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Research Article

Is Indeed (Each) Unhappy Family - Unhappy in its Own Way?

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Abstract

Problem: Perceiving and experiencing of familiy systems by their individual members may significantly differ. It prompts the questions of reasoning and justification of efforts for generalizing the results of family research, as well as applicability of insights from non-clinical population in the work with clinical. For the work with alcoholic families, theoretically and empirically particular systems, it is of a special significance to search for resolution of the above mentioned dilemmas.

Aim: The aim of the research would be a study on whether there are continuity and compatibility in the ways that individual family members of alcoholic families and families from non-clinical population assess their own family functioning.

Methodology: 140 members of alcoholic families participated in the research as well as 145 members of families from a non-clinical population (father, mother and firstborn child) with a father as an identified patient in clinical sample. The Family Adaptability and Cohesion Evaluation Scales IV has been applied.

Results: The two groups of families in comparison gave significantly different grades in all the scales and subscales of the applied questionaire and moreover, grades of the members of alcoholic families showed a greater rate of dispersion. Still, after testing the effects of group and position by the two-factor analysis of variance, in order to show whether discrepancies between different positions in family were more dominant in the clinical than in the control group, no interactions of the two factors have been found.

Conclusions: Considerably higher heterogeneity of the grades assessing family functioning in alcoholic families does support the idea that each such a family presents a phenomenon of its own. Finding that noteworthy discrepancies between different positions were not determined when comparing the groups or that, if some existed, they were equally expressed in both groups, indicates a dimensional nature of family (dys)functionality.

Keywords: *Perceiving Family System; Individualized Approach to Family; Integration of Family System Perceptions; Qualitative and Quantitative Approach to Family; (Dis)Continuity of Family (Dys)Functionality*

Introduction

The findings of researching perception and experience of family functioning suggest substantial differences in the ways that individual family members perceive their own family systems, on several levels [1-6]: a) between the families of a clinical and a non-clinical population, b) between the families of a same subpopulation and c) between the individual members of each family. Such empirical status generates multiple theoretical and practical dilemmas but first of all those regarding epistemological and logical foundation of the research works with family.

A search for similarities and dissimilarities in perceptions of how families and their members functioning, as well as the attempts to comprehend and intergrate them, are interlocked with general tendencies towards individualization of the approach to the family. Thereby, to actualization of this approach has mainly contributed reafirmation of the importance of individual and individuality within a frame of family systems approach, efforts to overcome dichotomy of idiographic/nomothetic and aspirations to improve the understanding of the families with manifestations of dysfunctionalities.

Considering the ways of possible resolution of the cited dilemmas, *alcoholic families* [7] were observed as a phenomenon where an attempt to its deeper understanding might bring some relevant insights. This type of family achieves endurance in time, in spite of numerous conflicts on different levels of the system and multiple dysfunctional patterns [8]. A common metaphore for these systems is that they are „paradoxally stable in their instability". Therefore, hypotetically - if such an amount of stress, present in an alcoholic family that, despite it, keeps integrity for years or even decades, could be transfered into a family from a non-clinical context, the latter, optimal and functional, would in relatively short time succumb to the stress and desintegrate. So, they represent theoretically and empirically quite distinct systems regarding family functioning on whole as well as the individuals that make them. Thus towards them directed research interest might contribute to a better understanding of complex relation of family health and deviations from it.

The systemic approach and individualization of the approach to the family

Efforts of the theoreticians and practicioners of family systemic approach to revise certain postulates of the theory upon which they had based their work, in order to upgrade its comprehesivness, scientific foundation and practical sense, have lead to individualization of the approach to the family, amongst other [9].

The theory of systems has been a revolutionary conceptual novelty in comprehending and by that also aproaching individuals with various forms of psychological suffering, disturbances and disorders. Implementation of the theory in the area of mental health care had a goal to unite approaches to both individuals and society in explaining human behaviour and resulted in a development of family systems approach in the sixties of the past century [10]. Basic impulse was the observation from clinical practice that, whenever a recovered individual returned to the unchanged family system, there was a higher probability of recurrence of the same psychological problem that had initiated a treatment [11,12].

Systemic approach introduced many innovative concepts and psychotherapy methods and techniques. However, the manner of applying its core postulates[1] stirred up some critical discussions. The epistemology of this approach presumes a balance of interest in particularities and characteristics of individuals, on one side, as well as of couples and families observed as units, on the other. Still, due to focusing on interactions and relations, the individual gets marginalized [10].

Family Psychology, as a scientific discipline established during the eight decade of the last century [13], is based upon "returning" of the individual into the family environment, while respecting the wholesomeness of family at the same time. So, for its research subject it takes functioning of an individual on individual level, relations of individuals in dyadic relationship and in family on whole. In accordance with this, it deals with a complete spectrum of family functioning, ranging from optimal to dysfunctional, setting an accent on the prevention work. Its postulates were taken for a general frame of this statement.

