pultallaz, Sheppard, and Lindstrom (1987) dealt with

adolescent life. Hall, Schaefer, and Greenberg (1987), and Lentz, Parks, Jenkins, and Jarrett (1986) worked with mothers of young children. Brown (1986) studied marital support during pregnancy. Duffy (1986), and Norbeck and Sheiner (1982) focused on single parents. Numerous studies exist that deal with many aspects of stress, illness, social support, health behaviors, and health motivation throughout life.

Negative aspects of social support such as conflicts and crises (Tilden, 1985) might cause distress in certain situations. However, Balint (1957) asserted that isolated clients seek more professional help. Minuchin, Rosman, and Baker (1978) identified clients who seek professional help as coming from psychosomatic families that have high levels of tension and crises.

Nurses need to look at situations where social support seems less than helpful. The person within the family who presents with illness might have additional needs beyond the obvious. If social support does not work for the presenting client, the nurse should look closer at the family process in an attempt to provide more beneficial interventions.

Rationale for the Study

There are situations in which helping behaviors of professionals, i.e., social support, do not have the desired effectiveness. There are influences upon social support that have not yet been identified. These influences might make people respond in ineffective ways.

Ryan (1987) identified a paradigm for determining potential problems in motivating life style changes. The potential problems are:

(a) Persons with high psychological readiness and adequate social

support; (b) persons with negative health beliefs and attitudes, but adequate social support; (c) persons with positive health beliefs and attitudes, but inadequate social support; (d) persons with negative health beliefs and attitudes, and inadequate social support.

Health researchers no longer focus on what types of illness the patient has, but rather, are asking what type of patient has the illness. Certain human behaviors predispose to disease, and others inoculate against disease. Social support, a construct referring to interpersonally supportive behaviors and relationships, may be thought of as a health behavior of the latter type (Pilisuk, 1982).

The whole client includes biological, psychological, social, cultural, and spiritual dimensions. Genetics specifies rules which govern the biological communications between generations. Transgenerational theory, as identified by Lieberman (1979), highlights areas involved in the communication of acquired practices, behaviors, and beliefs between generations. Social support is an acquired skill.

There are no rigorous laws governing the passage of family culture and tradition. Transgenerational theory is derived from schools of family therapy, and explains how an individual's level of functioning depends upon the characteristics of the total organism, and how characteristics are passed from one generation to another through the dimension of time within a family systems framework. Transgenerational theory is an attempt to catalyze the present through use of the past (Lieberman, 1979).

Hardy (1974) believed that nurses need to have a sound theory and

knowledge to guide their actions. There should be a sound rationale for the various treatments, therapies, and care. No longer should nurses be able to say that some social support works some of the time.

Transgenerational theory might not only influence, but might also be part of the cause of why helping behaviors such as social support are effective, or are not as effective as they should be.

Conceptual Framework

The conceptual framework for the present study was derived from the merger of transgenerational theory and the concept of social support using Gibb's paradigm for theory construction. Figure 1, page 11, is the conceptualization of the model of transgenerational support.

Initially, transgenerational theory and social support are discussed, followed by the conceptual framework.

Transgenerational Theory

Transgenerational theory is in its infancy. Conceptual contributions were derived from the disciplines of psychiatry, sociology, genetics, and family therapy. Transgenerational theory has many implications for nursing in that it ultimately relates to health, environment, and person, which are three of the four concepts identified by Flaskerud and Halloren (1980) as concepts common to most theories of nursing.

Transgenerational theory, first identified by Lieberman (1979), highlights areas involved in the communication of acquired practices, behaviors, and beliefs between generations. The theory shows how learned behavior is passed from parents to offspring and other members

of the family of origin. Genetics identifies rules which govern the biological communications between generations. There is no science developed with rigorous laws governing the passage of family culture and tradition. The focus in transgenerational theory is on the dimension of time within a family's systems framework.

Transgenerational theory catalyzes the present through use of the past. Lieberman (1979) identified the following origins of transgenerational theory.

Freud's theory, developed in the late nineteenth and early twentieth century, was the intrapsychic development and interplay between parents and children. Freud's idea helped establish ground rules regarding the limits imposed on relationships between people. One of Freud's threads is concentration on the first six to eight years of life, and how characterologic traits are molded from one generation to another. Freud included not only libidinal development, but also the behavioral concepts such as conditioning, imprinting, modeling, and social concepts (Mezer, 1970).

Adler, in the late nineteenth and early twentieth century, used social psychology and a social approach to mental hygiene (Ansbacher & Ansbacher, 1956). Adler used several principles to describe his therapy: (a) Unity--which states that humans are indivisible, and should be treated as such; (b) movement--expressed belief that life with movement and goals is incomprehensible; (c) cosmic influence--an individual does not and cannot exist isolated from family, community, and environment; (d) parts are spontaneously organized into a structural

whole; (e) action and reaction--individual actions bring on a reaction from society, and vice versa; and (f) balance--an ideal balance exists between individual and community needs. Therefore, individuals cannot be considered except in the context of both society and environment.

Bertalanffy (1968) sought to bring the exploration of wholes and wholeness from metaphysics into therapy. Systems theory is a theory about order; rules order relationships to time as well as space. Systems concepts of progressive segregation, centralization, and individualization can all be translated into patterns of development in individuals and families over time. System properties of relatedness, order, and hierarchy provide limits and validity to the belief that families act as if they are whole, and has added the scientific explanation for the design or purpose of a family through its use of the spatiotemporal rules governing systems.

In the mid-twentieth century, Paul was the first to use the term "transgenerational analysis." Paul surmised that transgenerational analysis was a decoding of life experiences. Most human beings grow up in a family setting. The family setting is a collision of each spouse's original family lifestyle (Paul & Paul, 1986). Paul saw the quality of relationships between an individual and the members of his family of origin as forming a crucial and often unrecognized influence on life. Bowen (1978) was an original thinker in the area of family systems theory. Bowen postulated two main variables in all human relationships; integration and differentiation of self.

The last origin of the theory identified by Lieberman (1979) was

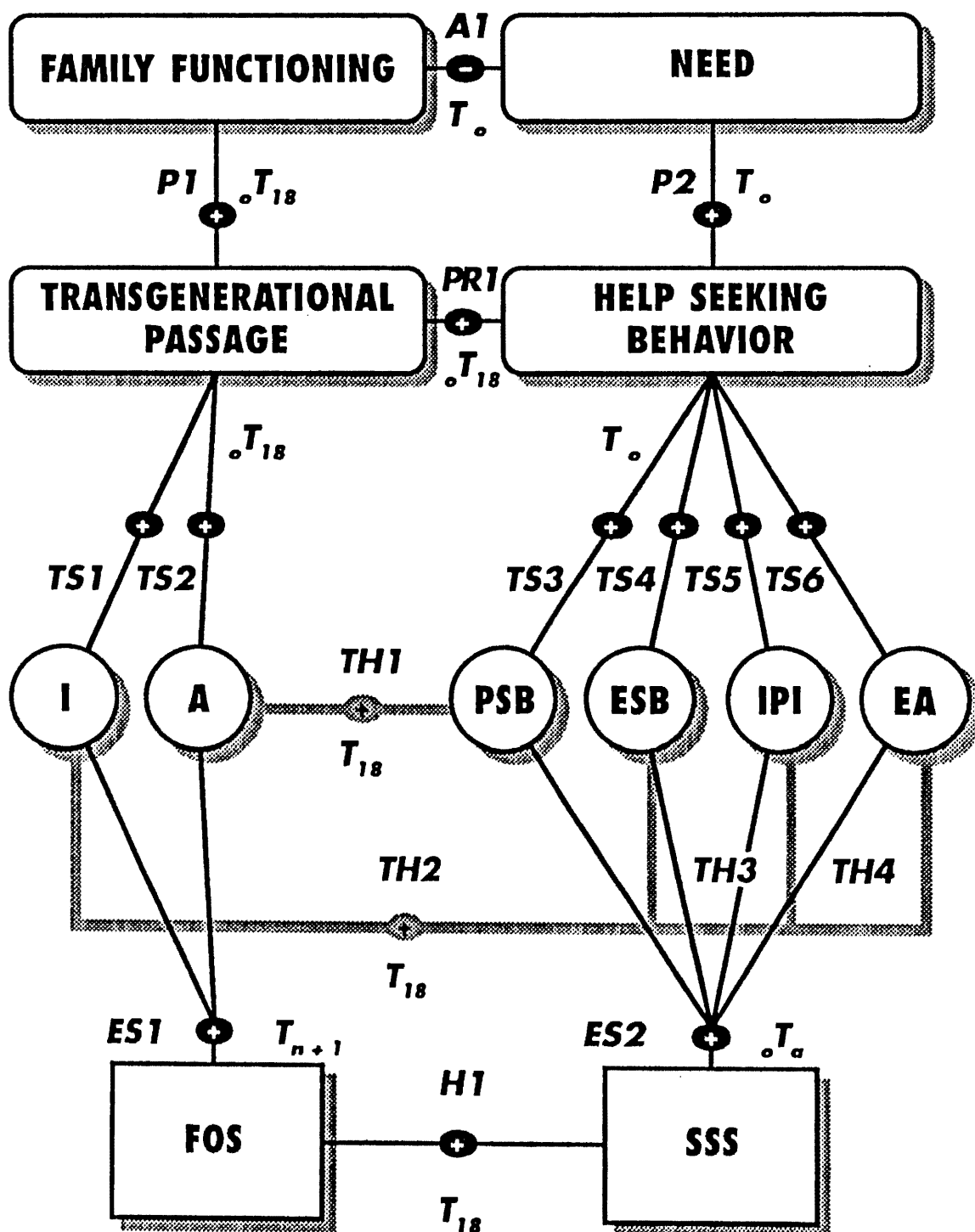


Figure 1. Model of Transgenerational Support.

that of Bowlby. Bowlby (1969) came forth with attachment theory, or the nature of emotional bonds between individuals. Other theorists developed the concepts of homeostasis, double bind, marital schism and skew, and pseudomutuality. Behavioral principles and biological science, especially genetics, have distinct influence on transgenerational theory.

Thus, transgenerational theory is in its infancy. Transgenerational theory was developed by family therapists trying to improve their practice. At present, transgenerational theory has both formal and informal aspects. Statements are generated from the concepts and constructs identified by Lieberman (1979). Transgenerational theory is one explanation of how communication of acquired practices, behaviors, and beliefs are passed on to offspring.

Social Support

Social support is identified as information that leads persons to believe that they are loved and cared for, esteemed and valued, a member of a network of communication, and a member of a network of mutual obligations including tangible services or mutual aid. Cobb (1976) and Weiss (1974) wrote of social relationships that have multiple functions including social integration, intimacy, opportunity for nurturance, reassurance of worth, attachment, obtaining assistance/guidance, and a sense of reliable alliance.

Brandt and Weinert (1981) defined social support as the availability of a spouse or confidant, close ties with friends, and the nearness of relatives. Norbeck, Lindsey, and Carrieri (1981) declared social

support as not just a simple contract or presence of another during a stressful experience, but that it is multidimensional. Both functional and network properties are important.

Four components of social support were identified by Kahn (1979). These components of supportive transactions were: (a) Affect, or the positive feelings shown toward a person such as being liked, or a lover; (b) affirmation, the endorsement of a person's behaviors, views, or perceptions; (c) again affect, but this time a feeling of respect or being admired; and (d) aid, the giving of symbolic or material aid to another.

House (1981) defined social support as a multidimensional concept that includes emotional, tangible, or informational types of functional support. House maintained that social support is composed of four characteristics: (a) Emotional--provision of empathy, caring, love, and trust; (b) instrumental--access to behaviors that directly help the person in need; (c) informational--providing information that the person can use in coping with personal and environmental problems; and (d) appraisal--transmission of information relevant to self-evaluation.

Muhlenkamp and Sayles (1986) summarized social support as necessary throughout the lifespan, involving interpersonal interactions that produce a sense of belonging, communication of positive affect, and augmenting feelings of personal efficacy and respect.

Caplan (1974) denoted characteristics of social support as coming from continuing relationships. The characteristics are; refuge or sanctuary for stability and comfort, information, guidance, feedback,

help in mobilizing psychological resources, mastering emotional burdens, providing materials and skills, help with tasks, and providing cognitive guidance.

Tolsdorf (1976) stated that structural variables are used to describe the basic morphological characteristics of a social network by mapping linkages of network members and summarizing the distribution of these points. The content describes the day-to-day quality of each of the linkages in the network, and are infinite. The twelve used in one study were primary kin, secondary kin, primary friend, secondary friend, economic, recreational, political, religious, sexual, fraternal mutual aid, and service.

The functional variables described those linkages in which one individual served some function for another individual. The functions were support, advice, and feedback. Support was defined as any action or behavior which functions to assist the focal person in meeting his personal goals, or in dealing with the demands of any particular situation. It might be tangible, such as money or other forms of assistance. It can be tangible, in the form of encouragement, personal warmth, love or emotional support. Advice was defined as the provision of information or guidance on how to achieve a certain goal or complete a certain task. Feedback is another form of information.

Chinn (1988) provided a summary of the concept of social support. "Social support is some sort of resource within a social network that provides, strength, energy, material or financial goods, or other physical or emotional commodities that assist in getting along in the

world" (p. x).

Weinert (1987) viewed social support as a construct composed of five underlying dimensions: Intimacy, social integration, nurturance, worth, and assistance demonstrating multidimensionality. Although social support is diverse in its concepts and measures, social support's operationalization was organized into three broad categories: Social embeddedness, perceived social support, and enacted support (Barrera, 1986; Gottlieb, 1978; Heller & Swindle, 1983).

Gottlieb (1978) reported on social support as the natural support systems ranging from the more organized self-help group to the spontaneous helping transactions extended within personal networks. Through 40 interviews the researcher identified 26 helping behaviors which were categorized into four main sub-concepts of social support: (a) Emotionally sustaining behaviors, (b) problem-solving behaviors, (c) indirect personal influence, and (d) environmental action.

Thus, social support was defined by the researcher as an active or passive, cognitive, affective, or behavioral process which an individual or group undertakes actively or passively for the purpose of giving needed assistance to another. In social support, the individual and other(s), by means of interactions, bonding, and reciprocity, arrive at some kind of perceived support, social embeddedness, nurturance, self-esteem, and help. If the individual is autonomous, the support is perceived, sought, and given at the person's request. If the person is nonautonomous, other(s) perceive the need, assess, plan, and carry out

intervention. In either case, the end is feedback for further action (De Lorenzo, 1987).

Merging Theoretical Perspectives

Transgenerational support presupposes the inheritance of psycho/socio/cultural/physical behaviors. Social support is one of these behaviors. Both social support and transgenerational theory can be thought of as a process, structured series of events, operations, or activities whose logic is orderly and predictable.

Transgenerational theory came out of schools of family therapy, and explains how an individual's level of functioning depends on what characteristics were passed from one generation to another through the family of origin. Social support is one theory of helping. An individual's ability to recognize needs, seek help, and use the available help or the help offered, depends upon characteristics that have been inherited and passed on through the original family. In the researcher's theory, the two constructs of family functioning and need were merged into a model of transgenerational support.

The Theoretical Framework

Gibbs (1972) divides theories into two distinct parts. The first is the intrinsic part consisting of statements that are in the form of empirical assertions. Intrinsic statements are more logically related if they are not clouded by analytic definitions. Keeping intrinsic statements free of analysis can lead to more synthesis, and therefore more creativity. The second part of a theory is extrinsic, and is the analytic part that defines the terms. Here for the sake of clarity,

the extrinsic part is presented first.

Extrinsic Part

Distinction between intrinsic and extrinsic parts of a theory has two reasons. First, logical relations are more evident when intrinsic statements are not interspersed with definitions; and second, the separation of the two parts underscores the difference between synthetic and analytic statements (Gibbs, 1972).

Unit Term. Unit terms are properties, and property implies a class of things, acts, conditions, or events. Another way of looking at a unit term is to describe it as nominal data. The unit term of the conceptual framework is parents. Parents are a territorially differentiated population. Parenthood is empirically applicable since independent researchers agree on the presence or absence of parenthood.

Parent--A person or persons who take the moral, legal, cultural, and psycho/spiritual responsibility for a minor child (De Lorenzo, 1988a).

Substantive Terms. Substantive terms designate properties of units. The substantive terms that designate properties of units are constructs, concepts, and referentials. Once the properties or attributes of units are identified, assertions can be made. Only by making the assertion that the properties of a unit share common attributes, can a model become informative.

Constructs. A construct is neither completely defined nor empirically applicable by the theorist. In a construct, not all of the properties of the idea are related or recognized. The phenomena of the

construct is not observable. In the model of transgenerational support the constructs were family functioning and need.

1. Family functioning--the way in which a family handles day-to-day living, including loss and replacement (Lieberman, 1979).
2. Need--a requirement within the person which stimulates a response to maintain integrity (Roy, 1984).

Concepts. The difference between concepts and constructs is that concepts may have complete definitions, although these may be questionable as observable phenomena, and hence not empirically applicable. The two concepts were transgenerational passage and help-seeking behavior.

1. Transgenerational Passage--physical, social, psychological, and cultural factors being transmitted from one generation to another within the family (Lieberman, 1979).
2. Help-seeking Behavior--looking for ways to satisfy a need (De Lorenzo, 1988a).

Referentials/Acronyms. A referential is an intrinsic term that designates a formula in the extrinsic part of a theory. Referentials appear as capitalized acronyms. Validity of these referential formulas is uncertain. "Even though referentials are taken as facts, they are actually assertions" (Gibbs, 1972). The referentials of the model were the following: (a) (A) Autonomy, (b) (I) intimacy, (c) (PSB) problem-solving behaviors, (d) (ESB) emotionally sustaining behaviors, (e) (IPI) indirect personal influence, (f) (EA) environmental action.

1. (A) Autonomy--claiming one's own identity (Hovestadt et al., 1985).
2. (I) Intimacy--a warm friendship that suggests close personal association and privacy (Hovestadt et al., 1985).
3. (ESB) Emotionally Sustaining Behaviors--behaviors that lead a person to feel esteemed, valued, loved, and a part of a network of communication and mutual obligation (Cobb, 1976).
4. (PSB) Problem-Solving Behaviors--actions that lead to solutions to a need (Gottlieb, 1978).
5. (IPI) Indirect Personal Influence--personal conviction of helper availability if needed (Gottlieb, 1978).
6. (EA) Environmental Action--social advocacy on behalf of another (Gottlieb, 1978).

Temporal Quantifiers. Designation of constructs, concepts, and referentials must have some reference to time. The reference to time means change, and change is either proportionate or absolute. In the conceptual model, time was assigned as follows:

1. 0_{T18} - From birth to 18 years of age.
2. T_0 - The point in time that the individual receives the degree of internal and external stimulation perceived as need.
3. T_{18} - Adulthood.
4. 0^{T18} - The point in time that psycho/socio/physio/cultural indications of help occur after stimulation.
5. T_{n+1} - The time that perception indicators designate a healthy family of origin.

Mathematical Formulations of Perceived Linkages. The mathematical

formula for transgenerational support was formulated as follows:

$$TS = f(A + I) = f(ESB + PSB + IPI + EA)$$

Where:

TS = transgenerational support

A = autonomy

I = intimacy

ESB = emotionally sustaining behaviors

PSB = problem-solving behaviors

EA = environmental action

IPI = indirect personal influence

A + I is a measurement of the health of the family of origin.

ESB + PSB + IPI + EA is a measurement of social support.

Each formula in the extrinsic part of a theory is a referential formula....the validity of any referential formula is a matter of uncertainty....the theorist asserts that it is empirically applicable....Accordingly, the formula represents a judgment by the theorist, and that judgment is based on imagination, intuition, or experience rather than logic, conventional or otherwise (Gibbs, 1972, pp. 130-133).

Intrinsic Part

There are two types of intrinsic statements, depending upon their position in the theory. Intuitive components of a model are direct assertions. Creating order in a model includes substantive and

relational assertions. Some assertions are direct; others are derived. Intrinsic statements propose a relationship between the substantive terms. The two relational statements usually used are "greater, greater" and "greater, less" (Gibbs, 1972).

Axioms. Axioms are direct rational statements between constructs. This theory had only one axiom.

A1: Among parents, the greater the family functioning during $0T_{18}$, the less the need at T_0 .

Postulates. Postulates are direct relational statements between constructs and concepts.

P1: Among parents, the greater the family functioning during $0T_{18}$, the greater the 'transgenerational passage' during $0T_{18}$.

P2: Among parents, the greater the need at T_0 , the greater the 'help-seeking behavior' at T_0 .

Propositions. Propositions are direct relational statements between concepts. The theory presented one proposition.

Prl: Among parents, the greater the 'transgenerational passage' at $0T_{18}$, the greater the 'help-seeking behavior' at T_0 .

Transformational Statements. Transformational statements are direct intrinsic statements between concepts and referentials.

TS1: Among parents, the greater the 'transgenerational passage' at $0T_{18}$, the greater the A at T_{18} .

TS2: Among parents, the greater the 'transgenerational passage' at $0T_{18}$, the greater the I at T_{18} .

TS3: Among parents, the greater the 'help-seeking behavior' at T_0 , the greater the ESB at $0T_a$.

TS4: Among parents, the greater the 'help-seeking behavior' at T_0 , the greater the PSB at $0T_a$.

TS5: Among parents, the greater the 'help-seeking behavior' at T_0 , the greater the IPI at $0T_a$.

TS6: Among parents, the greater the 'help-seeking behavior' at T_0 , the greater the EA at $0T_a$.

Theorems. Theorems are derived intrinsic statements where the substantive terms are referentials.

Th1: Among parents, the greater the A at T_{18} , the greater the PSB at $0T_a$.

Th2: Among parents, the greater the I at T_{18} , the greater the ESB at $0T_a$.

Th3: Among parents, the greater the I at T_{18} , the greater the IPI at $0T_a$.

Th4: Among parents, the greater the I at T_{18} , the greater the EA at $0T_a$.

Referents. To make the model testable, referents and epistemic statements are added. A referent is the particular numerical value that represents an assertion about the referential. Hypotheses are supported as consistent or inconsistent with assertions, and not with facts. The researcher is not present in others' experiences, but gets reports of those experiences.

The referents of the model were the Family of Origin Scale (FOS) and

Social Support Scale (SSS).

1. (FOS) Family of Origin Scale--a scale that measures the interwoven concepts of intimacy and autonomy as measures of the health of the family of origin (Hovestadt et al., 1985).
2. (SSS) Social Support Scale--a scale developed to measure the sub-concepts of ESB, PSB, IPI, and EA (De Lorenzo, 1988b).

Epistemic Statements. Epistemic statements are derived intrinsic statements where the substantive terms are referents.

Referents become evidence only when a prediction about them is derived from the theory, and such a prediction cannot be derived formally without epistemic statements, meaning statements that link the referentials in a theorem with sets of referents....Epistemic statements are not part of the theory proper; rather, they are made by an investigator when conducting and reporting a test (Gibbs, 1972, pp. 292-294).

