

BRIEF REPORT

KNOWLEDGE OF FAMILY HISTORY AS A CLINICALLY USEFUL INDEX OF PSYCHOLOGICAL WELL-BEING AND PROGNOSIS: A BRIEF REPORT

MARSHALL P. DUKE, AMBER LAZARUS, AND ROBYN FIVUSH

Emory University

Based on an instance of “clinical lore” we assess the efficacy of children’s and adolescents’ knowledge of family history as an index of psychological well-being and potential for positive change in clinical and educational settings. We report that knowledge of family history is significantly correlated with internal locus of control, higher self-esteem, better family functioning, greater family cohesiveness, lower levels of anxiety, and lower incidence of behavior problems. We suggest that through the use of a brief measure of family knowledge, practicing clinicians can rapidly generate a data-based correlate of children’s well-being and likelihood of overcoming psychological and educational challenges.

Keywords: prognosis, clinical index, family history, well-being

Among the most difficult but important predictions made by clinicians are those that reflect patients’ psychological well-being in general and their prognosis for recovery or successful completion of treatment or remediation regimens. “How well is this person likely to do?” “What are the chances for recovery?” “How likely is it that this child will respond well to the interventions

outlined in his or her individual educational plan (IEP)?” Over the years, there have been numerous systematic efforts to identify through theory and/or empirical methods clinically meaningful indicators to aid in these sorts of predictions (Fernandez-Ballasteros, 2003; Groth-Marnat, 2003). However, despite the availability of such scientifically derived indicators, many clinicians continue to generate and depend on what is typically termed *clinical lore* to help them address prognostic concerns. Further, more often than not, this clinical lore remains in clinical settings and is rarely studied systematically in laboratory settings. This is disadvantageous and self-defeating for both clinical scientists and practitioners. Proponents of the Boulder or scientist-practitioner model for clinical psychology have long trumpeted the value of integrating the science and art of clinical psychology. However, examples of the implementation of this ideal are infrequent. In this brief report, we seek to provide one example of such an integration.

Knowledge of Family History as an Index of Intervention Outcome

A potentially useful instance of clinical lore came to our attention serendipitously via one of our interviews with clinicians in preparation for initiation of the Family Narratives Project at the Sloan Center for the Study of Myth and Ritual in American Life (MARIAL) at Emory University (see Duke & Fivush, in press; Duke, Fivush, Lazarus, & Bohanek, 2003; Fivush, Bohanek, & Duke, in press). A veteran clinician with 30 years in practice who was also a grandparent of a family we interviewed in our pilot work said simply, “I can tell which kids I’m working with are most likely to respond to treatment and benefit most from educational plans and adjustments. It’s the ones who know about their family his-

Marshall P. Duke, Amber Lazarus, and Robyn Fivush, Department of Psychology, Emory University.

Correspondence regarding this article should be addressed to Marshall P. Duke, PhD, Department of Psychology, Emory University, Atlanta, GA 30322. E-mail: psyumd@emory.edu

tory.” This clinician went on to tell us that she routinely asked children and adolescents a few questions, such as where their parents met or what sorts of jobs their grandparents had. She stated she had observed over the years that those who knew such information had much stronger positive prognoses and better outcomes.

To be sure, there are many variables that have been put forth in the formal clinical science literature that relate family experience to well-being (e.g., Baumrind, 1989; see also, Darling & Sternberg, 1993; Pettit, Bates, & Dodge, 1997). However, it was noteworthy that the clinician with whom we spoke used very few of these formal clinical indicators. Rather, she made important clinical decisions based on her own experience combined with what she believed were useful findings from admittedly limited involvement with the formal clinical literature (via continuing education workshops, popular media like the New York Times Science Section, and informal conversation with colleagues and clients). With this practitioner’s observation about knowledge of family history and likelihood of positive outcomes in hand, in the spirit of the scientist/practitioner model, we decided to carry it back to the laboratory and determine its efficacy. We did so initially as a purely empirical effort; at the time, there were no data supporting its validity or, if it turned out to be valid, limited theoretical understanding of why it might be so.