Dichotomy of idiographic/nomothetic and individualization of approaching family

The approach to family on whole, as to a unique and inimitable entity, also contains a tendency towards overcoming of idiographic/nomothetic dichotomy [14], that deeply pervades the work with individuals as well as that with couples and families.

[1]"According to the systems theory the whole is more than the mere sum of its parts, and the interconnections between the parts add a specific and distinct quality and dimension to the whole" ([16], p. 253).

Black and Lebow metaphorically depicts the relationship between research and practice as an "unsuccessful marriage that lasts in time" ([15], p.10). They illustrate this by saying that each side has an essentially correct view, but their different worldviews hinder their communication. In the field of dealing with family, professionals were initially both researchers and practitioners. With the passage of time, the research methodology has become increasingly complex, which, among other factors, has led to the fact that clinical implications are becoming less and less clear. The refinement of the research methodology resulted in creation of various schools and models, which were, from the clinicians' perspective, less convincing than the previous, simpler research methods. Clinicians criticized the researchers' reductionism, rigidity, and neglect of individual traits, while researchers criticized the clinicians' limited empirical verification of what they do. Denying the importance, of research results and existing findings has its own notorious examples in practice, such as the group therapy for dealing with delinquents regardless of the empirical findings on the counter-productivity of the given environment for these clients [54,55]. Furthermore, in practice, Carl Whitaker's methods of confrontation and enactment have found their place in working with families with a schizophrenic member, despite the findings that the increase in emotional charge and the increase in their freedom of expression are predictors of schizophrenia relapse [15]. Finally, the psychometric perspective legitimizes its status in the eyes of practitioners as well as clients and the society, since it is viewed as something that could give psychotherapy the status of a legitimate and effective treatment of the defined conditions of certain couples and families [56].

Nomothetic perspective of researching family, including dealing with different levels of assesing family functioning (how is a family perceived and assesed by an individual, and how is it, at a level of collective grades, observed and assessed by a couple or a family), are of an undoubted practical importance [17]. Still, systematic examinations and attempts to integrate the received results in this area were insufficiently represented, while the findings of available researches indicate numerous difficulties in the trials for creating a complex picture of family functioning based upon assessments of its own units [18].

There are numerous empirical proofs of the objectively existing, strong and infuential corelations between behaviour of family members and of family on whole [19]. At the same time, the findings of the relevant researches with family point to a high level of mutual and internal group variabilities of perception of family system functioning, as in a clinical, so in a non-clinical population. Such findings instigate the questions a) is it possible to implement findings and insights from the work with the families of a non-clinical population into the work with those of a clinical one? b) to what extent are the attempts of integrating individual perceptions of a family system into a coherent entity at all possible? and c) is each and every family so unique and specific a phenomenon that any attempts of generalizing must be extremely debatable? At last, a question of the utmost importance is - does a family represent a sum of impressions, experiences and functions of its members or it represents something rather different by quality and quantity?

The Clinical Assessment Method [20] as a reasonable method of combining both dimensions - of theory and practice of clinical psychology. It is a term which is often equated with the process of implementing psychological measuring instruments for evaluation of behaviour or personality traits, isolating a particular behaviour and measuring it in order to predict future patterns. However, clinical evaluation is based on a different epistemological framework from the previously described, a psychometric one [20]. Its main goal is integration (as opposed to prediction), and the emphasis is on contextual understanding of individual data in the unit's totality (of a personality, or, in this case, of the dyad or entire family) which we observe and evaluate. Thus, the The Clinical Assessment Method is a series of procedures, regardless of their nature, which are carried out in order to improve the understanding of the client (dyad/family). In addition, the ruling principles at any stage of the The Clinical Assessment Method are concern for the welfare of a client and existence of a pre-formulated goal [20]. In planning and implementing clinical evaluation of a family, as opposed to clinical evaluation of an individual,

[2]Individuals or specific configurations such as dyads and triangulations in family systems.

