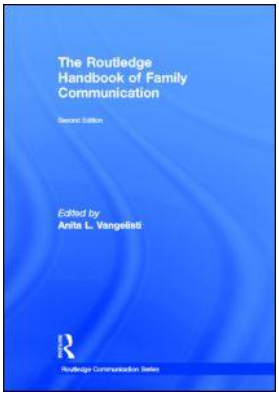

The Routledge Handbook of Family Communication

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Mental Health

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Mental Health

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It would be nearly impossible to understand any mental health problem without some appreciation of the family processes that predated or aggravated the disorder. Scientists and clinicians are increasingly recognizing the role of family interaction patterns in the cause, course, and treatment of mental health problems. Toward that end, a great deal of sophisticated and ground breaking research has been conducted on family communication patterns and processes that are associated with mental health problems. The origins of this research and theorizing are far older than the field of communication itself and show just how consequential family communication can be to the mental health of family members. This research also shows how important family processes can be distorted and corrupted by the mental health problems of those in the family system. Perhaps due to the nature of the populations studied in this body of research, most studies on family communication and mental health are conducted by people whose formal employment may be outside of the communication field, but whose methods, constructs, and scholarship fall squarely within family communication research.

Research and theory on family interactions and mental health make up part of the larger interpersonal paradigm in mental health (see Horowitz & Strack, 2010; Segrin, 2001 for reviews). According to this perspective, both the maintenance and disruption of mental health are thought to be strongly influenced by the nature of one's interpersonal relationships. Naturally, family relationships occupy a prominent position in the interpersonal landscape of most individuals. As the research reviewed in this chapter will show, there is a strong connection between family interaction processes and family members' mental health.

In the service of brevity, the mental health problems featured in this chapter are only described in rudimentary form. Interested readers can find more detailed descriptions of these problems in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edn, text revision) (American Psychiatric Association, 2000). Also, this chapter excludes analysis of substance use disorders as that is the topic of Chapter 28, and child abuse and neglect as major risk factors for a multitude of mental health problems as that is the topic of Chapter 29 of this volume.

Brief History of Research and Theory on Family Interaction and Mental Health

The recognition of dysfunctional family processes as both causes and consequents of mental health problems dates back well over 100 years. Freud (1966) wrote about the role

of both parent–child interactions (family of origin) and marital problems (family of orientation) in precipitating mental health problems. The neo-Freudian Harry Stack Sullivan (1953) greatly expanded the thesis that family and other interpersonal relationships played a key role in maintaining or disrupting mental health. Publication of the book, *Pragmatics of Human Communication* (Watzlawick, Bavelas, & Jackson, 1967) was a milestone in scholarly inquiry into family communication and mental health. Communication scholars revered the book for its insightful conceptualizations of interpersonal communication processes. Clinical psychologists and psychiatrists were intrigued by the seductive hypothesis that double bind family communication played a vital role in schizophrenia. The "double bind hypothesis" was never empirically validated and was quickly abandoned as an explanation for schizophrenia. However, it was perhaps the crest of a wave of inquiry into family interactions and mental health problems, specifically schizophrenia, that was being aggressively pursued in the 1950s and 1960s. Since then, it would be fair to say that research and theorizing on family interactions and mental health has grown exponentially with each passing decade, and family processes are now recognized as major factors in the development, course, and treatment of many different mental health problems.

Pathogenic Family of Origin Interactions

At birth, the human psyche exists only in primitive form. Throughout the first two decades of life extraordinary development occurs in cognition, emotion regulation, language, and personality. The family of origin is the crucible of this psychosocial development. Unfortunately, some families exhibit and enact pathogenic processes that not only inhibit this development, but that damage the psychological well-being of the child. In some cases, these destructive family processes have relatively immediate consequences and manifestations in child mental health problems. However, the effects of some other insidious family processes build gradually over time, exhibiting a sleeper effect that is ultimately manifest in adult mental health problems. In the sections that follow, several distinct and dysfunctional interaction patterns in the family of origin are discussed for their form and function in disrupting mental health.

Parental Affectionless Control

One particularly noxious parent–child interaction pattern that has been linked to numerous mental health problems is often referred to as "affectionless control." This is a combination of parental overprotectiveness or excessive control coupled with low care, sometimes to the point of neglect. Affectionless control is a paradoxical pattern of behavior in that the parent seeks to strictly control the child, often without rationale, while at the same time showing little affection or genuine concern for the child's well-being.

Depression is one of the most pervasive mental health problems in the world. It is an affective disorder marked by sad effect, anhedonia (inability to experience pleasure), feelings of guilt and worthlessness, and numerous somatic symptoms (e.g., sleep and appetite disturbance). Low parental care coupled with overprotection is a common family of origin profile reported by people with depression (Parker, 1983; Sheeber, Hops, & Davis, 2001). Parker found depressed outpatients to be 3.4 times more likely than matched control subjects to have at least one parent who exhibited affectionless control. Others have found that exposure to affectionless control as a child is associated with a fivefold increase in the likelihood of having major depressive disorder 20 years

later (Pilowsky, Wickramarantne, Nomura, & Weissman, 2006). Parental affectionless control appears to impart risk for depression in offspring by creating maladaptive cognitive patterns such as low self-esteem, self-criticism, and a self-blaming and defeating inferential style (Alloy, Abramson, Smith, Gibb, & Neeren, 2006). That is to say that children internalize this experience and it influences the way that they think about themselves and their world in such a way as to promote subsequent depression.