- E1: Among parents, the greater the $A = I$ at T_{18} , the greater the FOS at T_{n+1} .
- E2: Among parents, the greater the $ESB + PSB + IPI + EA$ at ${}_0T_a$, the greater the SSS at ${}_0T_a$.

Hypothesis. "In conducting and reporting tests, predictions about referents are statements in the form of derived assertions, and such a statement is identified as an hypothesis" (Gibbs, 1972, p. 295).

- H1: Among parents, the greater the scores on the FOS at T_0 , the greater the scores on the SSS at ${}_0T_a$.

Descriptive Statement. The next step was to describe the actual

relation between the sets of referents. "The descriptive statement stipulates a value as representing the association between the two sets of referents" (Gibbs, 1972, p. 296). The descriptive statement for transgenerational support was as follows: The Pearson product moment correlation coefficient between the referents FOS and SSS will be $+ .25$ or greater.

Features

The model has the level of a factor-relating theory or situation-depicting theory as identified by Riehl and Roy (1974). By testing the hypothesis the model might have support to consider a predictive model. Predictive models can be used in developing a prescriptive model.

Assumptions

1. Biological, social, cultural, spiritual, and psychological factors are passed along from generation to generation.
2. The family of origin has causal effects upon social support.
3. The healthier the family of origin, the higher the levels of social support.

Hypotheses

The following null hypothesis was formulated from the referentials of the conceptual framework: Among parents, there is no significant relationship between social support as identified by the Social Support Scale, and health of the family of origin as measured by the Family of Origin Scale.

Autonomy and intimacy denote health of the family of origin

(Hovestadt et al., 1985), and social support consists of problem-solving behaviors, emotionally sustaining behaviors, indirect personal influence, and environmental action (Gottlieb, 1978).

An additional hypothesis was formulated using the referentials of the conceptual framework, part two of the SSS, and the demographic variables: Among parents, there is no significant relationship between social support as identified by the Social Support Scale, health of the family of origin as measured by the Family of Origin Scale, race, an identified need, the person who helped satisfy the need, a rating of satisfaction with the help received, marital status, number of children, sex, age, occupation, perception of health, perception of adequacy of income, and perception of quality of life.

Definition of Terms

1. Parent--A person or persons who take the moral, legal, cultural, and psycho/spiritual responsibility for a minor child (De Lorenzo, 1988a).
2. Transgenerational Passage--Physical, social, psychological, and cultural factors being transmitted from one generation to another within the family (Lieberman, 1979).
3. Family of Origin Scale--A scale that measures the interwoven concepts of intimacy and autonomy as measures of the health of the family in which you grew up (Hovestadt et al., 1985).
4. Social Support--Cognitive, affective, or behavioral process which an individual or group undertakes actively or passively for the purpose of giving needed assistance to another person (De Lorenzo, 1987).
5. Social Support Scale--A scale developed by the researcher to measure

the sub-concepts of ESB, PSB, IPI, and EA identified by Gottlieb's (1978) inductive study.

6. Family of Origin--A group of people or significant others with whom a person grew up.

Limitations

The following limitations were identified for the present study: (a) Generalizability is to parents of children in grades nine through twelve; (b) Parents' ages ranged from 25 to 55; (c) Tools had adequate validity and reliability, but not "exhaustiveness."

Samples in model testing should be representative. Randomness is best. Randomness presumes a normal variation of the variables being studied. "In real life, however, rarely are samples truly selected randomly. Instead, convenience samples are often used, under the assumption that there is no particular difference in the sample that happens to be convenient....and any other possible sample" (Diers, 1979, p. 144). However, the sample was random, and the generalizability was only limited to parents of children in the grades studied.

Generalizability is also limited by the validity and reliability of the instruments. The more exhaustive the validity and reliability studies, the greater the generalizability to the total population.

Summary

In the present chapter, the problem, purpose, and rationale of the study were identified. In the conceptual framework, transgenerational theory and social support were joined in a model of transgenerational support using the Gibbs paradigm. Both the intrinsic and extrinsic

components of the model were formulated. The model was made testable by listing referents, epistemic statements, assumptions, and hypotheses.

Assessment of the possible causative factors of the health of the family of origin on social support might lead to new insights into how social support works. Research into how social support works is necessary if social support is to remain a viable nursing intervention. The study has implications in the beginning development and validation of a possible theory of transgenerational nursing.

The next chapter contains a review of the literature. The literature review consisted of current and classic sources that were relevant for the study. Varying points of view were critically examined.

CHAPTER II

REVIEW OF LITERATURE

Social support and transgenerational passage are phenomena which have been present since the first human beings and their offspring appeared on earth. Social support first began when at least two beings were present. Transgenerational theory began a little later than social support when the first couple had the first child. When, and how this event happened depends upon each person's individual interpretation of theories of creation.

Little literature exists on transgenerational theory, but there are authors who recorded ideas pertaining to the passage of acquired practices, behaviors, and beliefs between generations. Authors cited here believed transgenerational issues to be important in client care. The authors who dealt with issues of a healthy family, i.e., intimacy and autonomy, were also included. No research studies of transgenerational theory were identified by a library computer search.

Social support has numerous articles and research studies. Unfortunately, social support has many definitions, but little definitive answers as to exactly what social support consists of. The emphasis in this study is on the classic definitions and the studies that were performed with families. Varying points of view were critically examined.

Transgenerational Theory

Previous social and dynamic theories of the late nineteenth and early twentieth century laid the groundwork for transgenerational theory even though Lieberman (1979) was the first to use the term. Transgenerational theory grew out of the various schools of family therapy with an emphasis on systems theory.

Family systems theory consists of observation of the functioning of the whole family. "A whole which functions as a whole by virtue of its interdependence of parts is called a system and the method of discovering how this is brought about is general system theory" (Andres, 1974, p. 2). Systems theory determines structure, function, and evolution of systems by asking how; what is the sequence of events; what patterns repeat predictably; what laws or patterns of behavior operate in the system? Systems theory defines problems in terms of behavior patterns and functions.

Framo (1974) revealed that the first excitement and success as a clinical psychologist came when therapists began to work with families. Before that, individual therapy brought little feeling of success.

Revelation of the phenomenon of interlocking, multi-person motivational systems was a genuine breakthrough. Many heretofore inexplicable paradoxes and symptoms began to make sense; the family systems approach helped decode age-old human dilemmas. How to change a family was another story....For the first time practitioners...found a way to deal with the real problems of people--the relationships

with those who matter most to them (p. 95).

Bowen (1977) argued that emotional illness is a multigenerational process.

This postulated that the problem in the patient is a product of imperfections in the parents, and the parents a product of imperfections in the grandparents, continuing back for multiple generations, and that each generation was doing the best it could considering stresses and available resources (p. 186).

Erikson (1968) spoke of identity as a generational issue. The older generation provided the ideals that the next generation used or rebelled against in identity formation.

Carter (1978) in observing transgenerational scripts and nuclear family stress, held that unresolved issues in past relationships were carried into each new generation and relationship until these issues became themes. Examples of the issues included, but were not limited to, money, sex, parenting, divorce, and handling of illness and death.

Doctors and nurses are now looking at what kind of client has a disease. Holistic medicine should include client families, including both the family in which the client currently exists, and the family in which the client grew up. Boszormenyi-Nagy (1985) viewed generational issues as only the prerogative of psychological intervention, and very differently from physical medicine.

In contrast with physical medicine, in psychotherapy the consequences of therapeutic intervention can never be

confined to one client's interests. Even in classical, individual therapy, the patient's spouse, children, and parents too will be subject to consequences of the outcome, whether or not the therapist intends and knew so...implicitly, therapeutic design and contractual ethics include the health interests of all potential beneficiaries and victims of the interventions (p. 454).

Interpersonal consequences are the most important aspects of close relationships, and are the bases of relational and therapeutic ethics. "If the couple have small children, the therapist cannot be excused for an indifference to prospective consequences to the next generation" (p. 455).

There are many models of family development. Combrinck-Graham (1985) characterized the family as spiral and not linear, since death can occur at any stage in the life cycle. The family either comes together or is pulled apart. The family functions on previous experiences. Life events occur that alternately encourage intimacy, individuality, or self-expression.

The family system is immortal. Through repetitive processes of family formation, bearing children, raising them, and coming apart to form new families and begin the cycle anew, the family provides an environment for the crucial processes of negotiating closeness and intimacy and differentiation and individuation (p. 149).

In a model of transgenerational theory developed by De Lorenzo

(1988c) each person in the family has a spiral. An individual starts life with inherited features from a family of physical parents. Then, molded and constitutive features, which are changeable, were influenced by behavior, beliefs, and traditions. Throughout life, the person within the family responds to, by, and through bonding, collision, loss, replacements, secrets, and evolution.

Transgenerational theory was seen as an enormous set of spiraling cycles of inputs, throughputs, and outputs, with the feedback part of the spirals leading into another spiral. When two people came together in marriage, each's spiral ran parallel through life. As a child was born to the couple, a branch spiral of the two parents' spirals began a parallel spiral throughout life. All spirals exist in the external environment: both affected by the external environment, and effecting that same environment.

There were no quantitative studies found on transgenerational theory. Yet, McGoldrick and Gerson (1985) present numerous genograms of people showing the patterns of relationships and behaviors among specific famous historical figures. Life cycle transitions were studied over at least three generations. Identified transitions created tentative hypotheses about what led to change in a particular family. Family changes could have been viewed as changes in healthy or unhealthy levels of autonomy and intimacy.

Autonomy

Erikson (1959) proposed the first developmental stage to be that of trust. This trust meant that the baby could trust both mother to meet

the first needs, and self to be able to take steps such as crying to meet those same needs. The second developmental task was a sense of autonomy. Autonomy is the knowing of what I and you consist of, and a sense of me and mine. Erikson proposed that autonomy started in the second and third years of life.

Bowlby (1973) discussed separation. The concept is not the same as the concept of autonomy, but may be a precursor of the total growing into the autonomous adult. Bowlby's work dealt mainly with the anxiety and stress that result when separation is not developmentally correct.

The differentiation of self-concept deals with the degree to which a person becomes emotionally 'differentiated' from the parent. In a broad sense, the infant is physically separated from the mother at birth, but the process of emotional separation is slow and complicated, and at best incomplete (Bowen, 1974b, p. 74).

Bowen considered that differentiation of self occurred in childhood, and depended upon the differentiation of the parents, and on a healthy emotional climate in the family of origin. Functional levels of differentiation of self change as life situations change, being either favorable or unfavorable. To be autonomous, a person must have some degree of differentiation of self.

People struggle against their identification with their parents, and many have to go back and deal with those parents before they can go forward with the present family.

There is an appropriate pattern of relationship to parents in

adulthood, stemming from having established a self within the family of origin before separating from it....One's own level of differentiation is replicated in marriage following which one's self is emotionally interlocked with parents in the past generation, the spouse in the present generation, and children in the future generation (Framo, 1976, p. 82).

The more things change, the more they are the same in relationships. People confuse emotional freedom with physical separation. With physical separation must come the development of coping mechanisms which eventually make people emotionally less mutually interdependent. "Separation...may induce guilt feelings in the perpetrator, and guilt is the greatest obstacle to the success of genuinely autonomous emancipation" (Boszormenyi-Nagy & Spark, 1984, p. 32).

Autonomy must be considered in terms of relationships. Conflict is in the vertical loyalty system. Clients develop capacity for rebalancing between vertical commitments to grandparents, parents and children, and horizontal commitments to spouse and peers. Failure is overtly deplored, but covertly valued as proof of a loyal commitment to the family of origin. The adolescent must learn to discount rigidly binding obligations for repayment of the parents' availability and services by negotiation and compromise (Boszormenyi-Nagy & Spark, 1984).

Angyal (1973), Bowlby (1969), Framo (1976), and Bowen (1974b) all scrutinized the idea of fusion versus differentiation. The drive for autonomy is not denied, yet, the motive underlying the search for all other loves exists because one never gives up the need for the love

and acceptance of parents. During adulthood, children become equals with their parents. Children lose the parent-child relationship, and become friends. There is a need for independence on one hand, and a need for intimacy on the other. Healthy families of origin satisfy and develop both autonomy and intimacy in each member.

Intimacy

Bowen (1974b) surmised that the conflict between autonomy and intimacy were part of any psychopathology. These are universal human problems. Healthy families are responsible for both the conflicts and the solutions.

Erikson (1959) formulated the idea that intimacy was one stage of adulthood. Intimacy occurs after identity and autonomy, and does not just define sexual intimacy, but is "a true and mutual psychological intimacy with another person" (p. 101). Intimacy can only occur after a sense of identity is formed. Identity consists of talking about how one feels, how one perceives others, what one's plans, wishes and expectations are all about. Erikson (1968) presented that intimacy can be a mutual psychosocial intimacy with another person, be it in friendship, in erotic encounters, or in joint inspiration. "The condition of a true twoness is that one must first become oneself, [intimacy ultimately leads] to develop orgasmic potency in relation to a loved partner" (Erikson, 1959, p. 101).

Bowlby (1969) discussed attachment. Again, the concept is not the same as the concept of intimacy, but may be a precursor of growing into an intimate adult. Bowlby's work discusses the anxiety and stress that

develop when attachment in the family of origin is not healthy.

Summary

Constructive relationships are the result of adult behavior. Adulthood was described by Hovestadt et al. (1985) as reaching healthy levels of intimacy and autonomy. Transgenerational passage determines the functional level of autonomy and intimacy that each person reaches in adulthood. Transgenerational passage and social support share many of the preceding ideas. Social support by definition is a helping relationship. Transgenerational passage effects the social support relationship in the following way: if the client asked for help, who the client asked for help, what type of help was asked for and accepted, and if the relationship with the supportive person was constructive or destructive.

Social Support

Social support has been researched with every phase of life, health, and illness. No study was located in the available literature which dealt specifically with social support and transgenerational passage. However, there are numerous studies on social support dealing with various members of the family and family issues.

The available literature has been organized into the different themes of the studies. Problems arose when a study fell into more than one category, therefore, judgments were made about including studies into specific categories.

Social Support in Transgenerational Passage

Boszormenyi-Nagy and Krasner (1986) had convictions that each

person's decisions and actions have consequences which can affect people who have a significant relationship with that individual. A person must consider these consequences in order to satisfactorily relate to these people. Consequences flow from person to person, generation to generation, and from one system to its successor. Survival of the human species depends on transgenerational continuity and solidarity.

"Basic relationship patterns developed for adapting to the parental family in childhood are used in all other relationships throughout life. The basic patterns in social and work relationships are identical to relationship patterns in the family, except in intensity" (Bowen, 1974a, p. 170).

Bruhn and Philips (1987) revealed that a developmental basis for social support can be found in Maslow's concepts of basic needs. Bruhn and Philips surmised that basic needs for security, belonging, love, respect, and self-esteem are met by the social environment that each person is dependent upon. Social support is not only learned as one grows, but also continually evolves as growth and developmental tasks are completed. Individuals are either consumers or generators of social support.

How people gain support from relationships and the environment are not clear. When natural sources of support, i.e., relatives, friends, etc., are not positive, the individual needs to know how to mobilize sources of social support in addition to, or in lieu of, natural sources. Social support, its availability, accessibility, method of

mobilization, use, and effectiveness, is part of the complex, dynamic process of growth and development. As an individual becomes self-actualized, there is less need for social support. A self-actualized individual is self-sufficient and can become a source of social support for others (Maslow, 1968).

Thomas and Znaniecki (1958) surmised that there are socio-psychological laws that are passed from generation to generation. Polish peasants in both Europe and America were studied and described. Conclusions were limited to a social group at a certain period of its evolution. Conclusions help prepare the ground for the determination of exact laws of human behavior. When more groups have been studied using better methods, analogies will be possible and the ground will be prepared for the determination of laws of human behavior. Analogies allow for the presumption that such laws are possible. Conclusions of the study also exhibited that life in a permanent agricultural community in the old world changed so slowly for hundreds of years that each generation adapted itself to change with little effort or reflection. If change occurred, the person relied upon the group to give assistance. Social support helped the person to regain mental balance and recover the feeling that life in general was normal in spite of the unexpected disturbance. Life-organization depended on the continuity of social support within the group.

Haber (1987) found evidence to support family friends as resources available to the family in dealing with problems and developmental struggles from childhood to young adulthood. Following are some areas

in which friends were beneficial to clients: Bridging generation gaps, providing positive peer pressure, and providing helpful suggestions to parents based on the friend's experiences.

Support During Pregnancy and Birth

Brown (1986) studied marital support during pregnancy. Brown used a support behavior inventory based on House's conceptualization of social support: (a) emotional support--esteem, affection, trust, concern, listening, (b) appraisal support--affirmation, feedback, social comparison, (c) informational support--advice, suggestions, directives, information, (d) instrumental support--aid in kind, money, labor, time, and environment modification. There was no difference between men's and women's overall support satisfaction scores. There was variability in other areas. The results further showed that nursing interventions should be targeted at improving the support expectant mothers gave to the respective fathers.

Lentz et al. (1986) surmised that the birth of a baby is a major life change. Life change and intensity of support were positively related to illness. Size of the support network was negatively related to illness. There was no evidence for the buffering role of social support. Characteristics of instrumental support differ in their importance as predictors. Instrumental support that was perceived as most helpful was provided by small networks and by persons intensively involved in providing assistance with the infant.

Support and Adolescent Life

Dunn et al. (1987) studied social support and adjustment in gifted

adolescents attending a residential school. A long version of the Flemming, Baum, Gisriel, and Gatchel Social Support Scale was used. Findings were that lower levels of general social support was related to higher levels of reported psychological problems for both boys and girls. For girls, perceived support from family was associated with better school adjustment. Perceived support from peers was significant for both groups. Boys with lower levels of support from peers had greater psychological distress, whereas girls with lower levels of perceived support from peers sought guidance. Family support was shown to play a definite role in the adjustment process, and this might be because family support has developed children with a sense of security and the skills necessary to facilitate adaption. Peer social support may be more important to an adolescent's self-perception and self-esteem.

Another study done with adolescents looked at sex differences in adolescent life stress, social support, and well being. Again, the researchers developed a tool for supportive social relationships. As in the previous study, similar differences between the sexes were found. Females disclosed themselves more frequently to selected others, but females also reported a poorer level of emotional and psychological well-being. Expressing negative emotional experiences was more threatening to the female identity. Male and female adolescents both seemed to favor mothers over fathers, and peers over parents, as helpers. (Burke & Weir, 1978) Neither the Burke and Weir study nor the Dunn et al. studies reported validity or reliability measures for their

instruments.

Support and Single Parents

Norbeck and Sheiner (1982) researched the buffering effects on life changes. Social support related to single-parent functioning. New instruments were developed. A one-page checklist of 32 sources of support was developed and field-tested by Ablin and Gorman. Norbeck and Sheiner developed a structured interview to obtain information about the subjects' social support resources. The last instrument had content validity established by review by three clinical specialists. There was a significant negative correlation between the amount of social support and child problems. The study suggested that social support can help single parents.

Perceived and Enacted Social Support

McNett (1986) was interested in social support, threat, coping responses, and effectiveness in the functionally disabled, and used the Interpersonal Support Evaluation List (ISEL) to measure the perceived availability of social support. The subscales of tangible support, informational support (identified as appraisal), and belonging were used. The self-esteem scale was not used. The Ways of Coping Checklist (WCC), which was a subscale of social support, was also used.

Perceived effectiveness of social support was measured by asking the subject to what degree each type of support would be effective in dealing with each area of concern. A causal model was developed and tested. The findings indicated: (a) Perceived availability of social support was positively related to coping effectiveness through the

mediating variables of problem-focused and emotion-focused coping; (b) perceived availability of social support was positively related to the use of social support and the perceived effectiveness of social support; (c) perceived personal constraints of social support were not related to any causal model variable; (d) perceived availability of social support was related to reduced threat appraisal; (e) threat mobilized social resources, but did not influence the mobilization of other coping resources; and (f) the use of social support was not significantly related to coping effectiveness. All measures of social support were related to perceived threat. There was no significant causal relationship between social support and coping effectiveness. Another study that dealt with perceived social support was Schaefer, Coyne, and Lazarus (1981).

Bramwell (1986) looked at a support experienced by wives after the husband's first myocardial infarction. A semistructured interview was used to collect data. Bramwell found support in such areas as information supplied by the health care team, who also acted as confidants, and by assistants and guides. Comfort was provided by allowing the wife to call the unit at any time of the day or night. The wives helped their husbands with rehabilitation, exercise, diet, relaxation, nurturance, and emotional support. The wives actively sought information on what the support role requirements were, and how to be supportive. Implications were for nurses to help clients to develop support roles.

Gierszewski (1983) used a poor investigator-developed instrument to

measure social support. This instrument has moderate validity of $r = .40$, $p = <.003$. No reliability was reported. The author stated the fact that social support was not beneficial to the success of weight reduction, and in fact that it was harmful to those with internal locus of control. The results were probably due to the lack of established reliability and validity of the instrument.

Four other studies showed that social support buffered the effects of life changes on illness and stress. The studies were: Billings and Moos (1982), Murphy (1987), Norbeck et al. (1981), and Wilcox (1981).

Hubbard, Muhlenkamp, and Brown (1984) researched the relationship between social support and self-care practices, completing one descriptive survey on two different groups using Brandt and Weinert's (1981) Personal Resources Questionnaire (PRQ). The instrument taps the five dimensions of social support proposed by Weiss. There was a positive association between social support and health practice variables, but married participants scored significantly higher on both social support and health practice instruments only in a senior citizen's study. The effects of social support and health practices are interactive, but as yet no causal relationship has been established.

Browner (1987) studied the role of social support to job stress, and health at work. Five types of social support were measured:

(a) informational support--providing information that will aid in the solution of specific problems, (b) material support--tangible help in the form of goods and services, (c) appraisal support--information useful for self-evaluation or social comparison, (d) emotional support--

communications that lead individuals to feel that they are cared for and about, (e) normative support--information that leads individuals to feel they belong to a community or network of shared norms, beliefs, and values. The highest stress was generated by the institutional environment. The staff with supportive work-based networks reported significantly better health than those without such networks.

Hall et al. (1987) tested the idea that social support enhances psychological well-being irrespective of the occurrence of stressful life events. The subjects were low-income women with at least one child under the age of seven. Studying the stability of psychosomatic symptoms over a five-year period, Hall et al. (1987) compared associations of the quantity of social ties and the quality of primary intimate relationships with psychosomatic symptoms; assessing baseline symptoms, social ties, and quality of primary intimate relationships as predictors of psychosomatic symptoms. Psychosomatic symptoms remained stable over five years. The quantity of social ties was inversely associated with psychosomatic symptoms. Social ties may be a cause or a consequence of psychosomatic symptoms. The hypothesis that the quality of the primary intimate relationship would be more strongly associated with psychosomatic symptoms than would the quantity of social ties, was only partially supported. The quality of relationships with family members had a strong association with the probability of high psychosomatic symptoms.