additional dimensions are also included [10]. Understanding of the family is driven by a systemic paradigm. The object of observation and assessment are both the individual and the family as a whole. Because of this, concern about the welfare of the client becomes a very delicate issue, since in practice, the interests of the individual, i.e., the identified patient[3] and the family, are often at odds [57] and this is linked to defining the goal of the evaluation in the family setting, which is also often multiplied. It is determined by a perspective of the family member who defines it but different members of a family system may have diverse or even contradictory goals and consequently, such perceptions as well [21]. Take, for example, an alcoholic family - the family system initially aims to eliminate acute problems, i.e. physical violence of an alcoholic member. An alcoholic may in some way aim to maintain his authority in the family system, which was previously regulated by violence. A spouse who does not drink can aim to establish a non-violent relationship with an alcoholic, while at the same time maintaining their dominant role. Since children are often the "means" for maintaining the integrity of such families, parents can strive to keep the family together. Children, again, completely naturally, and as expected in terms of development, can have the goal of emancipating themselves and separating themselves from the family context. Therefore, we can ask a question - is the goal of evaluation the alcoholic's competencies for managing the family system or similar competences of the partner who does not drink? Or, is the goal of evaluation a level of supporting capacities of the family system, in relation to children leaving or staying? The way members see their family functioning will definitely depend on family positions and goals which the members strive for. Since the The Clinical Assessment Method offers a possibility to bridge the gap between nomothetic and idiographic, which has been deeply inlaid in our research, the research has been realized in accordance with the principles of this model.

(Dis)continuity of normal-patological and individualization of the approach to the family

The significance of individualization of the approach to the family is perhaps mainly reflected in the efforts for understanding a family in which is possible to recognize dysfunctioning in different segments of family functioning - starting with roles, through relations, up to the subsystems within a framework of family system - individuals, dyads and triangulations.

In order to attribute the status of distinctive entity to a dysfunctional family, according to the belief of the Family Psychology founding father, Luciano L'Abate, it is neccessary to uncover the answers to several key questions [22]:

- Has the assumption that "dysfunctional individuals in general grow up in dysfunctional families while functional individuals in general grow up in functional families" been disputed or overturned?
- Are the families with a dysfunctional member significantly different from those with all the members being "normal"?
- Is there a noticeable difference between the families whose members express various forms of psychopatology (e.g. a family with a member who displaying the symptoms of schizophrenia or major depression)?

L'Abate concludes that only had it been proven that dysfunctional individuals came from dysfunctional families and *vice versa*, would it be possible to unambiguously state the existance of continuity and connections between individual and family dysfunctioning.

Alcoholic families and (dis)continuity of normal-pathological

Alcoholic families as theoretically, practically and empirically often cited examples of a family dysfunction totality and have also been the starting points of many findings and observations that fundamentally challenged the relation of dysfunction between a family and its members.

[3]According to Minuchin [58], this is the member of the family who is "caring the symptom" in the name of whole system. Symptom can be assumed as system-maintaining and system-maintained device, or as the manifestation or expression of family disfunction.

A paradox of (dys)functioning of alcoholic families in totality and of the individuals that make them is visible already at the level of theoretical conceptualizations. According to Steinglass, alcoholic families are "...systems in which alcoholism and alcohol related behaviors have become central organizing principles around which family life is structured" [7]. This suggests that a drinking problem of one family member contaminates almost all aspects of family functioning and that alcoholism penetrates the family structure so deeply that its potential elimination represents a threat to stability of the whole system. Still, according to the same author, family strongly resists that. Most alcoholic families maintain integrity in time despite the continuous strain and/or many stressful and precarious situations.

Empirical side supports the point on a paradoxal stability of the fundamental instability of this type of family system. Firstly, from an occurance of the *toxicoman phase*[4] indicators of alcoholism, until commiting the family to a treatment, pass on average from 8,69 years for *inability of abstinence* up to 13 years for *tolerance drop* [18]. This means that the family in a way compensates the circumstance that the alcoholic stands on a treshold of apstinential syndrome or does express it every time when is unable to have an alcoholic drink, for almost nine years before turning to experts for help. Further, that progressive increase of sensibility to alcohol in alcoholics which is, among others, an indicator of organic lesions primerily on central nervous system and liver, exists in the family system up to 13 years before starting a treatment. When the families report for therapy, according to the theoretical postulates [7], it would be expected to encounter problems in all levels of functioning, especially regarding realization of roles, leadership and cohesiveness of those families. However, considering the observed efficiency in realization of family roles, members of the alcoholic families, in comparison with the families from a non-clinical population, do not report this as a more prominent problem in their own families [18].

Resilience concept [23] or the ideas embraced in the movement of positive psychology (Seligman and Csikszentmihalyi, 2000), additionaly distort the line normal-patological. The circumstance that dysfunctional families can yield the members with at least optimal if not even superior level of functioning in different spheres of living [24,25] does not contribute to a positive answer to one of the before mentioned key questions by L'Abate. On top of that, in a research conducted with a goal of defining psychological factors of living in alcoholic families [26] it was established that even the children from a non-clinical sample were not entirely free of problems, which was evident in more frequently expressed separation problems by the children from a non-clinical group than by the children from the alcoholic families. Regardless to psychological background of the received findings or numerous intervening socio-cultural variables, a general impression is that there is no clear line of distinction between family health and pathology, not even in the case of this much homogenous entities.