To assess the efficacy of our clinician colleague’s observation, we first developed a more formal, quantifiable measure of family knowledge, a selection of 20 questions that we called simply the “Do You Know?” scale (DYK; see the Appendix). The final 20 items on the scale emerged from an initial pool of 132 family knowledge items independently generated by three PhD clinical psychologists, four advanced graduate students in clinical psychology and two educational consultants. Items were sorted into groups based on type of information sought (e.g., major events, places lived, occupations, etc.) and either the most representative items or items resulting from melding of similar items were moved forward in the process. This process resulted in a 39 item scale.

The 39-item scale was then administered to a sample of 76 adolescents (40 girls and 36 boys) at a large high school in Atlanta. The group comprised 51 White students, 17 African American students and 8 Asian students. The high school

population ranged from lower middle to upper middle class socioeconomically (by estimate—no income or parental occupation data were collected). Based on scoring patterns in this sample, nondiscriminating items and confusing items were dropped, resulting in a 19-item final form. To this, we added the unusual item No. 20, dealing with an obviously fanciful piece of family knowledge seemingly used to encourage children to “put on a happy face,” that, surprisingly, 15% of our pilot participants endorsed. This final form was administered to a second sample of 22 students from the same high school. Scoring was straightforward with total number of yes responses representing students’ affirmation of knowledge of family history. (In a later study, and with an additional sample, we have determined that adolescents who say they know the facts indicated do, in fact, know them.) Four week test–retest reliability on the sample of 22 students was .93 indicating stability of scores over time. No cut-off scores were established for degrees of knowledge of family history; simple total scores on family knowledge were used in all statistical analyses.

As part of our larger project on family narratives, DYK was administered to a group of 40 adolescents between the ages of 10 and 14 (these were “target” participants in the study of family narratives in 40 families, 37 of which were White; no participants were receiving mental health services at the time of the study). Mean score for the DYK was 13.05; $SD = 3.53$. In addition to the DYK, participants and/or their parents were also administered the Family Functioning Scale (FFS) and the Family Traditions Scale (FTS; McCubbin, Thompson, & McCubbin, 1996; FFS group: $M = 194.72$; $SD = 24.74$, FTS group: $M = 10.44$; $SD = 5.05$); the Rosenberg Self-Esteem Scale (Rosenberg, 1965; group $M = 33.91$; $SD = 4.04$); the Nowicki–Strickland Locus of Control Scale for Children (Nowicki & Strickland, 1973; group $M = 12.31$; $SD = 1.09$); the Children’s Manifest Anxiety Scale (Reynolds & Richmond, 1978; Group Total Anxiety: $M = 8.63$; $SD = 2.11$) and the Child Behavior Checklist (Achenbach, 1991; group $M = 56.96$; $SD = 8.57$). Scores were then intercorrelated to determine whether there were any connections between knowledge of family history and these measures of family functioning and individual well-being. The results were pleasantly surprising.

As seen in Table 1, the more children said they

TABLE 1. Pearson *r* Coefficients Between DYK Scale Scores and Various Behavioral and Personality Variables

Variable	Do You Know?
Locus of control	-.70**
Rosenberg Self-Esteem	.61**
Family Functioning Scale	.39*
Family Traditions Scale	.48**
Children's Manifest Anxiety Scale	-.66*
Child Behavior Checklist	-.45*

Note. *N* = 40. DYK = Do You Know?

* *p* < .05. ** *p* < .01.

knew about their family histories the lower their anxiety, the higher their self-esteem, the more internally controlled they were, the better their family functioning, the fewer their behavioral problems, and the more cohesive their families. Notably, these correlations were not what Mischel (1968) famously called the standard “personality coefficient” of .30 (p. 78). With correlations in the .50s and .60s, we were dealing with a variable that in regression analyses was accounting for 30% to 40% of the variance.

Why Should Family History be Related to Prognosis?