Part II of the Personal Resources Questionnaire (PRQ) was used by Muhlenkamp and Sayles (1986) to look at social support, self-esteem, and

positive health practices. A causal model analysis showed that social support was significant in its direct effect on self-esteem, and through self-esteem, social support had an indirect effect on a positive life style.

Lin, Ensel, Simeone, and Kuo (1979) developed a social support scale. The item-total correlations ranged from .36 to .74, with the correlations being significant at the .001 level. The alpha of .52 was not as strong as it ideally should be. The analysis showed that, as expected, stressors are positively related to the incidence of psychiatric symptoms, and social support is negatively related to psychiatric symptoms.

Rutledge (1986) used the Norbeck Social Support Questionnaire (NSSQ) in a study of factors related to women's practice of breast self-examination. No significant relationships were found between breast self-examination frequency and perceived severity of breast cancer, perceived level of social support, and social network properties. Another study by McNett (1986) indicated that social support may have more of a relationship to the perceived threat of disease. Other studies that considered the direct benefits to health throughout life were the following: Dean and Lin (1977); Jordan-Marsh, Gilbert, Ford, and Kleeman (1984); Martin and Burks (1985); McFarlane, Nowman, Streiner, and Roy (1983); and Thotis (1982).

Social Network Ties and a Confidant

Social support has been measured as the quantity of social relationships or ties of an individual (Berkman & Syme, 1979; Billings &

Moos, 1981; Eaton, 1978). These researchers assumed that the greater the number of ties, the greater the number of benefits to mental and physical health. Later studies have shown that the quality of social support is much more important than the size of the network.

Social support can create demands, constraints, and conflicts, and the quality of social support is more important than the quantity. Social support may "cost" more than an individual is willing to pay, but most definitions of social support indicate a positive definition. Therefore, negative results are not social support (Schaefer et al. 1981).

Brown, Bhrolchain, and Harris (1975) found that a close, confiding relationship with husband or boyfriend was the only type of supportive relationship which protects women against the emotional effects of severe life events, although the lack of such a relationship in the absence of severe events was not associated with psychological symptoms.

Lowenthal and Haven (1968) found that a conflict buffered the detrimental effects of a decrease in social interaction and role status among elderly people. Miller, Ingham, and Davidson (1976) also studied availability of a confidant.

Confiding relationships seem to be especially important for women. Holtzblatt (1982) in interpretive inquiry (qualitative) research on women's friendships discovered the words feelings, connection, distance, support, clicking, and closeness. One final cultural meaning was described as not feeling alone in the world. Social support precludes aloneness.

Path and Causal Analysis

A positive significant correlation between self-esteem, social support, and life style among adults led to a theoretical causal model which was developed and tested with path analytic techniques. The direct and indirect effects of self-esteem and social support were found to account for 28% of the variance with a $p < .001$ by the model. Social support was an indirect influence on life style through a high direct influence on self-esteem (Muhlenkamp & Sayles, 1986).

A Lisrel VI, using the variables of social support, threat, and coping responses, was completed by McNett (1986) to look at a causal model of coping effectiveness among the functionally disabled. The model accounted for 61% of the variance in coping effectiveness. Again, the variable of perceived availability of social support had indirect effects on coping effectiveness through direct effects on problem solving and emotionally focused coping.

Gottlieb and Green (1984) used a random phone survey of over 3,000 subjects, 40% men and 60% women, in a path analysis of life events, social network, life style, and health as possible causative factors on personal health practices and consequences. Social structure factors both positively and negatively influenced life-style practices through social network and negative life events.

Costs and Negative Aspects

The negative aspects of social support give added credence to the idea that levels of social support depend upon the health of the family of origin. Social ties are two-edged swords. Any close relationship

creates a potential for conflict and may inhibit independence of personal growth. Caregivers must evaluate the tension, disputes, and interferences that cause the negative results of pain in social relationships as well as the positive results of support provided, as both can occur concurrently (Bruhn & Phillips, 1987).

Tilden (1985) has been the champion of the idea of costs and negative aspects of social support. Tilden and Galyen (1987) have printed the results of an instrument to measure the Cost and Reciprocity of Social Support (CARSS). Research was conducted with cancer patients. A two-way ANOVA revealed that "...it was only when accounting for the quality of the confidant relationship with respect to cost, conflict, reciprocity, and equity that the presence of a confidant was related to adjustment" (p. 14).

Sandler and Barrera (1984) researched unconflicted and conflicted support networks among college students. Conflictual relationships increased the levels of stress. Rook (1984) studied psychological well-being and the effects of positive or negative social ties. Negative social ties are more potent, and potentiate stress, thus exacerbating symptoms.

Holahan and Moos (1983) took measures they identified as family social support from the Moos Family Environment Scale, and named the new, shorter scale the Family Relationships Index (FRI). Next, the authors took measures they identified as Work Relationships Index (WRI) from the Moos and Insel Work Environment Scale. The sampling procedure involved a random selection of families within selected census tracts

in the San Francisco area.

Summary

Little research on transgenerational theory was available. Authors who used transgenerational theory in clinical practice were cited. These writings give credence to the idea that transgenerational theory exists, and social support may begin with the family of origin.

A selected few studies on social support were presented. There are copious studies on social support. The first research dealt with defining social support and its concepts. Correlational studies on the effects of social support and health are popular today. Yet, Gottlieb (1978) identified the start of this practice to the late 30's when social factors and life events were linked with health.

Studies in which the authors developed their own instruments led to few significant findings. These authors admitted to the lack of validity and reliability of the instrument as reasons for this fact.

A few studies appeared that looked at causal relationships by using some form of path analysis. Meta analytic work is also being done on social support. Causal and meta analyses could lead to the acceptance of social support as a valid area of intervention by the professional. Social support, with its roots in relationships and communication patterns developed in the family of origin, may be one possible theory for helping. These types of analyses might also identify other, more beneficial areas of research into helping.

Chapter 3 presents procedures for collection and treatment of data. Data collection and treatment includes descriptions of the population,

setting, and instruments validity and reliability. Results of instrument development and the pilot study will be included.

CHAPTER III

PROCEDURE FOR DATA COLLECTION AND TREATMENT

The present study was a correlational survey. A correlational survey was appropriate for a causal model or theory-testing hypothesis (Diers, 1979; Burns & Groves, 1987). Looking at the extent to which changes in the Family of Origin Scale (FOS) related to changes in the Social Support Scale (SSS) identified the study as correlational (Waltz & Bausell, 1981). If the SSS scores increased when the FOS scores increased, and the SSS scores decreased when the FOS scores decreased, the scales had linear relationship (Waltz, Strickland, & Lentz, 1984) and there was support for the idea that family of origin effects social support. The variables for the present study were social support and health of the family of origin.

Setting

The setting was the place where each subject desired to fill out the questionnaire. Subjects were randomly selected from a complete listing of all parents of students in grades nine through twelve in an independent school district in north Texas, in a city of approximately 100,000. There were approximately 4,000 students in this secondary school district. Two questionnaires were mailed out in one envelope--one for the father and one for the mother of each child in the study. Subjects were given stamped, researcher-addressed envelopes, and asked to mail back the completed questionnaire to the researcher.

Population and Sample

The population for the present study consisted of parents of over 4,000 school-age children in grades nine through twelve in an independent school district of a north Texas city (population 100,000). A random sample of parents meeting the following criteria was generated from the population.

1. Parents were eighteen years of age or older.
2. Parents were able to read and write English.
3. Parents had children in grades nine to twelve in a specific school district.
4. Parents had not taken part in either instrument development or the pilot study.

School district officials suggested a mailing of 1,000 for an estimated return rate of 10%. It was not known which children lived in single-parent homes, but the school district statistics indicated approximately 30%. The background sheet identified single parents, and these parents were included in the study. Two questionnaires were mailed out to each student's parents--one for the father and one for the mother. Single parents were asked to throw out the second questionnaire.

Each scale and each subscale was considered a variable for the multiple regression statistics. An ideal sample size was 210, since there were four subscales in the Social Support Scale (SSS), and three subscales in the Family of Origin Scale (FOS). This gave a variable-to-subject ratio of 0.03. "...the lower the variable-to-subject ratio,

the less the betas are likely to fluctuate from sample to sample, and the less likely the researcher is to make erroneous interpretations on the basis of the results" (Waltz & Bausell, 1981, p. 283).

Protection of Human Subjects

The research was conducted by use of questionnaires, and was limited to subjects 18 years of age and older. Consent to participate in the study was implied by filling out and returning the questionnaires. Permission to conduct the study was obtained from the graduate school (See Appendix B). Permission was obtained from the organization to be used (See Appendix C).

The following information was included in the cover letter (See Appendix D). The researcher was introduced. The research was explained. Each person was told that participation would be entirely voluntary and anonymous. Both the cover letter (Appendix D) and the first page of the Social Support Questionnaire (Appendix E) contained a sentence stating that completion of the questionnaires implied consent to participate in the study.

One potential risk to the subject was the possible loss of anonymity and public embarrassment by improper release of data. A number code was used on the return envelopes to identify subjects if a second mailing was necessary. The surveys were destroyed when the data was transcribed to a computer data base. Another risk was any emotional trauma in thinking about the family of origin, support systems, or each person's particular situation. The researcher made an offer to answer any questions the subjects might have. The subjects were also

encouraged to contact the researcher for further information. The cover letter contained the researcher's address and phone number.

Instruments

Two survey instruments were used in data collection. The Family of Origin Scale (FOS) was developed by Anderson (1980) to measure the health of the family in which one grew up. The Social Support Scale (SSS) (De Lorenzo, 1988b) measured social support in parents. The following is a discussion of the instrument development, testing, validity, and reliability.

Social Support Scale

After concept analysis and synthesis, an instrument to measure social support was developed. The instrument consisted of three parts: (a) A questionnaire developed after concept analysis and synthesis of social support; (b) a section identifying needs, the person who helped with the needs, and the satisfaction with that help; and (c) a background information sheet containing demographics.

Part 1 of the questionnaire consisted of 41 questions that were answered on a Likert scale from 1 (strongly disagree) to 5 (strongly agree). The following subconcepts of social support were included in these questions: Intimacy/attachment, part of a group, nurturance, reassurance of worth/self-esteem, and support/instrumental help.

Part 2 of the questionnaire asked parents to identify five needs experienced in the last three months. Next, the parent identified the person who helped with each one of the needs. And last, the help received for each need was rated from one to five. Part 3, as

identified before, contained demographics.

The questionnaire was given to nine student-parents of children from birth to 21 to evaluate if the language was clear and the directions were easy to read. These student-parents were also asked if the questions were understandable, and how much time the questionnaire took to complete. No changes were made in the questionnaire as a result of the student-parent responses. The responses were used to identify and to code the needs and helpers in part 2. Results of the demographic sheet were used to classify the responses to make coding easier. These nine questionnaires were also used to write computer programs for item, factor, and reliability analyses. A descriptive program was written to obtain frequencies and statistics on each response.

A nonprobability sampling technique known as network sampling was used to test the instrument. Both Burns and Grove (1987) and Nieswiadomy (1987) discussed networking as a valid type of nonrandom sampling. "You ask a person to help you get in touch with friends who would also meet your sample criteria....by finding a link in the social network, one subject will lead the researcher to others" (Brink & Wood, 1983, pp. 143-144).

The majority of the data were collected by a large network. The network included fellow students and their spouses, relatives and their co-workers, friends, neighbors, and acquaintances. Four hundred questionnaires were distributed in Texas, Arkansas, Missouri, Kansas, and Tennessee. One questionnaire was returned from Minnesota and another from Oklahoma.

Other convenience sample data collection took place. Agency permission was obtained, and one day was spent at a mall asking parents of children from birth to 21 to answer the questionnaire, and 52 usable questionnaires were completed. A fitness center allowed a poster and questionnaires with stamped, researcher-addressed envelopes to be displayed on the premises. The agency permission was obtained. There were eleven fitness classes during one week, and 30 of 52 questionnaires were distributed this way with stamped, researcher-addressed envelopes for return.

The above procedures were repeated until the predetermined number of at least 205 questionnaires were completed. The number 205 was determined sufficient for factor analysis since it was five times the number of questions (41) (Jennings, 1988).

Two hundred twenty-one questionnaires were completed and returned. Seventy-five percent of the people sampled worked full time outside of the home. The remaining demographics are summarized in Table 1, pp. 57-59.

Validity of the SSS. "Content validity verifies that the method of measurement actually measures expected content" (Johnson, 1988). No test is 100% valid. Therefore, validity is the degree to which a test measures what it is designed to measure. Content validity consists of item validity, or whether each item measures its intended content, and sampling validity which measures if the test measures the total content area (Jennings, 1988).

Content validity was measured by mailing fourteen packets to experts

Table 1

Demographic Summary of Instrument Sample

| Demographic Variables | Frequency | Percent |
|-----------------------------------|-----------|---------|
| Marital Status (N = 217) | | |
| Married | 178 | 82.0 |
| Divorced | 26 | 12.0 |
| Never Married | 5 | 2.3 |
| Separated | 5 | 2.3 |
| Widowed | 3 | 1.4 |
| Number of Times Married (N = 212) | | |
| Never | 4 | 1.9 |
| Once | 162 | 76.4 |
| Twice | 41 | 19.3 |
| Three Times | 5 | 2.4 |
| Sex (N = 217) | | |
| Female | 157 | 72.4 |
| Male | 60 | 27.6 |
| Age (N = 213) | | |
| 18 to 25 | 28 | 13.1 |
| 26 to 35 | 77 | 36.2 |
| 36 to 45 | 76 | 33.3 |
| >45 | 36 | 16.9 |

(table continues)

| Demographic Variables | Frequency | Percent |
|------------------------------|-----------|---------|
| Ethnicity (N = 212) | | |
| White | 203 | 95.8 |
| Hispanic | 5 | 2.4 |
| Black | 3 | 1.4 |
| Indian | 1 | .5 |
| Education (N = 210) | | |
| <8 | 4 | 1.9 |
| 9 to 12 | 73 | 34.8 |
| 13 to 14 | 48 | 22.9 |
| 15 to 16 | 42 | 20.0 |
| 17 to 18 | 22 | 10.5 |
| >18 | 21 | 10.0 |
| Number of Children (N = 212) | | |
| 1 | 49 | 23.1 |
| 2 | 105 | 49.5 |
| 3 | 37 | 17.4 |
| 4 | 15 | 7.1 |
| 5 | 4 | 1.8 |
| 7 | 2 | .9 |

(table continues)

| Demographic Variables | Frequency | Percent |
|-----------------------|-----------|---------|
| <hr/> | | |
| Income (N = 207) | | |
| <5,000 | 21 | 10.1 |
| 5,001 to 10,000 | 17 | 8.2 |
| 10,001 to 15,000 | 31 | 15.0 |
| 15,001 to 20,000 | 24 | 11.6 |
| 20,001 to 25,000 | 23 | 11.1 |
| 25,001 to 30,000 | 22 | 10.6 |
| >30,000 | 69 | 33.3 |

in the area of social support. All fourteen had authored or co-authored articles on social support in refereed journals. Experts were asked to complete a content rating form. The form was used to rate each question from one to five (five being the highest) for suitability in the area of social support and for suitability in each sub-concept. Comments were also made on each question. Four packets were returned to sender, address unknown. Four were not answered. Six were completed and returned. As suggested by Jennings (1988), if 75% of the experts evaluated the item as acceptable, that item was retained. Thirty-one of the fortyone questions used had a rating of 75% or higher. Six questions were eliminated as a result of the ratings. All of the negative items but one were rated low. The reason for the combined low scores of certain other items is probably due to the diversity of

definitions of social support such as those given in Cobb (1976), Gottlieb (1978), or Weiss (1974).

"Construct validity examines the fit between the conceptual definitions and operational definitions of variables" (Burns & Grove, 1987, p. 237). Construct validity started with concept analysis and synthesis using the Walker and Avant (1983) method of theory construction. Part of the concept analysis and synthesis for social support was discussed previously in the section on theoretical framework.

Factorial validity that examined the relationships between various items of the instrument (Burns & Grove, 1987) was completed through a factor analysis. First, a principal component factoring analysis was performed. Principal components factoring assumes that the items explain all of the variance of the constructs. Eigenvalues are identified until all variance is accounted for. "In component analysis only the factors having latent roots (eigenvalues) greater than 1 are considered significant; all factors with latent roots less than 1 are considered insignificant and disregarded" (Hair, Anderson, & Tatham, 1987, p. 247). In the SSS there were eight factors identified with eigenvalues ranging from 15.29 to 1.09.

Criteria for factor analysis was set at .40, and each question was considered a variable.

In short, factor loadings greater than +/- .30 are considered significant. Loadings of +/- .40 are considered more important, and if the loadings are +/- .50 or greater, they

are considered very significant....When the sample size is 200, $\pm .14$ and $\pm .18$ are recommended for the 5 and 1 percent levels of significance....It has been shown that as the analyst moves from the first factor to later factors, the acceptable level for loading to be judged significant should increase....a significant loading on the tenth factor with 20 variables would be $\pm .261$, but only $\pm .214$ with 50 variables (Hair et al., 1987, pp. 249-250).

When the factor analysis was run on 221 questionnaires, all items with a factor loading of $\pm .40$ and above were retained.

An item analysis was completed using a contrasted group approach. A contrasted group test uses groups having opposing responses. If the group's responses are significantly different in expected directions, evidence has been added to the validity of the instrument (Burns & Grove, 1987). To ascertain a contrasted group, item-analysis was run on the top and bottom quartiles of each question using a two-tailed t-test. All 41 questions were retained for a probability of $p < .01$; however, a rating of $p < .025$ would have been acceptable in a two-tailed test.

Reliability of the SSS. "Reliability is concerned with how consistently the measurement technique measures the concept of interest....Reliability testing is considered a measure of the amount of random error in the measurement technique....concerned with such characteristics as dependability, consistency, accuracy, and comparability" (Burns & Grove, 1987, p. 291). Like validity,

reliability is a matter of degree. "A reliability of .80 is considered the lowest acceptable coefficient for a well-developed measurement tool" (Burns & Grove, 1987, p. 291).

The current state of the art is to do a Cronbach's Alpha to determine the degree of reliability. The Cronbach Alpha is a statistical process which looks at the internal correlation of all the items. This is considered superior to test-retest reliability procedures (Jennings, 1988, p. 4).

Cronbach's alphas were run on the total scale and each of the subscales. A total reliability alpha of .947 was obtained after two negative items were deleted. The subscales ranged from alpha of .6057 to .8917. At this point, corrected inter-item total correlations ranged from .24 to .85. The items with intrascale correlations above .70 were deleted from each scale since questions with high inter-item correlations were asking the same thing.

An inter-rater reliability is the index of the consistency of scores in direct observation measurements. An inter-rater reliability was completed on the expert ratings. "It may also refer to the degree of agreement between judges who are evaluating the degree of congruence between newly constructed test items" (Johnson, 1988, p.4). The statistical test for this procedure is a chi-square, and is reported as a Kendall coefficient of concordance. A Kendall coefficient of concordance is a "measure of the relation among several rankings of N objects or individuals" (Siegel, 1956, p. 229). The Kendall coefficient of concordance was 0.1261. Thus, on all 41 questions, an inter-rater

reliability with $p > .001$ was obtained by running a Kendall coefficient of concordance. This indicates a high inter-rater reliability even though the ratings on some of the questions were low.

Changes in SSS due to Statistics. The instrument was retained for use in the pilot, however, some changes were indicated. Part two was composed of asking each subject to identify five needs that the subject had experienced in the last three months, and to identify the person who helped with each of those needs and to rate the satisfaction with the help given for each need. One man indicated that "answering part 2 took too much thinking." Part 2 was not answered by 32 (14.5%) of the respondents. By the fifth need identified, 173 (78.3%) had not answered those questions. Part 2 was changed to include only one set of questions identifying the need, the helper, and the satisfaction with that help. The demographic sheet had only minor changes, with the addition of asking how many people were in the family in which each person grew up (family of origin), asking for the perception of adequacy of income instead of actual income, asking for perception of health, and asking for perception of quality of life.

After factor analysis, the best combination of 23 items were retained, and an additional ten questions (a subconcept on problem solving) were added. Six items were lost by low expert ratings. Four more items were lost in two factors that could not be named. Eight items were deleted because the eight items cross loaded with each other, or had above .70 on item correlations within scales. The scales were self-esteem, nurturance, worth, intimacy/attachment, perception of

available help, family support, and group. The self-esteem, nurturance, worth, and intimacy/attachment covered Gottlieb's (1978) concept of emotionally sustaining behavior (ESB). Perception of available help was Gottlieb's (1978) concept of indirect personal influence (IPI). Family support was Gottlieb's environmental action (EA). One factor not identified by Gottlieb, i.e., group, was retained. The 23 retained items made up seven scales with a factor loading of $>.4$. The reliability of the shortened survey had an alpha of .9064. Scale alphas ranged from .8525 to .6683. Further improvements in the scale were completed after additional factor and reliability studies were completed on the pilot study. Those improvements are discussed in the pilot study section of this chapter.

Family of Origin Scale

The Family of Origin Scale (FOS) "represents an attempt to construct an instrument which can reliably measure perceived levels of autonomy and intimacy in one's family of origin. Based on these autonomy and intimacy scores, levels of perceived health in one's family of origin are inferred" (Hovestadt et al., 1985, p. 288).

Erickson (1950) was one of the first people to talk about developmental tasks beginning at birth. Erickson believed that the earliest personality development of babies included trust and autonomy. On these two personality traits were built the developmental tasks of identity and intimacy. Framo (1976) went on to look at the need of both separation and attachment in healthy adults. Boszormenyi-Nagy and Spark (1973) and Bowen (1978) dealt with increasing the autonomy or identity

of self in adulthood. All of these authors held views that "patterns of interaction in the family of origin are reflected and sustained in other relationships" (Hovestadt et al., 1985, p. 288).

"If the healthy person is one who can be both autonomous and intimate, then a major task of families is to assist its members in that development" (Hovestadt et al., 1985, p. 288). The FOS was developed because the researcher could find only two instruments dealing with family of origin issues that were not deficient. One was an autonomy questionnaire, and the other dealt with an investigation of healthy families. The FOS used the last study's theoretical basis for the development of the concepts and subconcepts.

Accordingly, in the FOS paradigm, the healthy family develops autonomy by emphasizing clarity of expression, personal responsibility, respect for other family members, and openness to others in the family and by dealing openly with separation and loss. Concurrently, the healthy family develops intimacy by encouraging the expression of a wide range of feelings, creating a warm atmosphere in the home, dealing with conflicts without undue stress, promoting sensitivity in the family members, and trusting in the goodness of human nature (Hovestadt et al., 1985, p. 290).