After all being said, individualization in approaching this subsample of the familes from a clinical population stands out as a possible way to understand the observed abberations. In that sense, it seem as efficient two practical steps. At first, deeper analyses of the registered discrepancies in evaluating family funtioning a) between individual members of the families (father-mother-child in clinical or non-clinical sample) and b) between the members of the families on the same positions of a clinical sample in comparison with a control group (e.g. fathers from clinical and non-clinical sample). Second step will be suggested model of integrating assessments by families into sensible units through empirical intersecting of positions of the interviewees and the groups to which they belong.

[4]Toxicoman phase is taken as a criterion of presence of the alcohol addiction [57]. and its characteristics are: tolerance drop - reaching the previous effect with ever lesser quantities of alcohol; loss of control over moderate drinking - consummation of one drink automatically leads to continued drinking until complete drunkenness; alcoholic amnesia - repeated partial or complete lack of memory in the periods of intoxication; inability of abstinence - attempting spontaneous drinking discontinuation, develops a "withdrawal syndrome" or abstinential syndrome, containing the signs of developed psychological and physical dependence - anxiety, tension, aggressiveness, body tremors, sweating, cramps and aches in entire body, with disorders of consciousness, possible fall into a coma and sometimes with lethal outcome.

Aim of the Study

The aim of this research has been the study on whether the way of assessing family system by its individuals creates an integrative assessment of family system in alcoholic families and families of a non-clinical population. In short, to examine the differences and/or similarities in the perception of variables of the applied model of family functioning.

Material and Methods

Subject

The subject of this research have been individual perceptions of the family systems. As a conceptual frame, Family Psychology has been chosen and the approach to the problem has been realized in accordance with the principles of The Clinical Assessment Method.

Sample

50 families have been included in the research, all of them involved in the systemic family therapy of alcoholism, with a father as the identified patient and another 50 families from a non-clinical population. In the course of sample construction, it was attempted that the families from a clinical sample and those from a control group be homogenous in the structure, age and educational attainment of their members. Questionarre survey included all the children over 12 in the familes, since it was the age limit which the author of the applied instrument quoted as a precondition for children in order to understand the statements from the questionairre [27]. The analysis included the assessments of firstborn children as well as the assessments of parents. The choice of firstborns in the families was determined by theoretically postulated psychological and social singularities of children, depending on their sibling position [60]. The choice of the children with identical sibling position had a goal to stabilize possible variability of results that might eventually arise from the fact that children, depending on their birth order in family, may differ in terms of conditions of family living in which they were brought up, resources they had available, complexity of family relations in which they were involved, by that also in characteristics of their own functioning. Mentioned differences are certainly important for the experience of a family system on whole.

The families from a clinical sample originated from seven representative institutions on the territorry of the Republic of Serbia and a corresponding number of the families from a control group were recruited from the same places of residence.

In this way, a sample was created with 140 interviwees from a clinical sample and 145 from a non-clinical. An average age of the fathers from the clinical group was 48,86 years (N = 50), mothers 46,04 (N = 50) and children 22,82 (N = 40). In the control group, an average age of the fathers was 48,88 years (N= 50), mothers 45,92 (N = 50), and children 23,06 (N = 45). In the clinical sample, out of 40 children, 45% were male and 55% female interviewees. In the non-clinical sample, there were 44,4% male and 55,6% female interviewees.

Instruments

In accordance with the chosen theme of analysis and display of results, the relevant records came from:

- The lists of basic socio-demographic datas - in compliance with the socio-cultural particularities of our area, as well as the needs of our research, a modified list of socio-demographic figures which is an integral part of the FACES IV questionairre.
- Questionairre of family rituals - a set of the questions constructed for the purpose of this research, with a goal of determinig whether alcohol has in deed become the central organizational principle of family living in the families of a clinical sample, in the function of triaging the families of a clinical sample to the families with alcoholism and alcoholic families [7].
- Scale of assesing a presence of abuse/addiction of alcoholism by Mini International Neuropsychiatric Interview, Version 5.0.0; M.I.N.I. 5.0.0 [61] - module for veryfing a presence of alcoholic addiction or abuse of the structured interview for assessment of axis I disorder for both valid clasifications - DSM-IV i ICD-10.

- Family Adaptability and Cohesion Evaluation Scales, Version IV - FACES IV [27] - based on David Olson's Circumplex model of marital and family systems. Central dimensions of the model are a) Cohesion - emotional interconnection between family members and b) Flexibility - quality and manifestations of leadership, organization, rules of negotiations and mutual relations. Six scales are created with aim to cover the full continuum of the basic dimensions. Disengaged and Enmeshed, unbalanced scales, were constructed to pinpoint more precisely representations of extreme values of Cohesion, as balanced scale, and unbalanced scales Rigid and Chaotic - for the extreme values of the balanced scale Flexibility. In this version of the questionaire were included the scale of Family Communications, regarding the positive communication skills existing on the level of dyadic relationships in family, as well as Family Satisfaction with family functioning defined as the level of expressed satisfaction of family members with family cohesion, flexibility and communication.