After supporting empirically the potential efficacy of the clinical observation about family history and clinical outcome, we sought some inchoate theoretical understanding of why this should be the case. If simply knowing family history could make for better states of well-being and improved prognoses, some might propose (tongue in cheek) that we simply teach people various facts about their families as part of clinical treatment. Clearly, this approach would not work! Rather, it is our belief that knowledge of family history reflects certain processes that exist in families whose members know their histories. One such process is the communication of family information across generations; important questions about this process would include “Who is passing this information?” and “When is this information transmitted?” In our study of family rituals at the Family Narratives Project, for example, we found that family stories seem to be transferred by mothers and grandmothers more often than not and that the information was typically passed during family dinners, family vacations, family holidays, and the like (Duke & Fivush, in press). Other data indicated that these

very same regular family dinners, yearly vacations, and holiday celebrations occur in families that have high levels of cohesiveness and that they contribute to the development of a strong sense of what we have called the *intergenerational self* (Fivush et al., in press). It is this intergenerational self and the strength and guidance that seem to derive from it that are associated with increased resilience, better adjustment, and improved chances of good clinical outcomes.

In that learning about one’s family is part of a large and complex ongoing process of family narrative coconstruction, we do not propose that knowledge of family history, per se, renders people stronger and more resilient. Rather, knowledge of family history seems to have potential as a marker—an index—that reflects that ongoing complex process. Other components of the process that might similarly serve as markers might be a family’s level of intergenerational communication, family cohesiveness, the presence of intrafamilial support systems, high levels of narrative coconstruction and presence of rituals that maintain continuity despite inevitable ups and downs that occur in all people’s lives. The clinical attractiveness of knowledge of family history as an index of well-being and potential for resilience and/or positive change, however, lies in its simplicity and ease of assessment (the DYK scale requires less than 5 min to administer and score). The findings presented in Table 1, that DYK is related strongly to so many well-established psychometric indicators of psychological well-being and good clinical outcome, attest to the potential of family knowledge as a clinically useful marker.

We are not unaware of the danger of mixing causation with correlation, and to be sure the data we report here are correlational. Further research is under way to determine the direction of causality within the correlations reported here and to cross validate these findings in both research and clinical populations. Although we cannot say at this point that knowledge of family history directly produces internal locus of control or higher self-esteem, or that it directly leads to fewer behavioral problems or lower anxiety, we can say that it appears to be a promising, easy-to-assess “index” or “marker” variable. Thus, in a clinical setting, simple and rapid assessment of family knowledge via the DYK scale can serve as a rough but powerful indicator of those variables with which it is strongly correlated, for example,

locus of control, level of adjustment, self-esteem, coping capacity, all of which would require much more time to determine psychometrically.

Used as described, DYK scores may have immediate clinical application as a rapid screening technique. If clinicians can estimate important predictive and prognostic factors through use of a simple 5 min scale, they will be at a marked advantage in treatment planning and diagnosis. Although the DYK is not the ultimate statistical predictor that Meehl (1955) sought, it seems to fall midway between totally "gut-level" clinical prediction and highly complicated and often cumbersome statistical prediction.¹ As we said earlier, such an index requires further study and refinement, but the strength of the correlations found in our data led us to prepare this brief report with three hopes in mind. First is the hope that our practitioner colleagues might find the DYK index helpful. Our second hope is that data on its use might be gathered by these same colleagues and submitted to us for compilation and further analysis (psymd@emory.edu). If both of these hopes are realized, our third hope would then be that in some way we have affirmed the inherent value of the scientist-practitioner model in clinical psychology.

¹ For enlightening recent reviews/meta-analyses of the statistical versus statistical prediction debate, see Aegisdottir et al., (2006); Aegisdottir, Spengler, and White (2006); and Grove et al. (2000).