Validity of the FOS. Construct validity was ascertained by using six nationally recognized authorities in family therapy. The final scale had 40 items that were rated from one to five on a Likert scale. One-half of the items were negative. A score of 1 indicated the least

healthy response, and 5 indicated a healthy response (Hovestadt et al., 1985).

A normative sample of 278 undergraduate and graduate students showed that the FOS discriminated between the subjects of high and low scores. There were no significant differences in scores between the groups of blacks and whites (Hovestadt et al., 1985).

Empirical validation was obtained by the questionnaire being used in several studies. The results of one study showed a difference between men in alcohol- and non-alcohol-distressed marriages (Holter, 1982). A second study concluded that there was a significant difference among college students' perception of marriage, depending upon FOS scores (Fine & Hovestadt, 1984). Additional empirical validation was shown in a study by Canfield (1983). The validity and reliability used in all of these studies was that reported by Hovestadt et al., (1985).

Reliability of FOS. Two reliability studies were reported (Hovestadt et al., 1985). A test-retest over a two-week interval with 41 graduate psychology students had a reliability coefficient of .97 $p < .001$. "Test-retest coefficients for the 20 items of the autonomy concept ranged from .39 to .88 with a median of .77; test-retest coefficients for the 20 items of the intimacy concept ranged from .46 to .87 with a median of .73" (Hovestadt et al., 1985, p. 293). Another study of 116 undergraduate students produced a Cronbach's alpha of .75 and a Standardized Item alpha of .97 (Hovestadt et al., 1985).

Data Collection

A list of random numbers was generated, and the names of 1,000

parents of ninth to twelfth graders in an independent school district were selected with the random numbers. In the first mailing, the cover letter, FOS, SSS, demographic sheet, and a stamped, researcher-addressed envelope was included in a packet for each parent. The return envelopes were numbered from 1 to 1,000. Subjects were given two weeks to return the completed questionnaires. A log of the returned instruments was completed. A second mailing of the same packet was not necessary.

Pilot Study

The problem statements of the pilot study were the following:

(a) Does the SSS have adequate validity and reliability for measuring social support in parents of children between birth and 21 years of age; (b) does the FOS have adequate validity and reliability for measuring the health of the family of origin in parents of children between birth and 21 years of age; (c) was there a significant relationship between the SSS and the FOS in the total scales and subscales; (d) was there a relationship between the SSS and the demographics, i.e., marriage status, number of times married, age, race, number of children, occupation, health status, income, quality of life, and number of people in the family that you grew up in; (e) was there a relationship between the FOS and the demographic variables listed above; (f) was there a relationship between the need identified, the helper identified, and the satisfaction with that help, the SSS, FOS, and demographic variables?

Two hundred ten questionnaires were completed and returned. Seventy-two percent of the parents sampled worked full time outside of

the home. Data on frequencies of the other demographics and Part II are summarized in Table 2 (pp. 69-72) and Table 3 (pp. 73-74).

Social Support Scale. The final questionnaire developed through statistical analysis had four factors and fifteen items, and showed that the SSS had enough validity and reliability to be used as a research tool. The four factors were emotionally sustaining behavior (ESB), environmental action/indirect personal influence (EAIPI), problem-solving behavior (PSB), and GROUP. Self-esteem, nurturance, worth, and intimacy/attachment all loaded on one factor renamed ESB. Family support and perception of available help loaded together, and the factor was renamed EAIPI. The factors of GROUP and PSB remained the same. Eigenvalues on the factors were 1.113 or higher. The items correlated between .105 and .66. The four factors accounted for 65.2% of the cumulative variance. Varimax rotation was used with a sort level of .45 (see Table 4, p. 75). The reliability of the total scale showed a Cronbach's alpha of .8785. The factors were environmental action/indirect personal influence (EAIPI) with an alpha of .8586, emotionally sustaining behaviors (ESB) with .7736 alpha, problem-solving behavior (PSB) with .7684 alpha, and group (GROUP) with .6727 alpha. The number of negative items remained at 26.6%.

Family of Origin Scale. The final modified FOS developed through statistical analyses had three factors and twelve items. The factors were autonomy/intimacy (AUTOINT), acceptance of separation and loss (ACCSEP), and clarity of expression (CLAREX). The modified FOS had adequate validity and reliability to be used as a research tool.

Table 2

Demographic Summary of Pilot Sample

| Demographic Variables | Frequency | Percent |
|-----------------------------------|-----------|---------|
| Marital Status (N = 206) | | |
| Married | 165 | 80.1 |
| Divorced | 20 | 9.7 |
| Never Married | 13 | 6.3 |
| Separated | 6 | 2.9 |
| Widowed | 2 | 1.0 |
| Number of Times Married (N = 207) | | |
| Never | 13 | 6.3 |
| Once | 154 | 74.4 |
| Twice | 27 | 13.0 |
| Three Times | 11 | 5.3 |
| Three | 2 | 1.0 |
| Age (N = 176) | | |
| 18 to 25 | 32 | 18.2 |
| 26 to 35 | 78 | 44.0 |
| 36 to 45 | 53 | 30.1 |
| >45 | 13 | 7.5 |

(table continues)

| Demographic Variables | Frequency | Percent |
|--------------------------------------|-----------|---------|
| Sex (N = 188) | | |
| Female | 155 | 82.4 |
| Male | 33 | 17.6 |
| Number in Family of Origin (N = 203) | | |
| 2 | 1 | .5 |
| 3 | 9 | 4.4 |
| 4 | 42 | 20.7 |
| 5 | 58 | 28.6 |
| 6 | 31 | 15.3 |
| 7 | 20 | 9.9 |
| 8 | 12 | 5.9 |
| 9 | 11 | 5.4 |
| 10 | 7 | 3.4 |
| 11 | 2 | 1.0 |
| 12 | 4 | 2.0 |
| 16 | 1 | .5 |
| 17 | 1 | .5 |
| 20 | 2 | 1.0 |
| 22 | 1 | .5 |
| 23 | 1 | .5 |

(table continues)

| Demographic Variables | Frequency | Percent |
|------------------------------|-----------|---------|
| Ethnicity (N = 203) | | |
| White | 170 | 83.7 |
| Black | 19 | 9.4 |
| Hispanic | 8 | 3.9 |
| Indian | 3 | 1.5 |
| Other | 3 | 1.5 |
| Education (N = 205) | | |
| <8 | 9 | 4.5 |
| 9 to 12 | 95 | 46.3 |
| 13 to 14 | 41 | 20.0 |
| 15 to 16 | 38 | 18.5 |
| 17 to 18 | 15 | 7.3 |
| >18 | 7 | 3.5 |
| Number of Children (N = 195) | | |
| 1 | 65 | 33.3 |
| 2 | 65 | 33.3 |
| 3 | 40 | 20.5 |
| 4 | 16 | 8.2 |
| 5 | 8 | 4.1 |
| 7 | 1 | .5 |

(table continues)

| Demographic Variables | Frequency | Percent |
|---|-----------|---------|
| Income (N = 205) | | |
| Adequate for Needs | 78 | 38.0 |
| So-so | 82 | 40.0 |
| Inadequate for Needs | 45 | 22.0 |
| Perception of Health (N = 206) | | |
| Good | 184 | 89.3 |
| So-so | 21 | 10.2 |
| Poor | 1 | .5 |
| Perception of Quality of Life (N = 204) | | |
| Good | 158 | 77.1 |
| So-so | 44 | 21.5 |
| Poor | 2 | 1.0 |

Table 3

Summary of Part Two: Pilot SSS

| | Frequency | Percent |
|-------------------------|-----------|---------|
| Needs (N = 193) | | |
| Money | 58 | 30.0 |
| Children | 43 | 22.3 |
| Relationship With Other | 25 | 13.0 |
| House | 14 | 7.3 |
| Own Health | 11 | 5.7 |
| Job | 11 | 5.7 |
| Someone to Talk To | 7 | 3.6 |
| Lonely | 5 | 2.6 |
| Other | 4 | 2.0 |
| Information | 3 | 1.6 |
| Transportation | 3 | 1.6 |
| Housing | 2 | 1.0 |
| No Needs | 2 | 1.0 |
| Family Health | 1 | .5 |

(table continues)

| | Frequency | Percent |
|------------------------|-----------|---------|
| <hr/> | | |
| Helper (N = 196) | | |
| Relative | 131 | 66.8 |
| Friend | 22 | 11.2 |
| No One | 13 | 6.6 |
| Professional Agency | 7 | 3.6 |
| Professional | 7 | 3.6 |
| Self | 6 | 3.1 |
| Co-Worker | 4 | 2.0 |
| Significant Other | 3 | 1.5 |
| Other | 2 | 1.0 |
| Neighbor | 1 | .5 |
| Satisfaction (N = 190) | | |
| Very Dissatisfied | 7 | 3.7 |
| Dissatisfied | 12 | 6.3 |
| Neutral | 39 | 20.5 |
| Satisfied | 59 | 31.1 |
| Very Satisfied | 73 | 38.4 |
| <hr/> | | |

Table 4

Pilot Study Factor Analysis: SSS

| | FACTOR 1 | FACTOR 2 | FACTOR 3 | FACTOR 4 |
|--------|----------|----------|----------|----------|
| Item 1 | .80 | | | |
| 2 | .79 | | | |
| 3 | .75 | | | |
| 4 | .73 | | | |
| 5 | .69 | | | |
| 6 | | .81 | | |
| 7 | | .79 | | |
| 8 | | .69 | | |
| 9 | | .56 | .45 | |
| 10 | | | .82 | |
| 11 | | | .76 | |
| 12 | | | .70 | |
| 13 | | | | .80 |
| 14 | | | | .69 |
| 15 | | | | .65 |

Construct validity, using factor analysis on the pilot data, produced eigenvalues of 1.1049 or higher on each of the three factors. The three factors accounted for 66.3% of the cumulative variance. Factor loadings ranged from .52 to .85. Varimax rotation was used with a sort level of .50 (see Table 5, p. 77). A .50 loading would be considered very significant (Hair et al., 1987).

Reliability of the modified FOS was ascertained using Cronbach's alpha. The reliability alpha of the total scale was .8863. The factors were autonomy/intimacy (AUTOINT) with an alpha of .8769, acceptance of separation and loss (ACCSEP) with .7790 alpha, and clarity of expression (CLAREX) with .6860 alpha. The items in each factor correlated between .1245 and .6179. The number of negative items dropped from 50% to 33%. The modified FOS is presented in Appendix H.

Pilot Data Analysis. First, the frequencies and percent of both the demographics and Part II of the SSS were computed, and are shown in Table 2 (pp. 69-72) and Table 3 (pp. 73-74). Next, the validity and reliability of both the SSS and FOS were computed, and were reported previously in the text and on Table 4 (p. 75) and Table 5 (p. 77).

A Pearson product moment correlation coefficient was completed.

A correlation coefficient is an index of relationship between two variables....When two variables are either perfectly positively or negatively correlated a direct relationship exists such that either a higher score on one variable is always associated with a higher score on the other variable, or vice versa. The perfect correlations are

Table 5

Pilot Study Factor Analysis: FOS

| | FACTOR 1 | FACTOR 2 | FACTOR 3 |
|--------|----------|----------|----------|
| Item 1 | .80 | | |
| 2 | .80 | | |
| 3 | .76 | | |
| 4 | .73 | | |
| 5 | .65 | | |
| 6 | | .85 | |
| 7 | | .77 | |
| 8 | | .61 | |
| 9 | | .59 | |
| 10 | | | .84 |
| 11 | | | .71 |
| 12 | | | .52 |

reported as either plus one or minus one (Roscoe, 1975, p. 94).

The correlation coefficients and their probabilities are listed in Table 6 (pp. 78-80). The significant variables included in Table 6 are as follows: RACE, NEEDS (The most important need in the last three months was identified), SAT (The satisfaction with the help for the need was rated), HELPERS (The person who helped with that need), MARSTAS (marriage status), NOCHILD (number of children in the family), SEX,

Table 6

Pilot Correlation

| | RACE | NEEDS | HELPERS | SAT | MARSTAS | NOCHILD | SEX |
|---------|----------|----------|----------|---------|-----------|----------|-----------|
| RACE | 1.00 | | | | | | |
| NEEDS | -.0705 | 1.00 | | | | | |
| HELPERS | -.0725 | .6894*** | 1.00 | | | | |
| SAT | .0339 | .0460 | -.0597 | 1.00 | | | |
| MARSTAS | .0537 | -.0540 | -.0857 | .0135 | 1.00 | | |
| NOCHILD | .2008** | -.0089 | -.0146 | -.0346 | -.0119 | 1.00 | |
| SEX | .1211* | .1519* | .1757** | -.0530 | .0748 | .0243 | 1.00 |
| AGE | .3136*** | .1208* | .1537* | -.0765 | -.0310 | -.0045 | .3613*** |
| OCCS | .1712** | .1406* | .2483*** | .0035 | .0650 | .2643*** | .0884 |
| HEAL | -.0177 | .0062 | .0116 | -.1021 | .1629** | .0168 | .0612 |
| INC | .0754 | .0679 | .0916 | .1453* | -.3477*** | .0699 | .0795 |
| QOL | -.1418* | -.1351* | -.0150 | -.1618* | .3208*** | -.0420 | .0722 |
| TOTFOS | .0188 | -.0457 | .0089 | .0439 | .0056 | -.0485 | -.2214*** |
| AUTOINT | -.0293 | -.0727 | -.0714 | .0817 | .0419 | -.0837 | -.2670*** |
| ACCSEP | .0400 | -.0187 | .0672 | -.0158 | .0045 | .0114 | -.0552 |
| CLAREX | .0622 | -.0040 | .0646 | .0303 | -.0611 | -.0359 | -.2189*** |
| TOTSSS | .1769** | .1164* | .1962** | .1178 | -.1838** | .1599** | .0260 |
| EAIPI | .0759 | .1929*** | .2306*** | .1569* | -.1179* | .0387 | -.0145 |
| ESB | .1709** | .0470 | .1732** | .0379 | -.1997** | .1152* | .0990 |
| PSB | .2020** | .1060 | .1202* | .1194* | -.1721** | .2042*** | -.0093 |
| GROUP | .0992 | -.0733 | .0294 | .0012 | -.0676 | .1537* | .0375 |

*p \leq .05**p \leq .01***p \leq .001

(table continues)

| | AGE | OCCS | HEAL | INC | QOL | TOTFOS | AUTOINT |
|---------|----------|---------|----------|-----------|-----------|----------|----------|
| AGE | 1.00 | | | | | | |
| OCCS | .1767** | 1.00 | | | | | |
| HEAL | -.0127 | -.0255 | 1.00 | | | | |
| INC | .0580 | .0320 | -.1309* | 1.00 | | | |
| QOL | .0458 | .0089 | .2511*** | -.3008*** | 1.00 | | |
| TOTFOS | -.1489* | .0667 | .0013 | -.0736 | -.1722** | 1.00 | |
| AUTOINT | -.1916** | .0165 | -.0170 | -.1382* | -.1290* | .8840*** | 1.00 |
| ACCSEP | -.0753 | .0750 | .0504 | -.0205 | -.1496* | .8214*** | .5428*** |
| CLAREX | -.0729 | .0985 | -.0353 | .0191 | -.1608* | .7672*** | .5447*** |
| TOTSSS | -.0155 | .1363* | -.0533 | .1667** | -.3676*** | .2617*** | .1469* |
| EAIPI | -.0365 | .0138 | -.0617 | .1345* | -.3182*** | .2854*** | .2128*** |
| ESB | .0003 | .1214* | .0111 | .0775 | -.3343*** | .1422* | .0726 |
| PSB | -.0492 | .1585* | -.0845 | .2050** | -.3234*** | .1760** | .0541 |
| GROUP | .0758 | .1630** | .0052 | .0526 | -.0864 | .1540* | .0700 |

*p ≤ .05

**p ≤ .01

***p ≤ .001

(table continues)

| | ACCSEP | CLAREX | TOTSSS | EAIPI | ESB | PSB | GROUP |
|--------|----------|----------|----------|----------|----------|-------|-------|
| ACCSEP | 1.00 | | | | | | |
| CLAREX | .5045*** | 1.00 | | | | | |
| TOTSSS | .2745*** | .2684*** | 1.00 | | | | |
| EAIPI | .2826*** | .2223*** | .8147*** | 1.00 | | | |
| ESB | .1462* | .1628** | .7226*** | .4382*** | 1.00 | | |
| PSB | .1926** | .2487*** | .8035*** | .4932*** | .4431*** | 1.00 | |
| GROUP | .1822** | .1582* | .6741*** | .3707*** | .4301*** | .4348 | 1.00 |

*p ≤ .05 **p ≤ .01 ***p ≤ .001

AGE, OCCS (occupation), HEAL (perception of health), INC (perception of adequacy of income), QOL (perception of quality of life), TOTFOS (total family of origin score), AUTOINT (autonomy/intimacy), ACCSEP (acceptance of separation/loss), CLAREX (clarity of expression), TOTSSS (total support score), EAIPI (enacted support/indirect personal influence), ESB (emotionally sustaining behavior), PSB (problem-solving behavior), and GROUP (considering self part of a group).

A probability level of significance of .05 was selected. This represents 95 percent confidence level. "The region of rejection is a proportion of the area in the theoretical sampling distribution which is equal to the level of significance" (Roscoe, 1969, p. 172).

Finally, a regression analysis was performed using total support (TOTSUP) and the support subscales of environmental action/indirect personal influence (EAIPI), emotionally sustaining behaviors (ESB), problem-solving behavior (PSB), and group (GROUP) as the dependent variables. Total health of the family of origin (TOTFOS), and the three family of origin subscales of autonomy/intimacy (AUTOINT), acceptance of separation/loss (ACCSEP), and clarity of expression (CLAREX) were the independent variables (see Figure 3, p. 84). "In regression studies, the interest is in how much variance in a dependent or criterion variable is explained or predicted by the independent or predictor variable" (Waltz & Bausell, 1981, p. 272).

The regression coefficient was reported as R, and had a range of 0 to 1. The regression coefficient represents the strength of the relationship between the criterion and all predictors taken together.

" R^2 represents the proportion [percentage] of variance in the criterion variable scores that is predictable or explained by all predictor variables" (Waltz & Bausell, 1981, p. 279).

The regression analysis was performed in order to begin a path analysis of the transgenerational support model. A path analysis was reported as a path diagram, and was a useful device for graphically looking at the patterns of causal relations among sets of variables.

Path analysis is a method designed to determine the tenability of a theoretical model formulated by the researcher. The researcher designs the study on the basis of a theoretical formulation, explanatory scheme, or causal model and then determines whether the resulting data are consistent or inconsistent with the model. If the data are inconsistent with the model, doubt is cast on the model that generates it. Consistency of the data with the model is not proof of the model, but lends support to it (Waltz & Bausell, 1981, p. 290).

The variables were endogenous in that they vary with other variables in the model. In a path diagram the first variable can only cause the second variable. The second variable cannot cause the first variable at the same time. Thus, the path is recursive or unidirectional (Blalock, 1969). Therefore, endogenous variables may be dependent on a second set of variables, and again independent from a third set of variables.

The major assumptions that underlie the application of path analysis are:

1. The relations among the variables in the model are linear, additive, and causal.
2. The residual variables are not intercorrelated nor are they correlated with other variables in the system.
3. There is a one-way causal flow in the system (that is, reciprocal causation between variables is ruled out).
4. The variables are measured on an interval scale (Waltz & Bausell, 1981, p. 291).

Each path was reported as an R or Beta. A Beta was used here because it was the standard that allowed for a better comparison of the different paths (Norusis, 1983). The paths were named by a P with two subscripts. The first subscript was the dependent variable, and the second subscript was the independent variable. Two preliminary path diagrams were calculated from the pilot data. Path diagram 1 is the path showing the transgenerational model between the two total scales of FOS and SSS (see Figure 2, p. 84). For this regression, multiple R equals .2617, R^2 equals 6.85%, $F(1,208)$ equals 15.2984, significant F equals .0000.

After the calculation of all path coefficients, there were two criteria for deletion of certain paths; either the paths were not statistically significant; or, the path was meaningless. As in other research, the path coefficients with a probability of less than 0.05 were not meaningful. Yet, 0.1 may be meaningful in behavioral research,

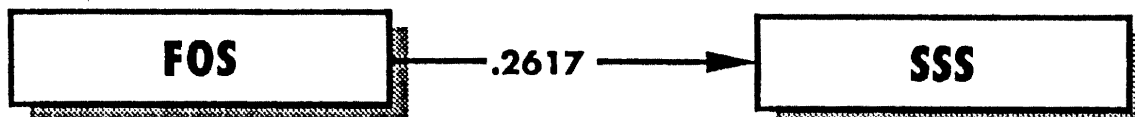


Figure 2. Path Diagram of Pilot Transgenerational Support Model Using the FOS and SSS.

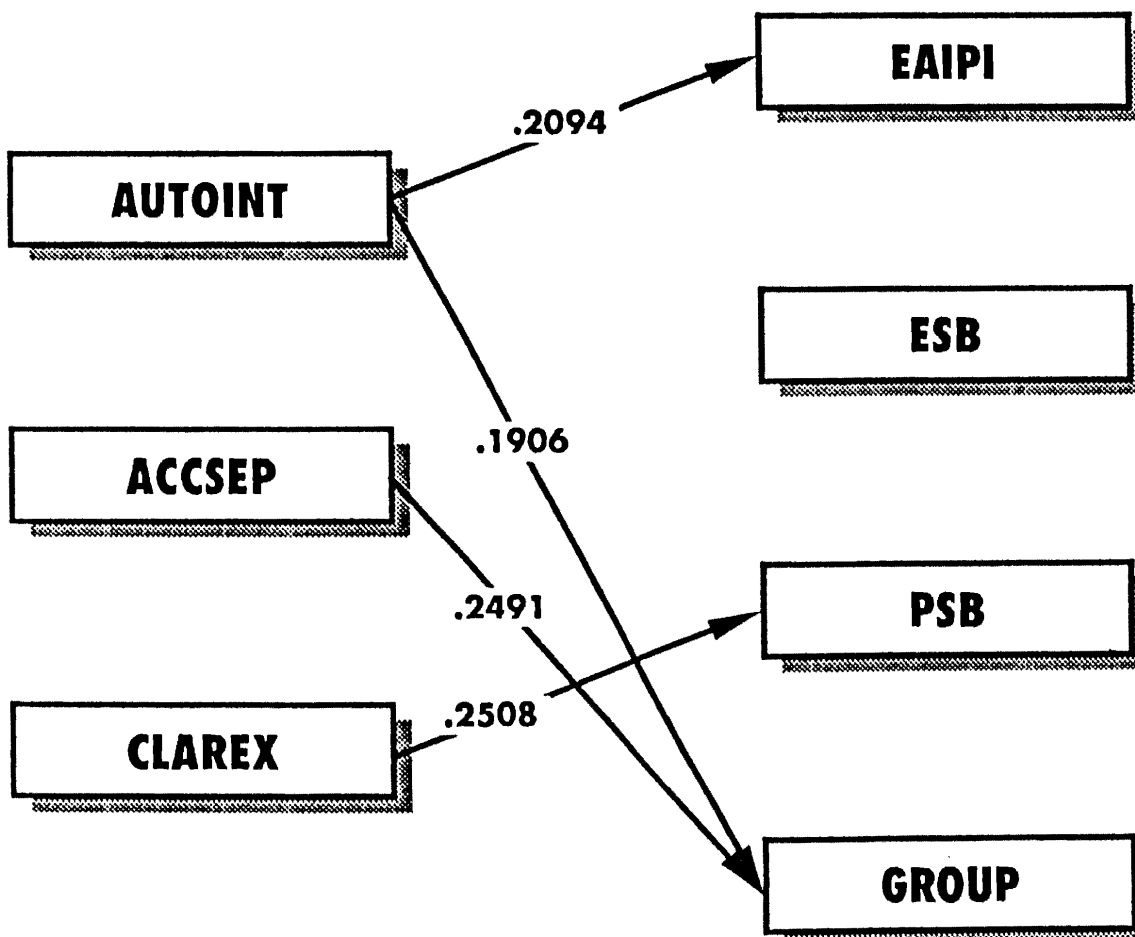


Figure 3. Path Diagram of Pilot Transgenerational Support Model Using the SSS and FOS Subscales.

and probabilities of 50% or less are used for new treatments in medical research (G. H. Jennings, personal communication, February 15, 1989).