Data processing

The Leven's test equality of means was applied for the estimation of the dispersion of scores given by test subjects in the examined groups. According to the results of Leven's test, the significance of differences between the groups of families for analysed dimensions of family functioning was tested with the two-sample t-test or with the Welsh's unequal variance t-test. The two-factor analysis of variance considered the type and nature of the association of group affiliation (alcoholic families/non-clinical population) and family positions (father/mother/firstborn child) with selected measures of family functioning.

Results

The first step of the analysis, shown in table 1, was the assessment of whether members of alcoholic families differ among themselves with regard to their evaluation of selected aspects of family functioning. Levene's test shows a significant difference in the variance for Cohesion ($F = 22.413$, $p < .000$), Flexibility ($F = 16.158$, $p < .000$), Communication ($F = 38.315$, $p < .000$) and Satisfaction ($F = 25.546$, $p < .000$). Also, for Disengaged ($F = 29.008$, $p < .000$) and Chaotic ($F = 6.040$, $p = 0.015$). Participants' responses to Enmeshed ($F = 1.372$, $p = .242$) and Rigid ($F = .100$, $p = .752$) are characterized by homoscedasticity.

FACES IV	Sample	M	SD	Levene Statistic	df1	df2	p
Cohesion	CG	28.0000	6.99268	22.413	1	278	.000
	CS	30.8239	3.69646				
Flexibility	CG	23.7031	4.48332	16.158	1	278	.000
	CS	25.7676	3.10265				
Disengaged	CG	16.4609	5.48714	29.008	1	277	.000
	CS	13.7746	3.48938				
Enmeshed	CG	16.5547	4.76504	1.372	1	277	.242
	CS	15.0423	4.07879				
Rigid	CG	20.0625	4.13693	.100	1	277	.752
	CS	18.2676	3.84803				
Chaotic	CG	18.2969	5.71689	6.040	1	277	.015
	CS	16.2183	4.79526				
Family Communication	CG	39.0234	9.23232	38.315	1	277	.000
	CS	45.2042	5.44155				
Family Satisfaction	CG	33.9844	9.13157	25.546	1	268	.000
	CS	41.3380	6.10533				

Table 1: *The equality of variances for the clinical sample and control group on the FACES IV scales.*

CS: Clinical Sample; CG: Control Group.

In terms of mean measurement values, two groups of families, as shown in table 2, differed significantly on all scales of the FACES IV. Thus, observing the basic dimensions of the Circumplex model, members of the alcoholic families reported significantly lower Cohesion or a weaker mutual emotional connection between family members (Wilks' λ = .938, F = 17.682, p < .000). They also reported on significantly lower Flexibility, i.e. they assigned significantly lower scores to quality and manifestations of leadership and organization, rules on mutual relationships and negotiations within their families (Wilks' λ = .932, F= 19.666, p < .000). In terms of the unbalanced scales of the questionnaire, members of alcoholic families tend to assign higher scores to their family functioning in those scales that address extremity, i.e. imbalance in family functioning. Therefore, they score higher in Disengaged (Wilks' λ = .919, F= 23.497, p < .000) and Enmeshed (Wilks' λ = .971, F= 7.892, p < .005), as measures of extreme values of the Cohesion scale, as well as in Chaotic (Wilks' λ = .962, F= 10.543, p < .001) and Rigid (Wilks' λ = .952, F= 13.640, p < .000), within the Flexibility scale. Members of alcoholic families give considerably lower scores to Family Communication (Wilks' λ = .854, F= 45.948, p < .000), i.e. report less developed overall communication skills of the family. They also report a lower degree of Satisfaction (Wilks' λ = .813, F = 61.569, p < .000) in terms of the level of cohesion and flexibility, as well as the quality of communication within the family.

FACES IV	Sample	M	SD	Wilks'Lambda	F	df1	df2	p
Cohesion	CG	28.0000	6.99268	.938	17.682	1	268	.000
	CS	30.8239	3.69646					
Flexibility	CG	23.7031	4.48332	.932	19.666	1	268	.000
	CS	25.7676	3.10265					
Disengaged	CG	16.4609	5.48714	.919	23.497	1	268	.000
	CS	13.7746	3.48938					
Enmeshed	CG	16.5547	4.76504	.971	7.892	1	268	.005
	CS	15.0423	4.07879					
Rigid	CG	20.0625	4.13693	.952	13.640	1	268	.000
	CS	18.2676	3.84803					
Chaotic	CG	18.2969	5.71689	.962	10.543	1	268	.001
	CS	16.2183	4.79526					
Family Communication	CG	39.0234	9.23232	.854	45.948	1	268	.000
	CS	45.2042	5.44155					
Family Satisfaction	CG	33.9844	9.13157	.813	61.569	1	268	.000
	CS	41.3380	6.10533					