Presently, the American Psychiatric Association recognizes two categories of eating disorders as mental health problems, namely anorexia nervosa and bulimia nervosa (American Psychiatric Association, 2000). People with anorexia nervosa refuse to maintain an appropriate body weight and often have an intense fear of gaining weight, coupled with a distorted body image. Bulimia nervosa is defined by recurrent episodes of uncontrolled binge eating, inappropriate compensatory behaviors to control weight gain (e.g., self-induced vomiting), and an undue influence of body shape and weight on self-evaluations. Both concurrent and retrospective analyses point to affectionless control as a prominent feature of the family of origin of people with eating disorders (e.g., Latzer, Hochdorf, Bachar, & Canetti, 2002). For example, lack of parental care (Webster & Palmer, 2000), excessive parental overprotectiveness and intrusiveness (Rorty, Yager, Rossotto, & Buckwalter, 2000), alienation and detachment between mother and daughter (Cunha, Relvas, & Soares, 2009), and excessive parental control (Wonderlich, Ukestad, & Perzacki, 1994) are features of the family environment that go hand in hand with eating disorders. The paradox of affectionless control is nicely illustrated in findings showing that parents of anorexia patients were simultaneously more nurturing and comforting but also more ignoring and neglecting of their daughters in comparison to parents of healthy controls or bulimia patients (Humphrey, 1989). It is entirely reasonable to presume that the affectionless control parent–child interaction pattern has teleological significance in eating disorders. Eating disorders are often hypothesized to be a covert expression of the struggle for control between the patient and the overcontrolling parent.

In addition to depression and eating disorders, parental affectionless control also appears in the family background of people with certain personality disorders. One such example is borderline personality disorder. The core features of this mental health problem involve instability of interpersonal relationships, effect, and self-image. People with borderline personality disorder exhibit intense and variable mood, combined with more generally aberrant and aloof behavior, excessive daydreaming, a dissociated self-image, frantic efforts to avoid abandonment, impulsivity, suicidal behavior and threats, feelings of emptiness, and problems with anger control. Poor maternal and paternal caring, to the point of neglect, is often found in the family of origin background of those with borderline personality disorder (Nordahl & Stiles, 1997). This lack of parental caring is often coupled with a greater overprotectiveness (Links, 1992) similar to that reported by other psychiatric groups. The lack of parental care can be pronounced to the point of attacking and rejecting behavior from the parent to the child (Stern, Herron, Primavera, & Kakuma, 1997). Parental affectionless control has also been implicated in histrionic personality disorder. People with histrionic personality disorder exhibit a pervasive pattern of excessive emotionality and attention seeking. Their social interactions are characterized by inappropriately seductive or provocative behavior, rapidly shifting and shallow emotions, excessively impressionistic speech that is lacking in detail, and self-dramatization. Research has shown that parental overprotection coupled with low parental care is prevalent in the family backgrounds of people with cluster B personality disorders (i.e., antisocial, borderline, histrionic, and narcissistic) (Nordahl & Stiles, 1997). Related

family processes that have been linked to histrionic personality disorder include high achievement orientation and high levels of parental control (Baker, Capron, & Azorlosa, 1996).

Affectionless control is extraordinarily corrosive to the fragile and developing psyche of a child. Adults who exhibit this pattern of parenting behavior are undoubtedly struggling with a pathological approach-avoidance conflict and have failed to effectively bond with their child in a way that allows for emotional support and availability. Affectionless control may confuse children and leave then wanting and disconnected from the security that is ordinarily found in a parental figure. Consequently a variety of mental health problems (e.g., depression, eating disorders, personality disorders) ensue. The common denominator of these particular problems is a less than favorable view of the self. This negative self-image, along with the efforts to compensate for it that are expressed in symptoms of these mental health problems, is cultivated from an early age by the intrusive and overcontrolling parent who otherwise fails to provide for the emotional needs of the child.

Family Adaptability and Cohesion

Systems-oriented researchers have emphasized adaptability and cohesion as two dimensions of family relationships that are crucial to healthy family functioning, provided that neither are too extreme (Olson, 2000). Adaptability refers to the family's ability to alter its power structure and roles to meet developmental demands and external stressors. Cohesion reflects the family's emotional bonding and sense of internal connection. Communication is the means by which families both express and adjust these two important processes. Extreme, and especially low, levels of adaptability and cohesion represent a profile of family dysfunction in which the atmosphere is ripe for offspring mental health problems.