Regression coefficients are somewhat more comparable when the BETA weights are calculated. As stated previously, path coefficients were reported as BETA coefficients, and BETA weights were arrived at through regression analysis. "BETA weights...are the coefficients of the independent variables when all variables are expressed in standardized (Z-score) form. The BETA coefficients can be calculated directly from the regression coefficients" (Norusis, 1983, p. 156).

To test the hypothesis that all groups under study were equal, an F-test for the ANOVA (analysis of variance) was reported. "A significant F statistic indicates only that the population means are probably unequal. It does not pinpoint where the differences are" (Norusis, 1983, p. 111).

Adjustments to Final Data Collection. Based on the pilot study, several adjustments were made for data collection:

1. A random sample of the population was used. One thousand children were identified, and two questionnaires were sent to each home. Officials of the school district suggested the previous number with an estimate of a 25% return rate. Thirty percent of the homes were anticipated to be single-parent homes. If there was a 25% response rate, and if 30% of the fathers answered, the 2,000 questionnaires should have generated 300 to 600 responses. If 210 responses were not generated, a second mailing was to take place.
2. The number of questions were reduced through repeated factoring

and reliability studies. The pilot revealed that 20 to 30 minutes were needed for the questionnaires to be completed due to the various reading abilities of the respondents. Shorter questionnaires should have greater response rates. Officials of the school district suggested that the pilot questionnaires be cut to 20 questions each. The FOS had twelve questions, and the SSS had fifteen questions.

Treatment of Data

Several statistical programs using the SPSS^X (Norusis, 1983) were written to analyze the data. First, a descriptive statistics program, compiling frequencies and percentages, was computed on the data included in the background information sheet and Part 2 of the SSS. Descriptive statistics are measurements at the lowest level, and simply identify groups in which objects, persons, or characteristics belong (Siegal, 1956). The statistics included frequencies and percentages.

To answer hypothesis 1, that among parents, there is no significant relationship between social support and health of the family of origin, first, a Pearson product moment correlation coefficient was reported as an r correlation coefficient between -1 to $+1$. This coefficient is an index of the relationship between any two variables. A significance level of $.05$ was selected. If a probability of $p < .05$ or lower was found, there was evidence to reject the null hypothesis.

To answer hypothesis 2, that among parents, there is no significant relationship between social support, health of the family of origin as measured by the Family of Origin Scale, race, an identified need, the person who helped satisfy the need, a rating of satisfaction with the

help received, marital status, number of children, sex, age, occupation, perception of health, perception of adequacy of income, and perception of quality of life, additional Pearson product moment correlation coefficients were completed. The same significance level of .05 was selected, and again the probability of $p = < .05$ or lower was evidence to reject the null hypothesis.

A path diagram of the transgenerational support model was drawn after regression analyses were performed. The regression coefficient is reported as R, and has a range of 0 to 1. The regression coefficient represents the strength of the relationship between the criterion and all predictors taken together. " R^2 represents the proportion [percentage] of variance in the criterion variable scores that is predictable or explained by all predictor variables" (Waltz & Bausell, 1981, p. 279).

Regression coefficients were somewhat more comparable when the BETA weights were calculated. As stated previously, path coefficients were reported as BETA coefficients, and BETA weights were arrived at through regression analysis. "BETA weights...are the coefficients of the independent variables when all variables are expressed in standardized (Z-score) form. The BETA coefficients can be calculated directly from the regression coefficients" (Norusis, 1983, p. 156).

To test the hypothesis that the groups under study were equal, an F-test for the ANOVA (analysis of variance) and the significant F was reported. "A significant F statistic indicates only that the population means are probably unequal. It does not pinpoint where

the differences are" (Norusis, 1983, p. 111).

The path analysis determined the tenability of the transgenerational support model. Each path was reported as an R or Beta. A Beta was used here because Beta is the standard that allows for a better comparison of the different paths (Norusis, 1983). The paths were named by a P with two subscripts. The first subscript is the dependent variable, and the second subscript is the independent variable.

After the calculation of all path coefficients, there were two criteria for deletion of certain paths; either the paths were not statistically significant, or, the path was meaningless. As in other research, the path coefficients with a probability of $p = < .05$ were not meaningful. However, $p = < .05$ may be too stringent for the first testing of a new model (Murdough & Hinshaw, 1986).

Since the sample for the dissertation differed from the instrument development and pilot samples, and since the dissertation sample was a random sample and only included parents of children in grades nine through twelve, reliability, item, and factor analyses were performed to establish further validity and reliability of the study. A principal component factor analysis was run separately on each questionnaire. Only factors with eigenvalues of 1 or above were considered significant. To be considered important, factor loadings were set at .40. Pearson product moment correlations reported as an r were used to examine the redundancy among items (Hinshaw, Allen, Atwood, & Gerber, 1978). Items with correlations of $> .70$ are redundant. Cronbach's alpha looked at the reliability of the total scales and each subscale. An alpha of

$>.80$ was considered adequate for total scales, and alphas of $>.6$ were adequate for subscales.

Summary

The study was a correlational study. After appropriate instrument development and a pilot study, two questionnaires with the necessary validity and reliability for a comprehensive study were composed. Appropriate statistical procedures for data analysis were tested. The data collection and treatment were identified. The research was completed after approval was received from the dissertation committee and the graduate school. The next chapter discusses analyses of actual data. This includes a description of the sample and the findings.

CHAPTER IV

ANALYSIS OF DATA

Data were collected from one mailing of 2,000 sets of questionnaires to parents of 1,000 children in grades nine through twelve in an independent school district. A random list of 1,000 numbers were generated from a list of 4,049 students in the independent school district. Student names were cross-indexed across schools, eliminating any duplication, and if two children were found with the same last name and address, only one set of questionnaires was sent to the parents. Other parents were eliminated because there were no addresses with the student names. These names were replaced with more random selections until a total of 1,000 students were identified. Two sets of questionnaires were mailed to the parents.

There was no way to identify which of the children lived in single-parent homes. The officials at the independent school district reported that thirty percent of the homes were single parent, therefore, on random selection, the researcher estimates that 300 sets of questionnaires were eliminated. Additionally, 36 envelopes were returned to the researcher as undeliverable due to incorrect addresses with no forwarding addresses. This represented an additional loss of 72 sets of questionnaires. Therefore, it was estimated that a total of 1,628 questionnaires reached the targeted sample.

One hundred seventy-five questionnaires were returned in the first

two weeks, yielding 83% of the desired number of 210 questionnaires needed for the regression analyses. Therefore, a second mailing was not undertaken. Personnel at the school district suggested a mailing of at least 1,000 questionnaires, and to expect a low return rate of 10%. After six weeks there were 190 usable questionnaires returned, for a return rate of 11.74% of the estimated 1,628 questionnaires that reached the subjects. Five questionnaires were returned completed by students, and not the parents.

The data from the returned questionnaires were analyzed using SPSS^X (Norusis, 1983) statistical program. Descriptive statistics, Pearson product moment correlation coefficients, regression coefficients, ANOVA, reliability, item, and factor analyses were computed. Results of the analyses, beginning with a description of the sample, are presented in the following sections.

Description of Sample

The sample consisted of 190 parents of children in grades nine through twelve in an independent school district in north central Texas. Description of the sample was measured by the demographic variables of marital status, sex, age, ethnicity, number of children, occupation, and perception of adequacy of income. Table 7 (pp. 92-94) describes the sample based on the demographic variables. Additionally, the sample was asked to rate the perception of their health, and the perception of their quality of life.

The majority of the subjects were married (85.1%). The remaining subjects (14.9%) were either separated, divorced, or widowed. The

Table 7

Demographic Summary of Study Sample

| Demographic Variables | Frequency | Percent |
|--------------------------|-----------|---------|
| Marital Status (N = 188) | | |
| Married | 160 | 85.1 |
| Divorced | 17 | 9.0 |
| Widowed | 7 | 3.7 |
| Separated | 4 | 2.1 |
| Sex (N = 188) | | |
| Female | 121 | 64.4 |
| Male | 67 | 35.6 |
| Age (N = 186) | | |
| 18 to 25 | 1 | .5 |
| 26 to 35 | 13 | 6.9 |
| 36 to 45 | 127 | 68.27 |
| 45 | 45 | 24.19 |
| Ethnicity (N = 187) | | |
| White | 169 | 90.4 |
| Black | 13 | 7.0 |
| Hispanic | 5 | 2.6 |

(table continues)

| Demographic Variables | Frequency | Percent |
|------------------------------|-----------|---------|
| Number of Children (N = 183) | | |
| 1 | 24 | 13.0 |
| 2 | 67 | 36.2 |
| 3 | 53 | 28.6 |
| 4 | 20 | 10.8 |
| 5 | 8 | 4.3 |
| 6 | 8 | 4.3 |
| 7 | 3 | 1.6 |
| 8 | 2 | 1.1 |
| Occupation (N = 183) | | |
| Service | 33 | 18.0 |
| Educator | 27 | 14.7 |
| Homemaker | 23 | 12.5 |
| Management | 21 | 11.5 |
| Other | 21 | 11.5 |
| Health Professional | 19 | 10.4 |
| Clerical | 18 | 9.9 |
| Industry | 14 | 7.7 |
| Sales | 4 | 2.2 |
| Truck Driver | 2 | 1.1 |
| Unemployed | 1 | .5 |

(table continues)

| Demographic Variables | Frequency | Percent |
|--|-----------|---------|
| Perception of Adequacy of Income (N = 186) | | |
| Adequate For Needs | 110 | 59.1 |
| So-So | 49 | 26.3 |
| Inadequate For Needs | 27 | 14.5 |
| Perception of Health (N = 188) | | |
| Good | 158 | 84.0 |
| So-So | 28 | 14.9 |
| Poor | 2 | 1.1 |
| Perception of Quality of Life (N = 188) | | |
| Good | 143 | 76.1 |
| So-So | 42 | 22.3 |
| Poor | 2 | 1.6 |

respondents were two to one female (64.4%) to male (35.6%). Age was divided into four groups, with the 36- to 45-year group being 68.3%, and the above-45-year group being 24.19% of the sample. Subjects 35 years and under made up 7.4%. The average age was 42.6. Ethnicity can be collapsed into two groups of white (90.0%) and nonwhite (9.7%). Each subject had an average of 2.82 children.

A variety of occupations were reported. A large number (36.7%) could be considered professionals. These occupations fell into categories of education, health care, and management. Ten subjects failed to list their occupation.

The last three questions on the demographic sheet asked subjects to rate their perceptions of adequacy of income, health, and quality of life. Income was considered adequate for needs by 59.1%, so-so by 26.3%, and inadequate for needs by 14.5%. Subjects perceived their health as good (84%), so-so (14.9%), and poor (1.1%). Last, when asked about their quality of life, 76.1% considered it good, 22.3% considered it so-so, and 1.6% considered it poor.

The demographic data were used in both correlation and regression analyses to examine the relationship of the demographic variables with both social support and health of the family of origin. The next section includes the findings of the correlation and regression analyses related to the two hypotheses.

Findings

Two survey instruments were used in data collection; the Social Support Scale, and the Family of Origin Scale.

The Social Support Scale (SSS) (De Lorenzo, 1988b) measures social support in parents. The instrument consists of three parts: (a) A questionnaire developed after concept analysis and synthesis of social support; (b) a section identifying needs, the person who helped with the needs, and the satisfaction with that help; (c) a background information sheet containing demographics.

Part 1 of the questionnaire consisted of 15 questions that were answered on a Likert scale from 1 (strongly disagree) to 5 (strongly agree). The following subconcepts of social support were included in these questions: environmental action/indirect personal influence

(EAIPI), emotionally sustaining behaviors (ESB), problem-solving behavior (PSB), and group (GROUP).

Part 2 of the questionnaire asked parents to identify one need experienced in the last three months. Next, the parent identified the person who helped with the need. And last, the help received for the need was rated from 1 to 5. Part 3 contained demographics.

The final questionnaire (see Appendix E), developed through statistical analyses, had four factors and fifteen items, and showed that the SSS had enough validity and reliability to be used as a research tool. Eigenvalues on the factors were 1.113 or higher. The items correlated between .105 and .66. The four factors accounted for 65.2% of the cumulative variance. Varimax rotation was used with a sort level of .45 (see Table 4, p. 75). Study specific reliability was estimated using Cronbach's alpha at .8785. The factors were environmental action/indirect personal influence (EAIPI) with an alpha of .8586, emotionally sustaining behaviors (ESB) with .7736 alpha, problem-solving behavior (PSB) with .7684 alpha, and group (GROUP) with .6727 alpha. The number of negative items remained at 26.6%.

The Family of Origin Scale (FOS) was developed by Anderson (1980) to measure the health of the family in which one grew up. The final modified FOS developed through statistical analyses had three factors and twelve items. The modified FOS had adequate validity and reliability to be used as a research tool. Construct validity using factor analysis on the pilot data produced eigenvalues of 1.1049 or higher on each of the three factors. The three factors accounted for

66.3% of the cumulative variance. Varimax rotation was used with a sort level of .50 (see Table 5, p. 77). A .5 loading would be considered very significant (Hair et al., 1987). Factor loadings ranged from .52 to .85.

Reliability of the modified FOS was ascertained using Cronbach's alpha. The reliability alpha of the total scale was .8863. The factors were autonomy/intimacy (AUTOINT) with an alpha of .8769, acceptance of separation and loss (ACCSEP) with .7790 alpha, and clarity of expression (CLAREX) with .6860 alpha. The items in each factor correlated between .1245 and .6179. The number of negative items dropped from 50% to 33%. The modified FOS is presented in Appendix H.

Hypothesis One

As was previously stated, the data relative to the two hypotheses were analyzed using various computer programs. The first analysis was a Pearson product moment correlation coefficient.

A correlation coefficient is an index of relationship between two variables....When two variables are either perfectly positively or negatively correlated a direct relationship exists such that either a higher score on one variable is always associated with a higher score on the other variable, or vice versa. The perfect correlations are reported as either plus one or minus one (Roscoe, 1969, p. 94).

The first hypothesis stated: Among parents, there is no significant relationship between social support as identified by the Social Support Scale, and health of the family of origin as measured by the Family of

Origin Scale. To answer this hypothesis, first, a Pearson product moment correlation was completed (see Table 9, pp. 104-106). The Pearson product moment correlation coefficient and the probability of the coefficient between FOS and SSS was $r = .2830$, $p < .000$.

A probability or level of significance of .05 was selected. This is a 95% confidence interval. "The region of rejection is a proportion of the area in the theoretical sampling distribution which is equal to the level of significance" (Roscoe, 1969, p. 172). Since the probability is $p < .000$, the null hypothesis is rejected and the alternate hypothesis is retained. Therefore, among parents, there is a significant relationship between social support as identified by the Social Support Scale (SSS), and health of the family of origin as measured by the Family of Origin Scale (FOS).

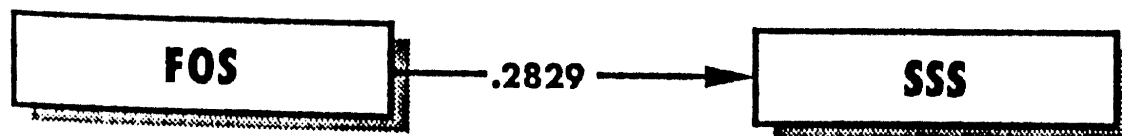
Next, a regression analysis was performed on TOTSSS and TOTFOS in order to begin a path analysis of the transgenerational support model. Total SSS was the dependent variable, and TOTFOS was the independent variable. "In regression studies, the interest is in how much variance in a dependent or criterion variable is explained or predicted by the independent or predictor variable" (Waltz & Bausell, 1981, p. 272).

The regression coefficient is reported as R, and has a range of 0 to 1. The regression coefficient represents the strength of the relationship between the criterion and all predictors taken together. " R^2 represents the proportion [percentage] of variance in the criterion variable scores that is predictable or explained by all predictor variables" (Waltz & Bausell, 1981, p. 279). In the present study,

regression multiple R equaled .2829, R^2 equaled .0800. These figures indicated that 8% of the variance in social support was due to the health of the family of origin. To test the hypothesis that the groups under study were equal, an F-test for the ANOVA (analysis of variance) was reported. "A significant F statistic indicates only that the population means are probably unequal. It does not pinpoint where the differences are" (Norusis, 1983, p. 111). In this calculation $F(1,188)$ equaled 16.3641, significant F equaled .0001.

Based on the results of the regression analysis, a path diagram was calculated. Path diagram 3 is the path showing the transgenerational model between the two total scales of FOS and SSS (see Figure 4, p. 99). A path diagram is a useful device for graphically looking at the patterns of causal relations among sets of variables.

Figure 4. Path Diagram between Total Scales of the Study.



Path analysis is a method designed to determine the tenability of a theoretical model formulated by the researcher. The researcher designs the study on the basis of a theoretical formulation, explanatory scheme, or causal model and then determines whether the resulting data are consistent or inconsistent with the model. If the data are inconsistent with the model, doubt is cast on the model that generates it. Consistency of the data with the model is not proof of the model, but lends support to it (Waltz & Bausell, 1981, p. 290).

Each path is reported as an R or Beta. Path coefficients will be reported as Beta. Regression coefficients are somewhat more comparable when the Beta weights are calculated, and Beta weights are arrived at through regression analysis. "Beta weights...are the coefficients of the independent variables when all variables are expressed in standardized (Z-score) form. The Beta coefficients can be calculated directly from the regression coefficients" (Norusis, 1983, p. 156).

A Beta was used here because it is the standard that allows for a better comparison of the different paths (Norusis, 1983). The paths are named by a P with two subscripts. The first subscript is the dependent variable, and the second subscript is the independent variable.

Hypothesis Two

The second hypothesis stated: Among parents, there is no significant relationship between social support as identified by the Social Support Scales, health of the family of origin as measured by the Family of Origin Scale, race, an identified need, the person who helped

satisfy the need, a rating with that satisfaction with the help received, marital status, number of children, sex, age, occupation, perception of health, perception of adequacy of income, and perception of quality of life. To complete the analysis of hypothesis two, a summary of Part 2 of the SSS was completed and presented in Table 8, pp. 102-103. Part 2 of the SSS was the least completed part of the questionnaire, hence, the low total numbers in the calculations. Ten subjects omitted the section completely. An additional eight subjects did not complete all of Part 2. The nonrespondents were 45% female, and 55% male.

A Pearson product moment correlation was performed on all of the variables. A probability level of significance of .05 was selected. The correlation coefficients and corresponding probabilities are listed in Table 9, pp. 104-106. The variables included in Table 9 are as follows: RACE, NEEDS (the most important need in the last three months was identified), HELPERS (the person who helped with that need), SAT (the satisfaction with the help for the need was rated), MARSTAS (marriage status), NOCHILD (number of children in the family), SEX, AGE, OCCS (occupation), HEAL (perception of health), INC (perception of adequacy of income), QOL (perception of quality of life), TOTFOS (total family of origin score), AUTOINT (autonomy/intimacy), ACCSEP (acceptance of separation), CLAREX (clarity of expression), TOTSSS (total support score), EAIPI (enacted support/indirect personal influence), ESB (emotionally sustaining behavior), and GROUP (considering self part of a group).

Table 8

Summary of Study Part Two: SSS

| | Frequency | Percent |
|-------------------------|-----------|---------|
| Needs (N = 181) | | |
| Money | 47 | 26.0 |
| Children | 39 | 21.5 |
| Own Health | 19 | 10.5 |
| Job | 17 | 9.4 |
| Relationship With Other | 17 | 9.4 |
| Someone to Talk to | 10 | 5.5 |
| Other | 7 | 3.9 |
| House | 6 | 3.3 |
| No Needs | 4 | 2.2 |
| Lonely | 4 | 2.2 |
| Advice | 4 | 2.2 |
| Information | 3 | 1.7 |
| Transportation | 3 | 1.7 |
| Family Health | 1 | .6 |
| Helper (N = 182) | | |
| Relative | 108 | 59.3 |
| Friend | 20 | 11.0 |
| No One | 20 | 11.0 |

(table continues)

| | Frequency | Percent |
|------------------------|-----------|---------|
| Co-Worker | 9 | 5.0 |
| Other | 9 | 5.0 |
| Teacher | 7 | 3.8 |
| Professional | 3 | 1.6 |
| Professional Agency | 3 | 1.6 |
| Significant Other | 3 | 1.6 |
| Satisfaction (N = 173) | | |
| Very Satisfied | 71 | 41.0 |
| Satisfied | 57 | 32.9 |
| Neutral | 27 | 15.6 |
| Dissatisfied | 2 | 1.2 |
| Very Dissatisfied | 16 | 9.2 |

As described in Table 9, there were no significant correlations between the FOS subscales, SSS subscales, RACE, NEEDS, and HELPER.

Satisfaction with the help received (SAT), was negatively correlated with income (INC) $r = -.1935$, $p \leq .01$, and quality of life (QOL) $r = -.2385$, $p \leq .01$. SAT was positively correlated with AUTOINT $r = .1689$, $p \leq .05$, and GROUP $r = .1819$, $p \leq .05$. SAT also was positively correlated with TOTSSS $r = .4316$, EAIPI $r = .4301$, ESB $r = .3367$, and PSB $r = .3482$ $p \leq .001$.