Table 2: *Means and standard deviations for the clinical sample and control group on the FACES IV scales, with the appropriate test of the difference between two sample means.*

When effects of the group and the position were tested by the two-factor analysis of variance (Table 3), in order to show whether the differences between different family positions were more pronounced in clinical sample than in the control group, the analysis showed that there was a major effect of group factor throughout all scales, which is in line with the results of the comparison of the mean values. The effect of the position was found only on the Disengaged (F = 2.842, p = 0.06 and ηp2 = 0.021) and Rigid (F = 3.248, p = 0.04 and ηp2 = 0.024) scales. In addition, children in the clinical sample, unlike their parents, reported a higher degree of Disengagement (Mc[5] = 18.0833)

[5]Mc - mean value for children

of family members in mutual relations and family life in general, i.e. they reported a more pronounced emotional distance. Mothers (Mm[6] = 15.5957), compared to fathers (Mf[7]= 16.0667), have expressed this as a less pronounced problem. In the control group, the children also reported a higher level of Disengagement (Mc = 14.2000), while mothers' estimates were positioned between the scores given by children and those given by fathers, closer to the scores given by their children (Mm = 13.8542 and Mf = 13.3061). According to the scores on the Rigid scale, fathers from the clinical sample mostly view their family systems as rigid and non-flexible (Mf = 20.8889), mothers do so to a lesser degree (Mm = 20.0426), while the children view this issue as a significantly less pronounced problem (Mc = 19.0556). In the control group, fathers also view their family systems as more rigid (Mf = 19.0204) than their wives (Mm = 17.8750) and children (Mc = 17.8667), whose scores on this scale are similar. The interaction of the two factors was not found for either the Disengaged scale (Figure 1) or the Rigid scale (Figure 2). Therefore, no significant differences between various positions were established between groups or, if they did exist, they were equally expressed in both the clinical and control groups.

Source	FACES IV Dimension	df1; df2	F	p	Partial Eta Squared
Group	Cohesion	1; 264	17.564	.000	.062
	Flexibility	1; 264	19.179	.000	.068
	Disengaged	1; 264	25.587	.000	.088
	Enmeshed	1; 264	7.751	.006	.029
	Rigid	1; 264	12.884	.000	.047
	Chaotic	1; 264	10.959	.001	.040
	Family Communication	1; 264	47.193	.000	.152
	Family Satisfaction	1; 264	61.523	.000	.189
Position	Cohesion	2; 264	.922	.399	.007
	Flexibility	2; 264	.011	.989	.000
	Disengaged	2; 264	2.842	.060	.021
	Enmeshed	2; 264	.983	.376	.007
	Rigid	2; 264	3.248	.040	.024
	Chaotic	2; 264	.587	.557	.004
	Family Communication	2; 264	1.649	.194	.012
	Family Satisfaction	2; 264	1.350	.261	.010
Position * group	Cohesion	2; 264	.199	.820	.002
	Flexibility	2; 264	.044	.957	.000
	Disengaged	2; 264	1.221	.296	.009
	Enmeshed	2; 264	.631	.533	.005
	Rigid	2; 264	.341	.711	.003
	Chaotic	2; 264	1.435	.240	.011
	Family Communication	2; 264	.327	.721	.002
	Family Satisfaction	2; 264	.081	.923	.001

Table 3: *The two-factor analysis of variance - the effects of group (clinical sample/control group) and position (father, mother, child) on the FACES IV scales.*