References

- ACHENBACH, T. (1991). *Manual for the Child Behavior Checklist*. Burlington, VT: University of Vermont, Department of Psychiatry.
- AEGISDOTTIR, S., SPENGLER, P., & WHITE, M. (2006). Should I pack my umbrella? Clinical versus statistical prediction of mental health decisions. *The Counseling Psychologist*, 34, 410–419.
- AEGISDOTTIR, S., WHITE, M., SPENGLER, P., MAUGHERMAN, A., ANDERSON, L., COOK, R., et al. (2006). The meta-analysis of clinical judgment project: Fifty-six years of accumulated research on clinical versus statistical prediction. *The Counseling Psychologist*, 34, 341–382.
- BAUMRIND, D. (1989). Rearing competent children. In W. Damon (Ed.), *Child development today and tomorrow* (pp. 349–378). San Francisco: Jossey-Bass.
- DARLING, N., & STERNBERG, L. (1993). Parenting style as context: An integrative model. *Psychological Bulletin*, 113, 487–498.
- DUKE, M., & FIVUSH, R. (in press). Family rituals and family hardiness. In B. Shore & M. Auslander (Eds.), *Family time: Myth and ritual in America*.
- DUKE, M., FIVUSH, R., LAZARUS, A., & BOHANEK, J. (2003). Of ketchup and kin: Dinnertime conversations as a major source of family knowledge, family adjustment, and family resilience (Working Paper 027–03). Atlanta, GA: Center for the Study of Myth and Ritual in American Life, Emory University.
- FERNANDEZ-BALLESTEROS, R. (2003). *Encyclopedia of psychological assessment*. New York: Sage.
- FIVUSH, R., BOHANEK, J., & DUKE, M. (in press). The intergenerational self: Subjective perspective and family history. In F. Sani (Ed.), *Individual and collective self continuity*. Mahwah, NJ: Erlbaum.
- GROTH-MARNAT, G. (2003). *Handbook of psychological assessment* (4th ed.). New York: Wiley.
- GROVE, W. M., ZALD, D. H., LEBOW, S., SNITZ, B. E., & NELSON, C. (2000). Clinical versus mechanical prediction: A meta-analysis. *Psychological Assessment*, 12, 19–30.
- MCCUBBIN, H., THOMPSON, A., & MCCUBBIN, M. (1996). *Family assessment: Resiliency, coping and adaptation: Inventories for research and practice*. Madison: University of Wisconsin Publishers.
- MEEHL, P. (1955). *Clinical versus statistical prediction. A theoretical analysis and a review of the evidence*. Minneapolis: University of Minneapolis Press.
- MISCHEL, W. (1968). *Personality and assessment*. New York: Wiley.
- NOWICKI, S., JR., & STRICKLAND, B. R. (1973). A locus of control scale for children. *Journal of Consulting and Clinical Psychology*, 40, 148–154.
- PETTIT, G., BATES, J., & DODGE, K. (1997). Supportive parenting, ecological context, and children's adjustment: A seven year longitudinal study. *Child Development*, 68, 908–923.
- REYNOLDS, C., & RICHMOND, B. (1978). What I think and feel: A revised measure of Children's Manifest Anxiety. *Journal of Abnormal Psychology*, 6, pp. 271–280.
- ROSENBERG, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

(Appendix follows)

Appendix

The “Do You Know . . . ?” (DYK) Scale

Please answer the following questions by circling “Y” for “yes” or “N” for “no.” Even if you know the information we are asking about, you don’t need to write it down. We just wish to know if you know the information.

1. Do you know how your parents met?
Y N
2. Do you know where your mother grew up?
Y N
3. Do you know where your father grew up?
Y N
4. Do you know where some of your grand-
parents grew up?
Y N
5. Do you know where some of your grand-
parents met?
Y N
6. Do you know where your parents were
married?
Y N
7. Do you know what went on when you
were being born?
Y N
8. Do you know the source of your name?
Y N
9. Do you know some things about what
happened when your brothers or sisters
were being born?
Y N
10. Do you know which person in your family
you look most like?
Y N
11. Do you know which person in the family
you act most like?
Y N
12. Do you know some of the illnesses and
injuries that your parents experienced
when they were younger?
Y N
13. Do you know some of the lessons that
your parents learned from good or bad
experiences?
Y N
14. Do you know some things that happened to
your mom or dad when they were in school?
Y N
15. Do you know the national background of
your family (such as English, German,
Russian, etc)?
Y N
16. Do you know some of the jobs that your
parents had when they were young?
Y N
17. Do you know some awards that your par-
ents received when they were young?
Y N
18. Do you know the names of the schools that
your mom went to?
Y N
19. Do you know the names of the schools that
your dad went to?
Y N
20. Do you know about a relative whose face
“froze” in a grumpy position because he or
she did not smile enough?
Y N