Marriage status (MARSTAS) was negatively correlated with ESB $r = -.1460$, $p \leq .05$, and GROUP $r = -.1365$, $p \leq .05$. MARSTAS also was

Table 9

Study Correlation

| | RACE | NEEDS | HELPERS | SAT | MARSTAS | NOCHILD | SEX |
|---------|----------|----------|---------|----------|-----------|----------|---------|
| RACE | 1.00 | | | | | | |
| NEEDS | -.0397 | 1.00 | | | | | |
| HELPERS | -.0364 | .7362*** | 1.00 | | | | |
| SAT | .0317 | -.0492 | .1309* | 1.00 | | | |
| MARSTAS | .0610 | -.0050 | .1031 | -.0763 | 1.00 | | |
| NOCHILD | .1550* | .0741 | .0324 | -.0291 | .0359 | 1.00 | |
| SEX | .1180 | .0121 | .0940 | -.1292* | .1904** | .0178 | 1.00 |
| AGE | .4141*** | .0153 | .0283 | -.1333* | .0469 | .2744*** | .1189 |
| OCCS | .6222*** | .0295 | .0425 | .0374 | .0315 | .1805** | .0671 |
| HEAL | -.0848 | .0111 | .0490 | -.0691 | .1199 | -.1548* | -.0164 |
| INC | .0076 | .0961 | .0500 | -.1935** | .2562*** | -.0504 | .0474 |
| QOL | .0520 | .0078 | .0321 | -.2385** | .3108*** | -.1349* | .1683** |
| TOTFOS | -.0303 | -.0469 | -.0773 | .1002 | -.0700 | -.1194* | -.0950 |
| AUTOINT | -.0349 | -.0525 | -.0578 | .1689* | -.0747 | -.1252* | -.1346* |
| ACCSEP | .0001 | -.0564 | -.0879 | .0390 | -.0278 | -.0829 | .0375 |
| CLAREX | -.0440 | .0031 | -.0491 | .0062 | -.0747 | -.0852 | -.1445* |
| TOTSSS | .0772 | .0310 | .0293 | .4316*** | -.2876*** | .0171 | -.0680 |
| EAIPI | .0246 | -.0041 | .0432 | .4301*** | -.2884*** | .0116 | -.0983 |
| ESB | .1160 | .0646 | .0291 | .3367*** | -.1460* | .0041 | -.0454 |
| PSB | .0769 | -.0246 | -.0086 | .3482*** | -.2773*** | .0204 | -.0819 |
| GROUP | .0400 | .1145 | .0353 | .1819** | -.1365* | .0169 | .0620 |

*p \leq .05**p \leq .01***p \leq .001

(table continues)

| | AGE | OCCS | HEAL | INC | QOL | TOTFOS | AUTOINT |
|---------|---------|----------|----------|-----------|-----------|----------|----------|
| AGE | 1.00 | | | | | | |
| OCCS | .2295** | 1.00 | | | | | |
| HEAL | -.0175 | -.1725** | 1.00 | | | | |
| INC | .0500 | -.0929 | .3082*** | 1.00 | | | |
| QOL | .0217 | -.1103 | .3292*** | .5095*** | 1.00 | | |
| TOTFOS | -.1250* | -.0402 | -.1225* | -.0824 | -.1999** | 1.00 | |
| AUTOINT | -.1205* | -.0192 | -.0898 | -.1201* | -.2025** | .9124*** | 1.00 |
| ACCSEP | -.1030 | -.0404 | -.0933 | -.0012 | -.0812 | .8111*** | .5882*** |
| CLAREX | -.0853 | -.0504 | -.1405* | -.0759 | -.2292** | .7861*** | .6386*** |
| TOTSSS | -.0590 | .0981 | -.1942** | -.3733*** | -.4795*** | .2830*** | .2609*** |
| EAPII | -.0001 | .0430 | -.1429* | -.3732*** | -.4678*** | .2724*** | .2563*** |
| ESB | .1067 | .1273* | -.1706** | -.1527* | -.3328*** | .2338*** | .2070** |
| PSB | .0563 | .1018 | -.1414* | -.4170*** | -.4779*** | .2652*** | .2485*** |
| GROUP | .0482 | .0458 | -.1814** | -.1239* | -.1220* | .0647 | .0533 |

*p ≤ .05

**p ≤ .01

***p ≤ .001

(table continues)

| | ACCSEP | CLAREX | TOTSSS | EAIPI | ESB | PSB | GROUP |
|--------|----------|---------|----------|----------|----------|----------|-------|
| ACCSEP | 1.00 | | | | | | |
| CLAREX | .4433*** | 1.00 | | | | | |
| TOTSSS | .2747*** | .1593* | 1.00 | | | | |
| EAIPI | .2325** | .1866** | .8902*** | 1.00 | | | |
| ESB | .2540*** | .1105 | .7670*** | .5822*** | 1.00 | | |
| PSB | .2436*** | .1606* | .8795*** | .7146*** | .5959*** | 1.00 | |
| GROUP | .1131 | -.0186 | .5246*** | .3231*** | .2471*** | .2908*** | 1.00 |

*p \leq .05 **p \leq .01 ***p \leq .001

negatively correlated with TOTSSS $r = -.2876$, $p = .001$, EAIPI $r = -.2884$, $p = .001$, and PSB $r = -.2773$, $p \leq .001$. MARSTAS was positively correlated with NOCHILD $r = .1904$, $p \leq .01$, and INC $r = .2562$, $p \leq .001$, and QOL $r = .3108$, $p \leq .001$.

Number of children (NOCHILD) was negatively correlated with HEAL $r = -.1548$, $p \leq .05$, QOL $r = -.1349$, $p \leq .05$, TOTFOS $r = -.1194$, $p \leq .05$, and AUTOINT $r = -.1252$, $p \leq .05$. NOCHILD was positively correlated with OCCS $r = .1805$, $p \leq .01$, and AGE $r = .2744$, $p \leq .001$.

SEX was negatively correlated with AUTOINT $r = -.1346$, $p \leq .05$, and CLAREX $r = -.1445$, $p \leq .05$. SEX was positively correlated with QOL $r = .1683$, $p \leq .01$.

AGE was negatively correlated with TOTFOS $r = -.1250$, $p \leq .05$, and AUTOINT $r = -.1205$. AGE was positively correlated with OCCS $r = .2295$, $p \leq .01$.

OCCS was negatively correlated with HEAL $r = -.1725$, $p \leq .01$, and a positive correlation with ESB $r = .1273$, $p \leq .05$.

HEAL was positively correlated with TOTFOS $r = -.1225$, $p \leq .05$, CLAREX $r = -.1405$, $p \leq .05$, EAIPI $r = -.1429$, $p \leq .05$, and PSB $r = -.1414$, $p \leq .05$. HEAL was negatively correlated with TOTSSS $r = -.1942$, $p \leq .01$, ESB $r = -.1706$, $p \leq .01$, and GROUP $r = -.1814$, $p \leq .01$. HEAL was positively correlated with INC $r = .3082$, $p \leq .001$, and QOL $r = .3292$, $p \leq .001$.

INC was negatively correlated with TOTSSS $r = -.3733$, $p \leq .001$, EAIPI $r = -.3732$, $p \leq .001$, and PSB $r = -.4170$, $p \leq .001$. INC was also negatively correlated with AUTOINT $r = -.1201$, $p \leq .05$, ESB $r = -.1527$, $p \leq .05$, and GROUP $r = -.1239$, $p \leq .05$. INC was positively correlated

with QOL $r = .5095$, $p \leq .001$.

QOL was only negatively correlated. QOL correlations were with TOTFOS $r = -.1999$, $p \leq .05$, and GROUP $r = -.1220$, $p \leq .05$. QOL was also negatively correlated with AUTOINT $r = -.2025$, $p \leq .01$ and CLAREX $r = -.2292$, $p \leq .01$. QOL's last negative correlations were with TOTSSS $r = .4795$, $p \leq .001$, EAIPI $r = -.4678$, $p \leq .001$, ESB $r = -.3328$, $p \leq .001$, and PSB $r = -.4779$, $p \leq .001$.

Besides positive correlations with its own subscales, TOTFOS was positively correlated with TOTSSS $r = .2830$, $p \leq .001$, EAIPI $r = .2724$, $p \leq .001$, ESB $r = .3328$, $p \leq .001$, and PSB $r = .2652$, $p \leq .001$.

AUTOINT had only positive correlations. AUTOINT was positively correlated with the other subscales of the TOTFOS. AUTOINT was positively correlated with TOTSSS $r = .2609$, $p \leq .001$, EAIPI $r = .2563$, $p \leq .001$, and PSB $r = .2485$, $p \leq .001$. AUTOINT's last positive correlation was with ESB $r = .2070$, $p \leq .01$.

ACCSEP had only positive correlations. ACCSEP was positively correlated with CLAREX, another subscale of the TOTFOS. ACCSEP had positive correlations with TOTSSS $r = .2747$, $p \leq .001$, ESB $r = .2540$, $p \leq .001$, and PSB $r = .2436$, $p \leq .001$. AUTOINT's last positive correlation was with EAIPI $r = .2325$, $p \leq .01$.

CLAREX had only positive correlations. CLAREX was positively correlated with TOTSSS $r = .1593$, $p \leq .05$, and PSB $r = .1606$, $p \leq .05$. CLAREX's last positive correlation was with EAIPI $r = .1866$, $p \leq .01$.

As expected, TOTSSS and its subscales of EAIPI, ESB, PSB and GROUP had positive correlations with each other. The correlations ranged from

$\underline{r} = .2471$ to $\underline{r} = .8902$, $p \leq .001$. These high correlations indicate a scale with subscales that have high factor loadings and high reliability.

The second hypothesis stated: Among parents, there is no significant relationship between social support as identified by the Social Support Scale, health of the family of origin as measured by the Family of Origin Scale, race, an identified need, the person who helped satisfy the need, a rating of that satisfaction with the help received, marital status, perception of adequacy of income, and perception of quality of life. As stated before, there were no significant correlations between the TOTFOS, TOTSSS, RACE, NEEDS, and HELPER. Therefore, that part of the null hypothesis is retained. The rest of the null hypothesis had correlations with $p \leq .05$, and that part of the null hypothesis is rejected and the opposite hypothesis is retained. The opposite hypothesis states that among parents, there is a significant relationship between social support as identified by the Social Support Scale, health of the family of origin as measured by the Family of Origin Scale, a rating of the satisfaction with the help received, marital status, number of children, sex, age, occupation, perception of health, perception of adequacy of income, and perception of quality of life.

Finally, a regression analysis using the variables with correlations of $p \leq .05$ was performed to complete the path analysis. The variables included in the path analysis were SAT (The satisfaction with the help for the need was rated), MARSTAS (marriage status),

NOCHILD (number of children in the family), SEX, AGE, OCCS (occupation), HEAL (perception of health), INC (perception of adequacy of income), QOL (perception of quality of life), the family of origin subscales of AUTOINT (autonomy/intimacy), ACCSEP (acceptance of separation), CLAREX (clarity of expression), the social support subscales of EAIPI (enacted support/indirect personal influence), ESB (emotionally sustaining behavior), PSB (problem-solving behavior), and GROUP (considering self part of a group).

The regression analysis produced the following results for the subscales: (a) For enacted support/belief that help is available (EAIPI), autonomy/intimacy accounted for 6.56% of the variance, and clarity of expression (CLAREX) accounted for 3.48% of the variance; (b) For problem-solving behavior (PSB), autonomy/intimacy accounted for 6.17% of the variance; (c) For emotionally sustaining behaviors (ESB), acceptance of separation (ACCSEP) accounted for 6.44% of the variance; (d) No regressions were significant with the variable GROUP (See Table 10, p. 111).

A path diagram was calculated from the results of the regression analysis. The path diagram (Figure 5, p. 112) illustrates the path showing the transgenerational model between the scales of FOS and SSS. Again, the path coefficients are reported as Betas. The paths are named by a P with two subscripts. The first subscript is the dependent variable, and the second subscript is the independent variable. Multiple regressions were performed stepwise to obtain the most important predictors. After the most important predictors were identified,

Table 10

Summary of Study Regression Analysis SSS and FOS Subscales

| DepVar | IndVar | Multl R | R ² | Beta | DF | F | Sig F |
|--------|---------|---------|----------------|-------|---------|---------|-------|
| EAIPi | AUTOINT | .2562 | .0656 | .2562 | (1,188) | 13.2135 | .0004 |
| | CLAREX | .1865 | .0348 | .1865 | (1,188) | 6.7810 | .0099 |
| PSB | AUTOINT | .2485 | .0617 | .2485 | (1,188) | 12.3751 | .0005 |
| ESB | ACCSEP | .2539 | .0644 | .2536 | (1,188) | 12.9604 | .0004 |
| GROUP | none | | | | | | |

multiple single regressions were performed delineating dependent variable (DepVar), independent variable (IndVar), multiple R (Multl R), R², Beta, degrees of freedom (DF), F, and significant F for each set of relationships (See Table 10).

Another path diagram resulted from the multiple regression and single regressions of the two sets of subscales, and the demographic data. Path diagram (Figure 6, p. 114) is the path illustrating the entire transgenerational model. Again, Betas were reported. Table 11, p. 113, is the summary of that information.

As illustrated in Table 11, enacted support/helper availability had a negative correlation with perception of quality of life (Beta = $-.4678$), which accounted for 21.88% of the variance; a negative correlation with marriage status (Beta = $-.2883$) which accounted for 8.31% of the variance; and a positive correlation with satisfaction

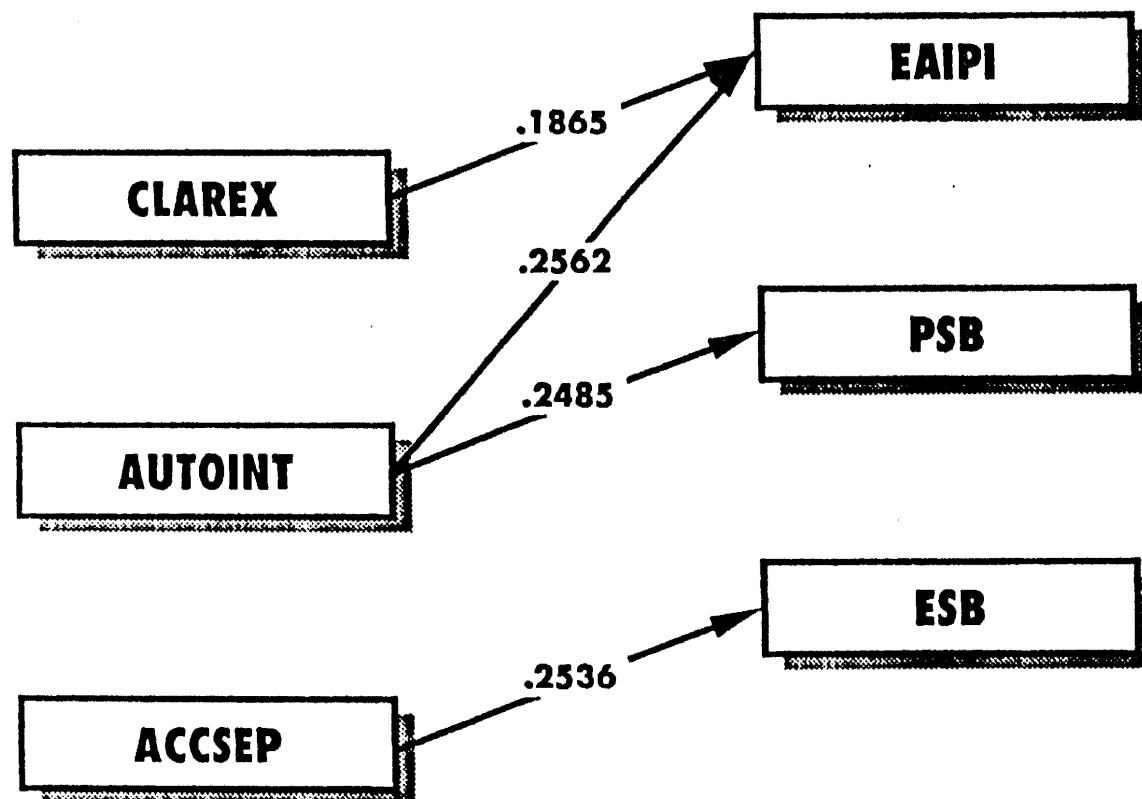


Figure 5. Path Diagram of Study Between SSS Scales and FOS Scales.

with the help received (Beta = .4300) which accounted for 18.49% of the variance.

Emotionally sustaining behaviors had a negative correlation with quality of life (Beta = $-.3328$), with 11.07% of the variance accounted for, and a positive correlation with satisfaction (Beta = $.3667$), with 13.44% of the variance accounted for.

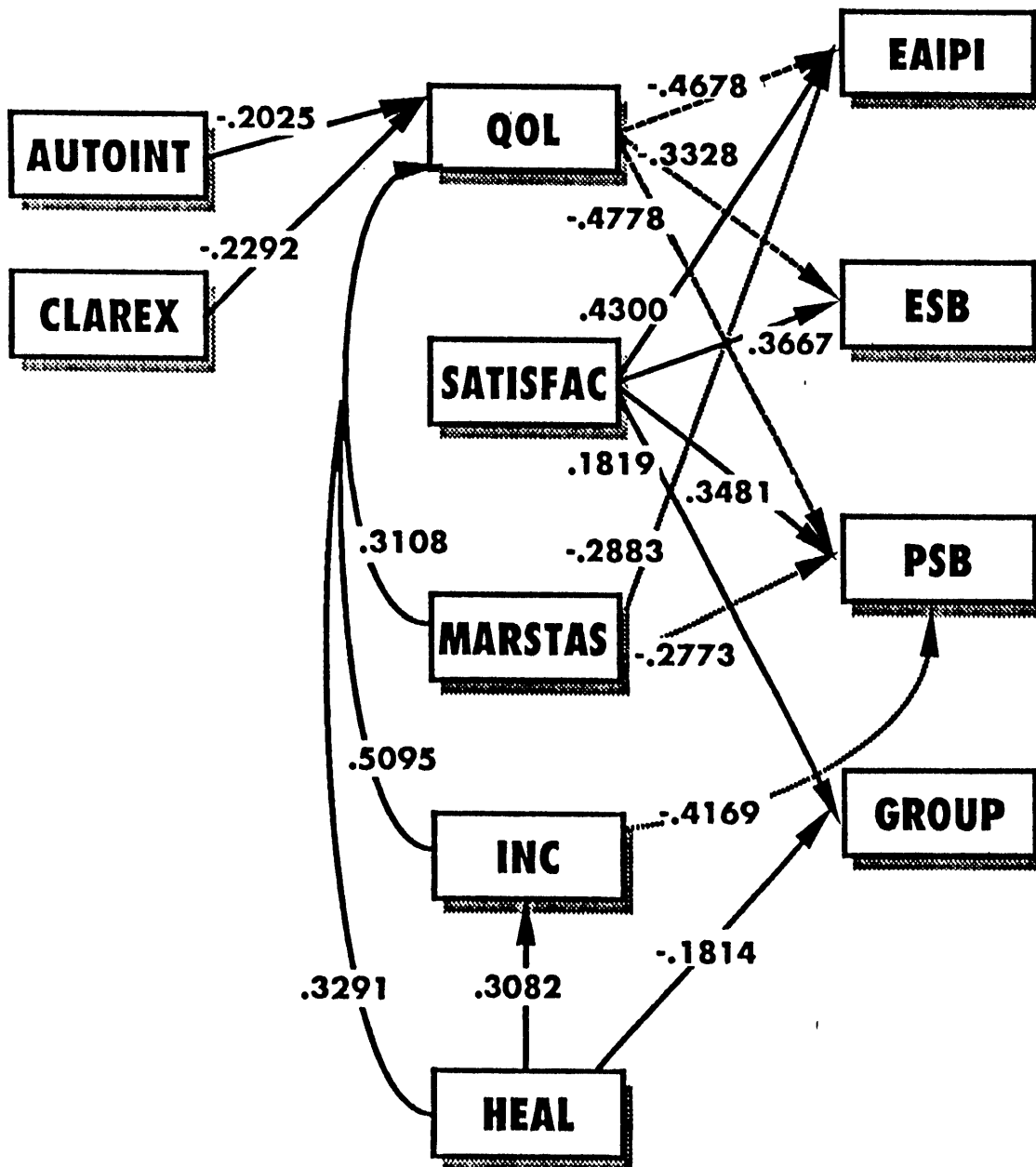
Problem-solving behaviors had negative correlations with quality of life (Beta = $-.4778$), variance 22.83%; marriage status (Beta =

Table 11

Summary of Study Regression Analysis SSS and FOS Subscales and
Demographics

| DepVar | IndVar | Mult R | R ² | Beta | DF | F | Sig F |
|--------|---------|--------|----------------|--------|---------|--------|-------|
| EAIPI | QOL | .4678 | .2188 | -.4678 | (1,186) | 52.108 | .0000 |
| | SAT | .4300 | .1849 | .4300 | (1,171) | 38.809 | .0000 |
| | MARSTAS | .2883 | .0831 | -.2883 | (1,188) | 17.053 | .0001 |
| ESB | QOL | .3328 | .1107 | -.3328 | (1,186) | 23.168 | .0000 |
| | SAT | .3667 | .1344 | .3667 | (1,171) | 26.569 | .0000 |
| PSB | QOL | .4778 | .2283 | -.4778 | (1,186) | 55.049 | .0000 |
| | MARSTAS | .2773 | .0779 | -.2773 | (1,188) | 15.666 | .0001 |
| | SAT | .3481 | .1212 | .3481 | (1,171) | 23.585 | .0000 |
| | INC | .4169 | .1738 | -.4169 | (1,184) | 38.719 | .0000 |
| GROUP | HEAL | .1814 | .0329 | -.1814 | (1,186) | 6.331 | .0127 |
| | SAT | .1819 | .0330 | .1819 | (1,171) | 5.851 | .0166 |
| QOL | AUTOINT | .2025 | .0410 | -.2025 | (1,186) | 7.956 | .0053 |
| | CLAREX | .2292 | .0525 | -.2292 | (1,186) | 10.314 | .0016 |
| | MARSTAS | .3108 | .0966 | .3108 | (1,186) | 19.888 | .0000 |
| | INC | .5095 | .2596 | .5095 | (1,184) | 64.519 | .0000 |
| | HEAL | .3291 | .1083 | .3291 | (1,186) | 22.600 | .0000 |
| INC | HEAL | .3082 | .0950 | .3082 | (1,184) | 19.318 | .0003 |

Figure 6. Path Diagram of Study: SSS Scales, FOS Scales, and Demographics.



-.2773), variance 7.79%; and income (Beta = -.4169), variance 17.38%. Problem-solving behavior had a positive correlation with satisfaction with helper (Beta = .3481), variance 12.12%.

Group membership had a negative relationship with perception of health (Beta = -.1814), variance 3.29%), and a positive correlation with satisfaction (Beta = .1819), variance 3.30%.