[6]Mm - mean value for mothers

[7]Mf - mean value for fathers

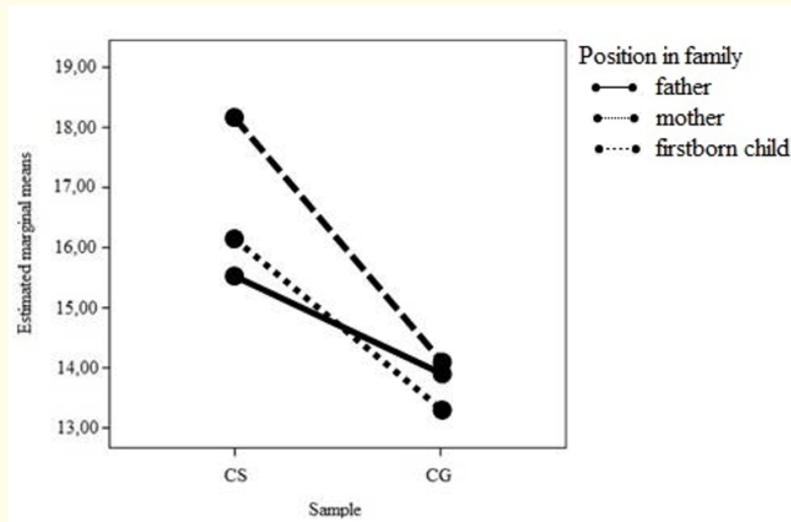

Figure 1: *Estimated marginal means of disengaged.*

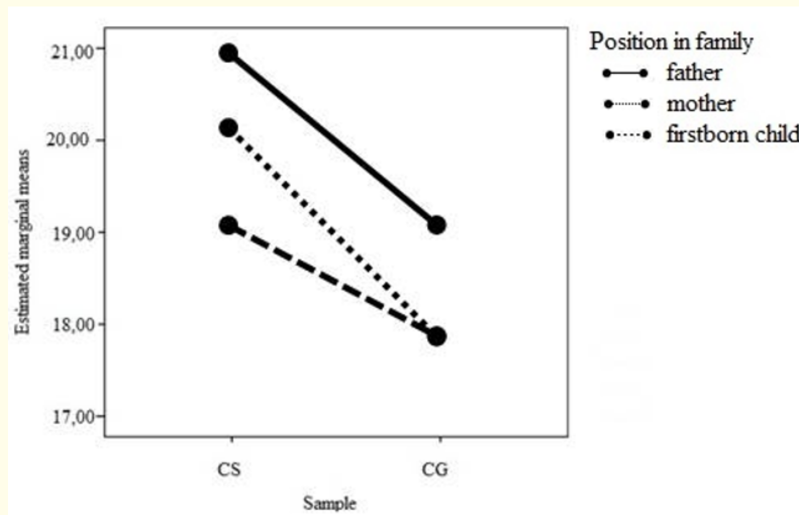

Figure 2: *Estimated marginal means of rigid.*

Discussion

One of the key characteristics of alcoholic families in this research is the presence of significant differences among individual members in the way they see their families. Thus, with the exception of scales Enmeshment and Rigid, members of alcoholic families have exhibited greater variability in responses when reporting on other aspects of the Circumplex model. Furthermore, the analysis of score results for unbalanced scales indicates that members of alcoholic families generally exhibit irregular functioning. Some of them see their families as extremely rigid and inflexible in terms of rules and relationships, and some as extremely chaotic in terms of who makes decisions, who

participates in which activity, who speaks, and who retreats. Also, some members of these families see their family as enmeshed, without sufficient personal space and options for developing individualism, while some report on a marked mutual psychological and emotional distance. This much diversity in evaluation further supports the fact that each alcoholic family is a singular phenomenon, and that each is "unhappy in its own way". This is not an unexpected finding since, depending on the disorder/illness of a family member, i.e. as the complexity of dysfunctional member patterns increases, the variability of scores assigned to family functioning increases as well [28-32].

The significant differences established between respondents from the perspective of their positions in the family have their own empirical component and reflection, as well as practical implications. First of all, if we observe the empirical status of dimensions on which the effect of position factors is determined, the results of validation studies reflect a high degree of variability with regard to how the respondents perceive and evaluate them. The lowest coefficients for internal consistency are associated with the scale for Disengaged [33,34]. The situation with the Rigid is similar, where coefficients of internal consistency range around 0.7 [35-37]. When it comes to practical work with families, it is important to note that children in both groups, compared with their parents, report a greater degree of non-involvement of individual members in mutual relations and family life in general, i.e. a more pronounced emotional distance. At the same time, the position of parents varied depending on the sample. In the clinical sample mothers virtually denied this form of discord in the family, while fathers were somewhere in between. Most of the fathers in the non-clinical sample experienced their family as optimally united, and the mothers' perception was more similar to their children than to their husbands. When it comes to the rigidity of family patterns and transactions, fathers in both groups are more inclined to emphasise it, while children do not recognize this as a feature of their own family. Therefore, it is the perception of mothers that shows a trend towards differentiating - in alcoholic families it is somewhere "half way" and in the control group, the evaluation of mothers again corresponds to that of first-born children. These findings raise new questions. For example, are the findings merely reflecting an association between what is desired and what is real, or between what is needed and what is achieved? Do the first-born children in this study, from the perspective of their developmental characteristics[8] [38], actually express a need to set boundaries by emphasizing distance a priori and through drawing attention to the excessive rigidity in the behaviour of members of their family, i.e. parents? Do fathers, when they indicate rigidity in family systems, actually present their own parenting attitudes and styles [39]? Do mothers in the clinical specimen, since they generally make significant efforts to maintain the integrity or image of functionality of a given system [40, 41], have a "scotoma" for the emotional and psychological distance of family members? Does the fact that children's and mothers' rates of family functioning in the control group are closer to each other point to developmental characteristics of the respondents or a cultural pattern [42], or both of these? What does it mean that parents from the clinical sample see their families as more rigid - is it that they endeavour to establish more rigorous control [43] or that they are communicating the experience of pressure, as one of the therapeutic demands is (re)integration family members into each other's life [8]? These questions are subjects in themselves, requiring separate research, with cultural variables as an important factor in determining results [44]. However, the differences between the clinical sample and the control group are only at the level of a trend. The assumption, that the ways in which individual perceptions fit into the complex picture of family functioning might be significantly different between these two groups of families, has not been confirmed. Indirectly, this also points to the fact that there is no specific pathology *per se*, but rather that patterns of dysfunction vary with regard to the extensiveness of their presence, and the skill of family members to adapt to them.