Perception of quality of life had negative correlations with autonomy/intimacy (Beta = -.2025), variance 4.10%, and clarity of expression (Beta = -.2292), variance 5.25%. Perception of quality of life had positive correlations with marriage status (Beta = .3108), variance 9.66%; income (Beta = .5095), variance 25.95%; and health (Beta = .3291), variance 10.83%.

Income was positively correlated with perception of health (Beta = .3082), variance 9.50%. The percentages of variance in these factors is small, yet they were significant at the $p \leq .001$ level.

Additional Findings

To measure validity, both factor and item analyses were performed. Varimax rotation was used. A factor analysis examining the relationships between various items of the instrument (Burns & Grove, 1987) was completed. The principal component analysis of the SSS is reported in Table 12, p. 116. The factor loadings of the SSS are summarized in Table 13, p. 117.

Principal components factoring assumes that the items explain all of the variance of the constructs. Eigenvalues are identified until all variance is accounted for. "In component analysis only the factors

Table 12

Principal Component Analysis: SSS

| Variable | Communality | Factor | Eigenvalue | Pct of Variance |
|----------|-------------|--------|------------|-----------------|
| SSS1 | .736 | 1 | 6.010 | 40.1 |
| SSS2 | .579 | 2 | 1.639 | 10.9 |
| SSS3 | .704 | 3 | 1.145 | 7.6 |

having latent roots (eigenvalues) greater than 1 are considered significant; all factors with latent roots less than 1 are considered insignificant and disregarded" (Hair et al., 1987, p. 247). In the SSS there were three factors identified with eigenvalues ranging from 6.010 to 1.145. These factors accounted for 58.6% of the variance (see Table 12). Criteria for factor analysis was set at .40. All factors loaded at .5 or higher. Factor loadings of .5 are considered very significant (Hair et al., 1987).

In the SSS, the questions and related factors obtained from the pilot were as follows: (a) EAIPI Q11, Q12, Q13, Q14, Q15; (b) ESB Q1, Q2, Q3; (c) PSB Q5, Q7, Q9, Q10; (d) GROUP Q4, Q6, Q8. It was noted that one factor in the study, PSB, was lost in the analysis (see Table 13, p. 117). Q5, Q7, and Q9 loaded on EAIPI, and Q10 loaded on ESB.

The principal component analysis of the FOS is reported in Table 14, p. 118. The factor loadings of the FOS are summarized in Table 15, p. 119. In the FOS there were two factors identified with eigenvalues greater than 1. The first factor's eigenvalue was 5.840, and the

Table 13

Study Factor Analysis: SSS

| | FACTOR 1 | FACTOR 2 | FACTOR 3 |
|--------|----------|----------|----------|
| Item 1 | | .847 | |
| 2 | | .707 | |
| 3 | | .733 | |
| 4 | | | .587 |
| 5 | .686 | | |
| 6 | | | .832 |
| 7 | .582 | | |
| 8 | | | .766 |
| 9 | | .569 | |
| 10 | .657 | | |
| 11 | .672 | | |
| 12 | .745 | | |
| 13 | .647 | | |
| 14 | .714 | | |
| 15 | .730 | | |

eigenvalue of the second factor was 1.418. These two factors accounted for 60.5% of the variance (see Table 13). Criteria for factor analysis was set at .40. All factors loaded at .5 or higher.

In FOS, the questions and related factors obtained from the pilot were as follows: (a) AUTOINT P3, P4, P6, P8, P11; (b) ACCSEP P2, P7,

Table 14

Principal Component Analysis: Study FOS

| Variable | Communality | Factor | Eigenvalue | Pct of Variance |
|----------|-------------|--------|------------|-----------------|
| FOS1 | .483 | 1 | 5.840 | 48.7 |
| FOS2 | .608 | 2 | 1.418 | 11.8 |

P10, P12; (c) CLAREX P1, P5, P9. It is noted that one factor, CLAREX, was lost in the analysis. All three of these questions loaded with AUTOINT.

As in the pilot and instrument development, an item analysis was completed using a contrasted group approach. A contrasted group test uses groups having opposing responses. If the groups' responses are significantly different in expected directions, evidence has been added to the validity of the instrument (Burns & Grove, 1987). To ascertain a contrasted group, item analysis was run on the top and bottom quartiles of each question using a two-tailed t-test. All questions had a probability of $p \leq .000$; however, a rating of $p \leq .025$ would have been acceptable in a two-tailed test.

To measure reliability, Cronbach's alphas were completed. "Reliability is concerned with how consistently the measurement technique measures the concept of interest....Reliability testing is considered a measure of the amount of random error in the measurement technique. It is concerned with such characteristics as dependability, consistency, accuracy and comparability" (Burns & Grove, 1987, p. 291).

Table 15

Study Factor Analysis: FOS

| | FACTOR 1 | FACTOR 2 |
|--------|----------|----------|
| Item 1 | .694 | |
| 2 | | .764 |
| 3 | .643 | |
| 4 | .706 | |
| 5 | .705 | |
| 6 | .745 | |
| 7 | | .779 |
| 8 | .712 | |
| 9 | .722 | |
| 10 | | .815 |
| 11 | .674 | |
| 12 | | .7514 |

Like validity, reliability is a matter of degree. "A reliability of .80 is considered the lowest acceptable coefficient for a well-developed measurement tool" (Burns & Grove, 1987, p. 291).

"The current state of the art is to do a Cronbach's Alpha to determine the degree of reliability. The Cronbach Alpha is a statistical process which looks at the internal correlation of all the items. This is considered superior to test-retest reliability procedures" (Jennings, 1988, p. 4). Cronbach's alphas were run on the

total scale and each of the subscales of both instruments.

A total reliability alpha of .8841 was obtained for the total SSS. The subscales had alphas of .8462 (EAIPI), .7782 (ESB), .7454 (PSB), and .6256 (GROUP). Inter-item total correlations on the total scale ranged from $p = .03$ to .67. A total reliability alpha of .9017 was obtained for the total FOS. The subscales had alphas of .8693 (AUTOINT), .8363 (ACCSEP), and .7700 (CLAREX). Inter-item total correlations on the total scale ranged from $p = .18$ to .70.

Two scales were lost in factor analyses. However, factor analyses, item analyses, and Cronbach's alphas indicated that both questionnaires had adequate validity and reliability for research.

Summary of Findings

A total of 190 people responded to the questionnaires. The average age was 42.6, and the average number of children was 2.82. Over half (57.9%) considered their income to be adequate for their needs. The majority of subjects (84%) perceived their health as good, and 75% considered their quality of life as good.

Analyses of the data indicated that there was a significant relationship between health of the family of origin and social support when using the total scales. Regression analysis indicated that 10.96% of the variance in social support was due to health of the family of origin. However, there was a great variety of correlations, both positive and negative, between the subscales of both questionnaires, part II of the SSS, and the demographic variables. Only race, identified needs, and identified helpers had no correlations with the

two questionnaire subscales.

Enacted support/helper availability had a negative relation with perception of quality of life and marriage status, and a positive relationship with satisfaction with help received. Emotionally sustaining behaviors had a positive relationship with quality of life, and a positive relationship with satisfaction. Problem-solving behaviors had negative relationships with quality of life, marriage status, satisfaction, and income. Group membership had a negative relationship with perception of health, and a positive relationship with satisfaction. Perception of quality of life had negative relationships with autonomy/intimacy, and clarity of expression. Perception of quality of life had positive relationships with marriage status and income. Income was positively related to perception of health.

Study-specific validity and reliability analyses were estimated. To determine reliability, Cronbach's alpha coefficients were computed for both of the instruments and for each subscale. Reliability of the social support scale was alpha .8841. The subscales ranged from .6256 to .8462. For the family of origin scale the alpha was .9017. The subscales ranged from .7700 to .8693.

Validity was measured by factorial analysis. In the social support scale, all items loaded at .569 or higher. However, all items in the factor of problem-solving behavior loaded with the enacted support/belief that help was available scale. The family of origin scale also lost one factor. The items of the clarity of expression scale loaded with the autonomy/intimacy scale. The following chapter contains a

discussion of the findings, including the conclusions and implications.

CHAPTER V

SUMMARY OF THE STUDY

The problem of the present study was to determine whether among parents, a significant relationship existed between social support and health of the family of origin. The problem was researchable. Instruments were developed to measure both social support and health of the family of origin. The Family of Origin Scale (FOS) was developed by Anderson (1980) to measure the health of the family in which one grew up. The Social Support Scale (SSS) (De Lorenzo, 1988b) measured social support in parents. The relationships between social support and health of the family of origin were shown in the transgenerational support model proposed by De Lorenzo (1988a). The study first examined the relationship between social support and health of the family of origin; and second, examined the relationship between SSS, SSS subscales, FOS, FOS subscales, and the demographic variables. One path analysis supported FOS partially causing SSS. A second path analysis demonstrated the causal relationship between the subscales of FOS and SSS. The final path analysis consisted of certain demographic variables being antecedents of social support, and certain subscales of FOS being antecedents of the demographic variables.

Summary

The present study utilized a descriptive-correlational approach. Following development of an instrument to measure social support, the

researcher completed a pilot study using both the FOS (Anderson, 1980) and the SSS (De Lorenzo, 1988b). The pilot study estimated levels of validity and reliability for the two instruments, and the feasibility of the study. In the current study, data were collected from one mailing of 2,000 sets of questionnaires to parents of 1,000 randomly selected children in grades nine through twelve in an independent school district. It was estimated that a total of 1,628 questionnaires reached the targeted sample. After six weeks, subjects returned 190 usable questionnaires, for a return rate of 11.74%.

The data from the returned questionnaires were analyzed using SPSS^X (Norusis, 1983) statistical programs. Descriptive statistics, Pearson product moment correlation coefficients, regression coefficients, ANOVA, reliability, item, and factor analyses were computed. The demographics and part 2 of the SSS were compiled using frequency distributions. Nominal level data were then converted to interval level data using dummy variables. By using dummy variables the nominal data were converted for use with the higher level data to perform both the Pearson product moment correlation and regression analyses, thus answering the second hypothesis.

The first null hypothesis stated that among parents, there is no significant relationship between social support as identified by the SSS, and health of the family of origin as measured by the FOS. This hypothesis was rejected and the alternative hypothesis was retained.

A second hypothesis was formulated using the referentials of the conceptual framework, part 2 of the SSS, and the demographic variables.

The second hypothesis stated that among parents, there is no significant relationship between social support as identified by the SSS, health of the family of origin as measured by the FOS, race, an identified need, the person who helped satisfy the need, a rating of satisfaction with the help received, marital status, number of children, sex, age, occupation, perception of health, perception of adequacy of income, and perception of quality of life. Parts of the second hypothesis were retained and parts were rejected, and the opposite hypothesis was retained.

To measure construct validity, both factor and item analyses were performed. In the SSS, one factor, PSB, was lost through the analysis. In the FOS, CLAREX was lost through the analysis. All questions were retained when the item analysis was completed.

To measure reliability, Cronbach's alphas were completed on the total scale and each of the subscales of both instruments. A reliability alpha of .8841 was obtained for the total SSS, and total reliability alpha of .9017 was obtained for the FOS. Factor analyses, item analyses, and Cronbach's alphas indicated that both questionnaires had adequate estimated validity and reliability for research.

Discussion of Findings

Demographics

The demographic variables were marital status, sex, age, ethnicity, number of children, occupation, perception of adequacy of income, the perception of their health, and the perception of their quality of life. Scott (1982) discussed the demographics of research subjects. Of the

top twenty characteristics of participants, the characteristics of education, a higher social class, intelligence, approval motivated, sociable, female, self-disclosing, achievement motivated, and married fit the survey sample. "This phenomenon has been termed 'volunteer bias', a research consideration in itself" (p. 80).

The majority of the subjects were married (85.1%). The remaining subjects (14.9%) were either separated, divorced, or widowed. The respondents were approximately two-to-one female (64.4%) to male (35.6%). Thus, both marital status and sex fit into the subject bias suggested by Scott (1982). Age was divided into four groups, with the 36- to 45-year group being 68.3%, and the above-45-year group being 24.19% of the sample. Subjects 35 years and under made up 7.4%. The average age was 42.6. Age of subjects was older than in the pilot (average 33), however, the 42.6 average age of the study subjects was expected since the study subjects were limited to parents of older children (high school age). Ethnicity can be collapsed into two groups of white (90.0%) and nonwhite (9.7%). The study did not ascertain the percentage of white and nonwhite in the sample population.

Each subject had an average of 2.82 children. The average number of children was higher in the older study population (2.82) than it was in the younger pilot population (2.21). Family size is getting smaller, and older parents may be combining several sets of children through divorce and remarriage. Eighty-five percent of the subjects were married.

A variety of occupations were reported. A large number (36.7%)

could be considered professionals. These occupations fell into categories of education, health care, and management. Ten subjects failed to list their occupation. The large number of professionals denoted subject bias. The question on occupation was answered by filling in a blank, and the subjects who did not list occupations may be unemployed. Using United States census codes would have provided more meaningful occupational categories.

The last three questions on the demographic sheet asked subjects to rate their perceptions of adequacy of income, health and quality of life. Income was considered adequate for needs by 59.1%, so-so by 26.3%, and inadequate for needs by 14.5%. Subjects perceived their health as good (84%), so-so (14.9%), and poor (1.1%). Last, when asked about their quality of life, 76.1% considered it good, 22.3% considered it so-so, and 1.6% considered it poor. The figures indicated that 33 more subjects perceived the quality of life good than perceived adequacy of income as good. In the pilot, where the data were collected at social service agencies and the health department, the difference was even more pronounced. In the pilot, 80 more subjects considered QOL as good than perception of income as adequate. In general, subjects had positive perceptions of QOL, were optimistic, or had positive attitudes toward life. It may be that the higher the education (and therefore a presumed higher level of income), the higher the expectations on what the quality of life should be. Subjects considered individual health as better than either perceptions of income or quality of life. However, 21 times as many subjects listed health of self (10.5%) as a need in the

study, as listed it in the pilot (.5%). The increased age of subjects in the study would lead to the beginning of individual degenerative health needs.

The survey was random. Yet, a random sample of mailed surveys may present a greater amount of sample demographic bias than other research designs. A face-to-face meeting with subjects would have lead to a greater response rate, and therefore a better representation of the given population, since people tend to have trouble refusing a direct request. However, another type of demographic bias would be introduced with the direct approach method.

Hypothesis One

The first hypothesis stated: Among parents, there is no significant relationship between social support as identified by the Social Support Scale, and health of the family of origin as measured by the Family of Origin Scale. Correlational studies showed significant relationships between FOS and SSS. Therefore, the null hypothesis was rejected and the alternate hypothesis was retained. Among parents, there is a significant relationship between social support as identified by the Social Support Scale (SSS), and health of the family of origin as measured by the Family of Origin Scale (FOS).

A regression analysis further confirmed the relationship between TOTSSS and TOTFOS, and began a path of the transgenerational support model. Health of the family of origin explained 8% of the variance in social support, validating the transgenerational support model.

There were no path or Lisrel analyses found in the literature that

addressed the exact variables of the study. Muhlenkamp and Sayles (1986) used path analytic techniques to test a theoretical causal model. Social support was an indirect influence on life style through a direct influence on self-esteem. The effects accounted for 28% of the variance in the model.

A Lisrel VI analysis, using the variables of social support, threat, and coping responses, was completed by McNett (1986) to look at a causal model of coping effectiveness among the functionally disabled. The model accounted for 61% of the variance in coping effectiveness. Again, the variable of perceived availability of social support had indirect effects on coping effectiveness through direct effects on problem solving and emotionally focused coping.

Gottlieb and Green (1984) used a random phone survey of over 3,000 subjects, 40% men and 60% women, in a path analysis of life events, social network, life style, and health as possible causative factors on personal health practices and consequences. Social structure factors both positively and negatively influenced life-style practices.

Models of helping and coping exist that include aspects of social support and transgenerational theory. None of the models reviewed had undergone empirical testing. Jordan-Marsh et al., (1984) developed a life-style intervention model. The conceptual framework included support structures.

Cox (1982) generated an interaction model of client health behavior. The model incorporated sociological determinants of behavior. Elements of client singularity included social influences, and client-

professional interaction included elements of affective support.

A criticism of social support as a process of helping, was common. Studies show that in some instances, the helper obtains more satisfaction than the one helped. Brickman et al., (1982) held that a dichotomy of the models of helping between the client and the helper may be the problem when the costs of social support are high. Although all four models of helping proposed by Brickman et al., (1982) could be used to look at transgenerational support and health motivation, the model of helping that best fits the current research was the compensatory model. The compensatory model proposed that there is a low attribution to self for responsibility for the problem, and high attribution to self for the responsibility for the solution. The perception of self is deprived from the failure of the social environment to provide entitled goods and services. Each individual is expected to act assertively, but some people need help in learning to do so. The implicit view of human nature is good. The potential pathology is alienation.

Hypothesis Two

The second hypothesis stated: Among parents, there is no significant relationship between social support as identified by the Social Support Scale, health of the family of origin as measured by the Family of Origin Scale, race, an identified need, the person who helped satisfy the need, a rating of that satisfaction with the help received, marital status, number of children, sex, age, occupation, perception of health, perception of adequacy of income, and perception of quality of

life. To complete the analysis of hypothesis two, a summary of part 2 SSS was completed. Part 2 of the SSS was the least completed part of the questionnaire. Among the needs identified, money led the list with 26%. The next need was for some sort of help with children (21.5%), own health (10.5%), and job and relationship with others tied at 9.4%. All other needs were identified 5.5% of the time or less.

The helper was a family member 59.3% of the time, with friend or "no one" tied for second at 11%. All other helpers were rated at 5% or less of the total. Perlman and Rook (1987) stated that support and assistance between kin is almost universal. Gourash (1978) agreed by admitting that family and friends are both the major source of unhappiness and the major source of aid.

As stated previously, subjects completed Part 2 of the SSS least. Ten subjects omitted the section completely. An additional eight subjects did not complete all of Part 2. The nonrespondents were 45% female, and 55% male. During data collection for the pilot, one man stated that Part 2 was "to hard," and another man said that Part 2 took too much thought. Part 2 provided lists of possible needs and possible helpers with those needs, and although a blank space was provided for other answers, none were included. After instrument development, the researcher realized that the needs list was sexually biased, and additional needs of men were included in the revised questionnaire. Yet, men had trouble identifying needs.

There were no significant relationships between the FOS subscales, SSS subscales, RACE, NEEDS, and HELPERS. Therefore, that part of the

second hypothesis was retained, and no further analysis was completed on the variables of RACE, NEEDS, and HELPERS. Satisfaction with the help received (SAT) was negatively related to income (INC) and quality of life (QOL). SAT was positively related to AUTOINT and GROUP. SAT was also positively related to TOTSSS, EAIPI, ESB, and PSB. SAT was included in Part 2 of the SSS, and the positive relationships to SSS and the subscales were expected.

Marriage status (MARSTAS) was negatively related to ESB, and GROUP. MARSTAS was also negatively related to TOTSSS, EAIPI, and PSB. The study did not ask questions that would account for the negative relationships. MARSTAS was positively related to NOCHILD, INC, and QOL. Subjects with children, a higher income, and good quality of life tended to be married. The school district indicated that 30% of the students came from single-parent homes, yet 85.1% of the respondents were married. The trend today is for both parents to work outside of the home, and that leads to a higher level of income.

Married couples had a higher quality of life. Perlman and Rook (1987) proposed that married individuals enjoy greater well-being than do singles. Schaver (1985) observed that a substantial number of people are not currently married. The independent school district where the data were collected had a 30% single-parent rate. Problems in present marriages are the result of dissatisfaction, violence, and the costs of giving support to others.

Our thesis has been that family social support is both widespread and beneficial. Evidence for it is provided by

statistics showing that 90% or more of Americans marry, that kin constitute roughly 40% of the members in individuals' social networks, that people exchange aid with relatives....Our antithesis has been the viewpoint that the American family is a troubled institution and that the value of social support can be challenged (Shaver, 1985, p. 40).

Subjects had a higher number of children, and NOCHILD was negatively related to HEAL, QOL, TOTFOS, and AUTOINT. Parents are raising teenagers in a climate of substance abuse, teenage pregnancy, low teen achievement levels, poor self esteem, and AIDS. The problems of today's society that contribute to difficulty in raising children is magnified when the children reach the pre-teens and teens. The parents' perceptions of quality of life and health were negatively related to the number of children. The negative relationship between NOCHILD and the subscale of AUTOINT may indicate poor parenting skills. The fact that NOCHILD was positively related to OCCS and AGE was reasonable, since the older subjects had more children, and therefore more fiscal responsibilities.

SEX was negatively related to AUTOINT and CLAREX, but was positively related to QOL. AGE was negatively related to TOTFOS and AUTOINT, but was positively related to OCCS. OCCS was negatively related to HEAL, and positively related to ESB.

Since SEX, AGE, and OCCS were transformed to dummy variables for purposes of correlation and regression analyses, no discussion of the variables' relationships with other variables was possible, except to

state the direction of the significant relationships. Information was not obtained that might explain how sex, ages, or occupations effected changes in directions of the relationships. Additional statistical tests need to be completed that use nominal data for the variables SEX, AGE, and OCCS. Gottlieb and Green (1984) conducted research that "supported previous observations on the health-enhancing effects of the structural variables of age, education, and income on life-style health practices and, independent of these relationships, on health status" (p. 99).

HEAL was positively related to INC, QOL, TOTFOS, CLAREX, EAIPI, and PSB. When perceptions of health increased, perceptions of adequacy of income, quality of life, health of the family of origin, clarity of expression, enacted/perceived support, and problem-solving behavior also increased. HEAL was negatively related to TOTSSS, ESB, and GROUP. When perceptions of health increased, total support, emotionally sustaining behaviors, and part of a group decreased. When perceptions of health decreased, the total support, emotionally sustaining behaviors, and group belonging went down.

INC was negatively related to TOTSSS, EAIPI, and PSB. INC was also negatively related to AUTOINT, ESB, and GROUP. When perception of adequacy of income went up, there was little need for support or problem solving. INC was positively related to QOL. Most subjects agreed that when income was adequate, the quality of life was good.

Quality of life was negatively related to FOS, SSS, and all of the subscales. When perceptions of quality of life went up, perceptions of

both social support and family of origin decreased. The decrease may be because perception of supportive actions were raised to unattainable levels. If the perception of the family of origin was poor, the present quality of life may seem better than childhood experiences. On the other hand, if childhood experiences were great, and perceptions of today's quality of life is poor, the negative relationship would be feasible. Nothing was compared in the literature that compared quality of life and the health of the family of origin. Subjects' perceptions of the quality of life went up when the health of the family of origin went down, and vice versa.

Besides positive relationships to TOTFOS subscales, TOTFOS was positively related to TOTSSS, EAIPI, ESB, and PSB. All of the subscales of TOTFOS were also positively related to all of the subscales of TOTSSS except GROUP. The positive relationships agreed with the proposed transgenerational support model. As expected, TOTSSS and its subscales of EAIPI, ESB, PSB, and GROUP were positively related.