The complexity of established relationships in alcoholic families and multiple levels of paradoxes of results are also reflected in the results of the study where the authors found that family cohesiveness simultaneously showed both a positive direct effect and a negative indirect effect on depressive symptomatology in children of alcoholics [29]. This is partly explained by one of the basic postulates of the Circumplex model of marital and family relationships that balanced levels of functioning are most optimal for the family, i.e., the

[8]The predominant age group in the category of first-born children were adolescents.

middle ranges of the dimensions of Cohesiveness and Flexibility, while extremes, operationalized using unbalanced scales, are considered harmful [27,45,46]. However, explanations of the (in)direct nature of impact are not available in the light of the curvinilear nature of those dimensions.

From the perspective of possible variability of the results, an also important fact is that an established and observed system of patterns and relationships in family is not absolute and unchangeable. The results of a Polish study on 124 alcoholic families suggest that, after 10 weeks of psychotherapy prompted by the husband's alcohol abuse, alcoholic families become increasingly similar to family members from the non-clinical population [28].

Conclusion

The described divergences in the way alcoholic families view their family systems from the theoretical postulates and the available research results, but particularly the numerous variability levels of the subjects' assessments, prove the complexity of measuring such a perplexing phenomenon - the family.

The idiographic approach is of indisputable clinical and therapeutic importance. Although, as such, it justifies its existence in practice, the departure a nomothetic position does not seem to be a satisfactory solution, since practitioners would not know how effective the realization of their tasks is, if their work was not properly psychometrically validated.

Therefore, the dispersion and deviation of the obtained results can be considered more as a base for defining points, refining and enhancing the methodology of the research approach to the family, where the basic postulates of Family Psychology are identified as the key postulates:

- Emphasizing the idea of origin in a systemic approach, that the family is something beyond the sum of its parts;
- Allocating equal importance to a subjective experience of an individual in creating a complex picture of family functioning.

Viewed from the perspective of practical work with families, discrepancies in the results emphasize the importance of:

- Individualization of approach to families - unexpectedly more frequent separation problems among children from the non-clinical group, or multiple discrepancy in this study of the acquired/reflected characteristics of alcoholic families from dominant teachings in the field of addictology, reveal that openness of professionals to the particularities of each individual family is necessary;
- The notion that the nature of family (dys)functionality is dimensional - the mentioned problems in the non-clinical group and the lack of confirmation for the initial assumption that members of alcoholic families view their families differently than the way that members of the non-clinical population view theirs, induce the continuity of family health and pathology - consequently, no matter how a specific problem exists, to a lesser or a greater extent, in "normal" families as well, alcoholic families have their own strengths and resiliencies; also, the results indicate that alcoholic families are not a secluded and incomprehensible world in themselves - they can be described using insight gained from working with non-clinical families;
- The necessity of engagement at different levels of prevention while working with families - as preventive actions seem justified for the non-clinical population as well, the scope of action expands and the number of potential beneficiaries increases, thus gaining importance for transdisciplinary integrative approach [23].

In addition, the interactive relation and the continuous exchange of the idiographic and the nomothetic, practice and research, creates a space for mutual development and enhancement. A comprehensive approach to families entails much more than strictly trying to observe regularities in certain aspects of the behaviour of members of these families, with the aim of anticipating, correcting and controlling them. Its essence is to approach the realities of these families, to examine their family life in a way that members of these families see it, and to create a family mosaic, with equal respect for the point of view of each member.

In line with everything presented, it is obvious that the The Clinical Assessment Method, as a meaningful combination of theoretical and practical dimensions of clinical psychology, offers the possibility to bridge the gap between the nomothetic and the idiographic, which has deeply permeated research.

Finally, results of this research suggest two key conclusions. First, it is scientific acceptable and reasonable to apply insights from nonclinical populations in clinical context. Second, there is unconditional need for respectable attention to the individuality of every single family, very similar to the principles of individualised or personalised approach in individual psychology.

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