As stated before, there were no significant correlations between the TOTFOS, TOTSSS, RACE, NEEDS, and HELPERS. Therefore, that part of the null hypothesis was retained. The rest of the variables in the null hypothesis had significant relationships, and that part of the null hypothesis was rejected and the opposite hypothesis was retained. The opposite hypothesis states that among parents, there is a significant relationship between social support as measured by the Social Support Scale, health of the family of origin as measured by the Family of Origin Scale, a rating of satisfaction with the help received,

marital status, number of children, sex, age, occupation, perception of health, perception of adequacy of income, and perception of quality of life.

Only variables with a significant relationship were used in a regression to complete the final two path analyses. The variables included in the path analyses were SAT (the satisfaction with the help received was rated), MARSTAS (marriage status), NOCHILD (number of children in the family), SEX, AGE, OCCS (occupation), HEAL (perception of health), INC (perception of adequacy of income), QOL (perception of quality of life), the family of origin subscales of AUTOINT (autonomy/intimacy), ACCSEP (acceptance of separation/loss), CLAREX (clarity of expression), the social support subscales of EAIPI (enacted support/indirect personal influence), ESB (emotionally sustaining behavior), PSB (problem-solving behavior), and GROUP (considering self part of a group).

The first regression pertaining to hypothesis two used the subscales of both the TOTSSS and the TOTFOS. The regression analysis produced the following results for the subscales: (a) For enacted support/belief that help is available (EAIPI), autonomy/intimacy accounted for 6.56% of the variance, and clarity of expression (CLAREX) accounted for 3.48% of the variance; (b) For problem-solving behavior (PSB), autonomy/intimacy accounted for 6.17% of the variance; (c) For emotionally sustaining behaviors (ESB), acceptance of separation (ACCSEP) accounted for 6.44% of the variance; (d) No regressions were significant with the variable GROUP.

A third and final path diagram resulted from the multiple regression and single regressions of the two sets of subscales and the demographic data. Enacted support/helper availability had a negative relationship with perception of quality of life, and accounted for 21.88% of the variance; a negative relationship with marriage status, which accounted for 8.31% of the variance, and a positive relationship with satisfaction with the help received, which accounted for 18.49% of the variance.

Emotionally sustaining behaviors had a negative relationship with quality of life, which accounted for 11.07% of the variance, and a positive relationship with satisfaction, which accounted for 13.44% of the variance. Problem-solving behaviors had negative relationships with quality of life (variance 22.83%), marriage status (variance 7.79%), and income (variance 17.38%). Problem solving had a positive relationship with satisfaction with helper (variance 12.12%).

Group membership was negatively related to perception of health (variance 3.29%), and positively related to satisfaction (variance 3.30%). Perception of quality of life was negatively related to autonomy/intimacy (variance 4.10%) and clarity of expression (variance 5.25%). Perception of quality of life was positively related to marriage status (variance 9.66%), income (variance 25.95%), and health (variance 10.83%).

Income was positively related to perception of health (variance 9.50%). The percentage of variance among these factors was small, yet, both were significant at the $p \leq .001$ level.

No models of transgenerational support were found in the literature.

However, two models that characterized transgenerational issues as determinants of health or client behavior, were found. Ellison (1987) submitted a constructive-developmental model of social support. "...The meaning of 'social support' will vary according to an individual's stage of psychosocial development; and second, social support, as it is presently known, may have its greatest heuristic value for one particular stage of human development-interpersonal stage" (p. 19). Dixon and Dixon (1984) formulated an evolutionary-based model of health and viability. Health and viability were evolutionary processes within a social and developmental context. As was previously stated, although the models had similarities to the present research, the strength of the transgenerational support model is in the beginning of empirical testing.

One study that had a similarity to the present research examined determinants of social support (Vinokur, Schul, & Caplan, 1987). Social support was negatively influenced by the personality characteristic of a generalized negative outlook. If personality characteristics have transgenerational properties, the results fit into, and add veracity to, the present model of transgenerational support.

Giacomo and Weissmark (1987) believed that a true generative theory was impossible in the therapeutic field.

Development of social systems are a never-ending, creative process. Social systems have ever-shifting sets of contexts with interactions. This is not a failure, weakness, or pathology in the process; it is its very nature...interaction

in human systems may contain elements of indeterminacy with a diversified variety of alternatives....Attempts to freeze this process by deriving rules will only be partially successful because gaps and inconsistencies can always be discovered (p. 457).

Conclusions and Implications

Based on the findings of the present study, the following conclusions were drawn: (a) Due to the amount of bias found in the demographics of the subjects, the results are not generalizable to the population of all parents of children in grades nine through twelve; (b) Transgenerational support is a multifaceted concept made up of the multifaceted concepts of social support and transgenerational theory; (c) The low percentage of total variance accounted for in the present study points to other variables (not studied) that play important roles in predicting social support; (d) Health of the family of origin was an appropriate concept to use in studying social support; (e) Men have a hard time identifying needs; (f) Parents' perception of quality of life decreases with increased numbers of children in the family; (g) Low levels of health of the family of origin may contribute to parenting problems; (h) Too many items may have been removed from both questionnaires, resulting in the loss of one concept in both social support and health of the family of origin.

In regards to conclusion (a), that due to the amount of bias found in the demographics of the subjects, the results were not generalizable to the population of all parents of children in grades nine to twelve;

problems with the demographic variables were previously discussed. A more heterogeneous sample of the population is mandatory before generalizations can be made to all parents.

Conclusions (b) and (c) deal with the multifaceted aspects of both transgenerational theory and social support. Fiore, Coppel, Becker, and Cox (1986) specified some concepts of social support as cognitive guidance, emotional support, socializing, tangible assistance, social reinforcement, physical comfort, nurturance, reassurance of one's worth, caregiving, and social network. Many subconcepts of social support result from the numerous definitions and lack of agreement, among researchers, of exactly what social support is.

Transgenerational theory is also a multifaceted concept. Hovestadt et al., (1985) used the two concepts of autonomy and intimacy to develop the FOS. Autonomy consisted of clarity of expression, responsibility, respect for others, openness to others, and acceptance of separation and loss. Intimacy's subscales were range of feelings, mood and tone, conflict resolution, and empathy and trust.

Gardner and Wheeler (1987) admitted that efforts directed toward theoretical definition and measurement of social support in nursing continues to be vague and inconsistent. Complex models are imprecise. Barrera (1986) surmised that

The term social support is not likely to disappear totally from our vocabulary....In fact, continued reliance on this heterogeneous concept presents the great danger of obscuring important differences and inhibiting the integration of

research findings....Life events cannot be prevented...
predictable stressors...might be accompanied by parallel
efforts to prepare significant others for increased strains
and to arrange for positive social interactions (pp. 438-439).

The next four conclusions were: (d) Health of the family of origin was an appropriate concept to use in studying of social support; (e) Men have a hard time identifying needs; (f) Parents' perceptions of quality of life decreases with increased numbers of children in the family; and (g) Low levels of health of the family of origin may contribute to parenting problems. All four of these conclusions dealt with health of the family of origin.

Caplan (1976) observed that support functions of a family consist of collecting and disseminating information about the world, guiding and feeding back information, guiding and acting as a mediator in problem solving, serving as a source of practical service and concrete aid, being a haven for rest and recuperation, being a reference and control group, acting as a source and validator of identity, and teaching of emotional mastery.

A model of transgenerational support was proposed. Beginning research added some dimensions to the model. Additional research on both concepts is needed. Social support's main contributions may be in the stress-related situations. Pilisuk and Parks (1987) held that contemporary medicine shows an increase in stress-related illness. The diseases mentioned include cancer, heart ailments, depression, accidents, suicide, homicide, cirrhosis of the liver, hypertension, and

stomach ulcers.

Roberts (1988) identified six reasons that clients would seek help from nurses. These categories have not yet been validated by research, and as such provide a rich framework for further testing.

1. Lack of support for a needed change in health-related behavior.
2. Acute lack of support related to a normal developmental crisis that involves a change in the network.
3. Acute lack of support related to a crisis that temporarily changes the need for support.
4. Acute lack of support related to a crisis that involves a loss of support.
5. Chronic lack of support that is adequate except in a crisis.
6. Chronic lack of support that is inadequate (p. 7).

Pilisuk (1982) focused on the practice aspect of social support, and proposed the following areas that clinicians should consider when planning social support interventions. Benefits of interventions must be demonstrated. Professionals should avoid domination and alteration of natural networks. The opinions of lay persons, who may know the most about social support, have to be valued. If possible, ways must be found to compensate and include indigenous workers expert at facilitating natural helping networks. Professionals should use social support in their own lives in order to prevent the isolationism and human deprivation that befalls busy professionals.

The final result of nursing research is to benefit society. In influencing the quality of nursing practice, research has policy implications. Policy decisions usually imply the reduced incidence of disease, lower medical costs, treatment, rehabilitation, and reduced mortality....Social support may be optimized by being made specific to the person and the situation. Eventually, scholars and practitioners will want to be able to specify what kind of support, from whom, when, and for what objective....In our view, much of the stress experienced by the individual stems from macro-level policy decisions and the general cultural values of the American society (Cohen & Syme, 1985, p. 40).

Social support has measurable physical attributes. Shaver (1985) spoke of neurochemical brain function shaping adult behavior, and that environmental events alter neurochemical brain function in adults. Stress response hormones also influence immune responses. Mediating hormones of the immune system include corticosteroids, growth hormone, insulin, and sex hormones. Manipulation of early life social experiences, changes in the psychosocial environment, and noxious stimuli influence the immune system's susceptibility to disease, i.e., cancer and tumor growth.

Pilisuk and Minkler (1985) also discussed "the individual and interpersonal responsibility for health and justifying major cutbacks in health and social programs" (p. 93). The goal is to mobilize social support. Gottlieb (1985) warned practitioners to be wary of the

professional who believes that the only way to do something (support) is the professional way. Practitioners need to know how ordinary people help each other. Yet, social support is cost effective because it "prevents people from transferring the responsibility for effective change to professionals and institutions" (p. 20). Support from relatives and friends gives people a sense of control over their own lives. Personal control over one's life should not be used as one way of cutting back on public services. People need professional help when their own resources are overwhelmed.

The final conclusion was that too many items may have been removed from both questionnaires, resulting in the loss of one concept in both the social support scale and the health of the family of origin scale. Three factors were identified in the SSS. The factors accounted for 58.6% of the variance. One factor, PSB, was lost in this analysis. Q5, Q7, and Q9 loaded on EAIPI, and Q10 loaded on ESB.

Two factors were identified in the FOS. The two factors accounted for 60.5% of the variance. Again, all factors loaded at .5 or higher. All three of the items from CLAREX loaded with AUTOINT. Both questionnaires had been pared to the least possible number of items. In future research, the number of questions should again be expanded to fully cover all concepts.

Cronbach's alphas were completed to estimate reliability of the questionnaire in the study. A total reliability alpha of .8841 was obtained for the total SSS. Subscale alphas ranged from .6256 to .8462. A total reliability alpha of .9017 was obtained for the total FOS. The

subscales had alphas of .8693 to .7700. Total reliability of both scales remained high even with the loss of one factor in each scale, because the lost items loaded on existing factors.

Shaver (1985) intimated that "Basic knowledge or the development of descriptive theories is essential to generating clinical knowledge or logical prescriptive theories in a professional discipline....Do the models fit a discipline committed to understanding the 'wholeness' of human behavior related to health" (p. 186)?

Nurses will have both to create a new political understanding for the basis of caring and to find ways to gain the power to implement it. Nursing can do much to have this happen through research on the importance of caring on patient outcome, studies of patient improvements in nursing settings where the right to care is created, or implementing nursing control of caring through a bargaining agreement (Reverby, 1987, p. 10).

An effective approach to nursing care must encompass all factors that act, either singly or in combination, on human health. The multifaceted concepts being studied led to the conclusion that the tip of the research iceberg has only been touched. Additional studies can be generated from the current study.

Recommendations for Further Study

As a result of the present study, the researcher determined the need for the following areas of research:

1. After further development of the social support instrument, and development of a new health of the family of origin scale, replicate the

present study using a more heterogeneous sample.

2. Perform a secondary analysis of the nominal data within the present study.

3. Perform a secondary analysis combining information of the pilot with the present study (approximately 400 subjects), and replicating the statistical analyses.

Additional studies might include:

4. Use of qualitative studies in identifying and rating men's needs.

5. Use of qualitative studies in identifying exactly what supportive actions consist of in specific situations.

6. Use of qualitative studies in identifying how ordinary people help each other.

7. Development of longitudinal studies of varying family size in identifying the effects of family size on children's developmental stages.

8. Development of specific support procedures for specific situations, and examine how these procedures affect support.

9. Define social support and examine its developmental aspects in various age groups.

10. Develop appropriate measures to be used in determining how social support effects the immune system.

The present study led the researcher to a greater appreciation of the diversity of the transgenerational support model. More specific concepts and measures of these concepts must be defined for research.

The transgenerational support model should be further refined to depict the hypothesized connections between the variables of interest.

Revelation of phenomenon of interlocking, multi-person motivational systems was a genuine breakthrough. Many heretofore inexplicable paradoxes and symptoms began to make sense; the family systems approach helped decode age-old human dilemmas. How to change a family was another story....For the first time practitioners...found a way to deal with the real problems of people--the relationships with those who matter most to them (Framo, 1974, p. 95).

"I do see this family approach as a philosophy and an orientation to the human condition....one that belongs outside the framework of the helping professions, perhaps in education" (Framo, 1974, p. 97).

Man's need for emphatic relationships is recognized, especially in parent-child contacts where what is learned will affect the far future, perhaps for several generations. We are only at the beginning of groping for ways of meeting this need, of helping families to maintain their unity while simultaneously allowing each member his separate kind of coalition that is strong enough to endure sincere diversity among its members and weak enough to dissolve itself gracefully with the passage of time, the deaths of older members, and the marriage of children. Our very need is our mandate for further searching (Paul, 1970, p. 352).

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APPENDIX A
Human Subjects Review Committee
Statement to Accompany Prospectus

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

PROSPECTUS FOR DISSERTATION

This prospectus proposed by: Kathleen De Lorenzo

_____ and entitled:

Social Support and Health of the Family of Origin: A Path Analysis

Has been read and approved by the members of (his/hers) Research Committee.

This research is (check one):

XX Is exempt from Human Subjects Review Committee review
because the study comprises survey research of adult subjects that
cannot be identified, is of no risk to subjects, and does not
contain sensitive subject matter.

_____ Requires Human Subjects Review Committee review
because _____

Research Committee:

Chairperson

Member

Member

Member

Member

Linda Harrington
Peggy J. Davis
Heleen A. Bush
Janet Hammit
Dlen Jennings

APPENDIX B

Permission From Graduate School

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
THE GRADUATE SCHOOL
P.O. Box 22479, Denton, Texas 76204 817/898-3400, 800-338-9255



March 21, 1989

Ms. Kathleen Ann De Lorenzo
8144 Carriage Lane
Wichita Falls, TX 76301

Dear Ms. De Lorenzo:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Leslie M. Thompson
Leslie M. Thompson
Dean for Graduate Studies
and Research

d1

cc Dr. Linda Harrington
Dr. Anne Gudmundsen

APPENDIX C

Permission From Organization

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Wichita Falls Independent School District
GRANTS TO Kathleen Ann De Lorenzo

a student enrolled in a program of nursing leading to a Doctoral Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Social Support and Health of the Family of Origin among parents:
A Path Analysis

The conditions mutually agreed upon are as follows:

1. The agency ~~(name)~~ (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency ~~(name)~~ (may not) be identified in the final report.
3. The agency ~~(name)~~ (does not want) a conference with the student when the report is completed.
4. Other _____

Date: 1/12/88

Kathleen Ann De Lorenzo
Signature of student

[Signature]
Signature of Agency Personnel
Superintendent
[Signature]
Signature of Faculty Advisor

* Fill out and sign three copies to be distributed as follows:
Original - Student; First Copy - Agency; Second Copy - TWU College of Nursing.

APPENDIX D
Cover Letter

March 20, 1989

Dear Parent(s),

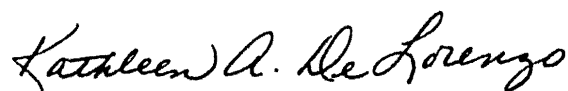
I am a registered nurse, and am working on my doctoral degree at Texas Woman's University in Denton, Texas. The purpose of this letter is to ask you to participate in my dissertation. My research concerns the ability of parents to ask for, give, receive, and accept help. The research will look at the relationship between social support and the family that you grew up in. The information will be useful to nurses in meeting the needs of parents in various situations.

There are two questionnaires to fill out. The Family of Origin Scale has 12 questions, and the Social Support questionnaire has 15 questions. There is also a Background Information Sheet. Your participation in this study is voluntary. Your answers will be anonymous, and only the researcher will see the completed surveys.

I would appreciate it if each father and mother would fill out one set of questionnaires and return them together in the one envelope. However, if only one parent chooses to participate, or if you are a single parent, please fill out only one set of questionnaires and return them.

Completion of the questionnaire will imply your willingness to participate in the study. Your help will be most appreciated. If you have any questions, please contact me at (817) 855-4358.

Thank you,



Kathleen A. De Lorenzo
8144 Carriage Lane
Wichita Falls, TX 76301

APPENDIX E
Social Support Scale

Social Support Questionnaire

Completion of this questionnaire implies consent to participate in the study.

DIRECTIONS: Please read each of the following statements. Rate your agreement with each statement from 1-strongly disagree, to 5-strongly agree. Circle the most appropriate number.

- 1 - strongly disagree
- 2 - disagree
- 3 - neither agree nor disagree
- 4 - agree
- 5 - strongly agree

EXAMPLE: I like cats. 1 2 3 4 5

- | | |
|--|-------------------|
| 1. Someone lets me talk about personal and private problems. | 1 2 3 4 5 |
| 2. I am not alone in the world. | 1 2 3 4 5 |
| 3. I have someone I can confide in. | 1 2 3 4 5 |
| 4. I dislike group activities. | 1 2 3 4 5 |
| 5. I cannot find someone to provide me information about my needs. | 1 2 3 4 5 |
| 6. I like doing things with others. | 1 2 3 4 5 |
| 7. I don't have anyone who can refer me to places where I can get help. | 1 2 3 4 5 |
| 8. I enjoy spending time with others who have similar interests. | 1 2 3 4 5 |
| 9. No one can discuss my problems with me to help me gain new understanding. | 1 2 3 4 5 |

I have someone who:

- | | |
|--|-------------------|
| 10. Provides suggestions or advice to help me meet my needs. | 1 2 3 4 5 |
| 11. Praises me. | 1 2 3 4 5 |

CONTINUED ON REVERSE SIDE

- | | | | | | |
|---|---|---|---|---|---|
| 12. Gives me the information I need. | 1 | 2 | 3 | 4 | 5 |
| 13. Would help me move. | 1 | 2 | 3 | 4 | 5 |
| 14. Encourages me to take care of myself. | 1 | 2 | 3 | 4 | 5 |
| 15. Helps me when I am sick. | 1 | 2 | 3 | 4 | 5 |

PART 2: Directions: This section asks for three responses.

1. In the following list, circle the one most important need that you have had in the last three months.

Self sick; child sick; relationship with child; money; advice; transportation; information; housing; handicap; relationship with other; lonely; household tasks; job; someone to talk to; food. If your most important need was not listed, please specify:

2. Circle the one person who helped to satisfy the need identified in the above question.

Child; friend; spouse; brother; sister; father; mother; other relative; nurse; doctor; counselor; public agency; private agency; neighbor; co-worker; priest; minister; significant other; self-help group; no one. If the person who helped with the need is not listed, please specify:

3. Circle the number that rates your satisfaction from 1-very dissatisfied, to 5-very satisfied.

1 2 3 4 5

APPENDIX F
Background Information Sheet

BACKGROUND INFORMATION

DIRECTIONS: Please answer the following items about yourself by checking the appropriate line, or by writing in the space provided.

- A. Marital Status?
____ 1. Never married
____ 2. Separated
____ 3. Divorced
____ 4. Widowed
____ 5. Married
- B. ____ Number of children, including step-children, in your present family?
- C. Your sex?
____ 1. Female
____ 2. Male
- D. ____ Your age?
- E. ____ Race?
- F. _____ Your present occupation?
- G. My total family income per year is:
____ 1. Adequate for my needs
____ 2. So-so
____ 3. Inadequate for my needs
- H. My present health is:
____ 1. Good
____ 2. So-so
____ 3. Poor
- I. The present quality of my life is:
____ 1. Good
____ 2. So-so
____ 3. Poor

Comments: Please feel free to share any thoughts or comments you have about this questionnaire.

THANK YOU FOR YOUR PARTICIPATION.

APPENDIX G

Permission for Family of Origin Scale

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
COLLEGE OF NUTRITION, TEXTILES, AND HUMAN DEVELOPMENT
Department of Family and Consumer Studies, P.O. Box 23973, Denton, Texas 76204 (817) 896-2483



August 1, 1988

Dear Mr. De Lorenzo,

Feel free to use the Family of Origin Scale (of which I am the original author) in your research. The Horvath article has all the current information available. The FOS is not factor analyzed, so you can only use the total score, not the subscale scores.

Hope all goes well with you and your study. I'm glad the F.O. class was of help to you.

Sincerely,
William T. Anderson, Ed.D.

APPENDIX H
Family of Origin Scale

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William T. Anderson

Revised
Family of Origin Scale

Directions: The family of origin is the family in which you have 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 ways of doing things. Thus, there are no right or wrong choices in this scale. What is important is that you respond as honestly as you can.

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

1. Strongly disagree that it describes my family of origin.
 2. Disagree that it describes my family of origin.
 3. Neutral.
 4. Agree that it describes my family of origin.
 5. Strongly agree that it describes my family of origin.
-
1. I found it difficult to understand what other family members said and how they felt..... 1 2 3 4 5
 2. We talked about our sadness when a relative or friend died..... 1 2 3 4 5
 3. My parents openly admitted it when they were wrong... 1 2 3 4 5
 4. My family was receptive to the different ways various family members viewed life..... 1 2 3 4 5
 5. I often had to guess at what other family members thought or how they felt..... 1 2 3 4 5
 6. In my family, I felt free to express my own opinions. 1 2 3 4 5
 7. We never talked about our grief when a relative or family friend died..... 1 2 3 4 5
 8. Sometimes in my family, I did not have to say anything, but I felt understood..... 1 2 3 4 5
 9. I found it easy to understand what other family members said and how they felt..... 1 2 3 4 5

10. If a family friend moved away, we never
discussed our feelings of sadness..... 1 2 3 4 5
11. My family members were usually sensitive
to one another's feelings..... 1 2 3 4 5
12. When someone important to us moved away, our
family discussed our feelings of loss..... 1 2 3 4 5