People with eating disorders will often report low levels of cohesion in their family of origin (e.g., Latzer, Hochdorf, Bachar, & Canetti, 2002; Waller, Slade, & Calam, 1990). Although low family cohesion is often reported by young people with eating disorders as well as their parents (e.g., Waller et al., 1990), eating disordered children give lower ratings to their family's cohesiveness than their parents do (Hoste, Hewell, & le Grange, 2007). Regardless of which family member's perception is actually "correct," the fact that the parent and child with an eating disorder differ in their view of the family's cohesiveness says something in itself about these family relationships. Investigations of family adaptability in eating disorders have yielded less consistent results than those of cohesion. Some evidence indicates a negative association between family adaptability and symptoms of eating disorders (e.g., Vidovic, Jures, Begovac, Mahnik, & Tocilj, 2005; Waller et al., 1990). However, other investigations revealed more chaos, less organization, more inconsistent discipline, greater role reversal, and more poorly defined boundaries in families of girls with eating disorders or symptoms of eating disorders (e.g., Ross & Gill, 2002; Rowa, Kerig, & Geller, 2001). All of these patterns are suggestive of excessive adaptability. As in the case of cohesion, parents of young women with eating disorders do not feel that boundary violations are a problem in the family, in sharp contrast to perceptions of their daughters who readily report boundary problems (Rowa et al., 2001). In most studies, people with eating disorders seem to have been raised in a family that is marked by extreme levels of adaptability (either too much or too little), indicating potentially detrimental family relations.

Very low or very high levels of family cohesion, to the point of enmeshment, may also predispose people to develop depression (Jewell & Stark, 2003). Children in families with low cohesion often do not feel connected to, or cared for by, their parents. Low family cohesion has been documented as a particularly powerful predictor of adolescent depression in African American families (Herman, Ostrander, & Tucker, 2007). At the other extreme, in enmeshed families the emotional well-being of the parent and child are so strongly linked that issues that are upsetting to a parent invariably upset and distress the child. In some families enmeshment is expressed in the form of co-rumination (i.e., extensively discussing, rehashing, and speculating about problems), and this communication behavior is associated with increased symptoms of depression in adolescents (Waller & Rose, 2010).

Extreme family adaptability or cohesion are each associated with a number of other offspring mental health problems. These include social anxiety (Peleg-Popko & Dar, 2001), schizophrenia (Phillips, West, Shen, & Zheng, 1998), and the development of personality disorders (Gontag & Erickson, 1996). In some cases, the presence of a child with a significant mental health problem could alter the family's adaptability and cohesion. At the same time there is a compelling rationale, informed by both theory and empirical results, indicating that when these vital family processes reach extreme levels, child mental health deteriorates.

Communication Deviance

Communication deviance is a family interaction pattern that has been uniquely linked to the onset and course of schizophrenia. Schizophrenia is a formal thought disorder characterized by bizarre delusions, hallucinations, grossly disorganized or catatonic behavior, inability to initiate and persist in goal-directed activity, affective flattening, and impoverished and disorganized thinking evident in speech and language behavior. Early research on family interaction and schizophrenia revealed that patients' families often exhibited odd and unfocused styles of interacting with each other in which they experienced difficulty establishing and maintaining a shared focus of attention through their discourse (Miklowitz, 1994; Wynne, 1981). Topics of conversation will often drift or abruptly change direction with a lack of closure. Such interactions are marked by a blurred focus of attention and meaning. This characteristic style of family communication has been labeled "communication deviance" (Singer, Wynne, & Toohey, 1978). Wynne theorized that people learn to focus their attention and derive meaning from external stimuli through their interactions, particularly with parents, during the early years of life (Wynne, 1981). Odd and deviant styles of communication among the parents were presumed to interact with biological predispositions to contribute to thought and communication disturbances in children who were unable to relate to, and understand, their parents.

Communication deviance is often assessed through analysis of discourse during family problem solving discussions (e.g., Velligan, Funderburg, Giesecke, & Miller, 1995; Velligan et al., 1996). This technique, referred to as interactional communication deviance (ICD), codes the family's discourse into categories such as *idea fragments, contradictions and retractions,* and *ambiguous references.* A complete index of the categories and their definitions is provided in Table 31.1.

Communication deviance is more prevalent among parents of schizophrenia patients than it is in parents of either nonschizophrenic patients or healthy controls (e.g., Miklowitz, 1994; Subotnik, Goldstein, Nuechterlein, Woo, & Mintz, 2002). This unusual

Table 31.1 Interactional Communication Deviance Scoring System

ICD Code	*Definition*	*Examples*
Idea fragments	Speaker abandons ideas or abruptly ends comments without returning to them	"But the thing is as I said, there's got . . . you can't drive in the alley."
Unintelligible remarks	Comments are incomprehensible in the context of conversation	"Well, that's just probably a real closing spot."
Contradictions or retractions	Speaker contradicts earlier statements or presents mutually inconsistent alternatives	"No, that's right, she does."
Ambiguous references	Speaker uses sentences with no clear object of discussion	"Kid stuff that's one thing but something else is different too."
Extraneous remarks	Speaker makes off-task comments	"I wonder how many rooms they have like this?"
Tangential inappropriate responses	Non sequitur replies or speaker does not acknowledge others' statements	Patient: "Sometimes I work on the back yard." Mother: "Let's talk about your schoolwork."
Odd word usage or odd sentence construction	Speaker uses words in odd ways, leaves out words, puts words out of order, uses many unnecessary words	"It's gonna be up and downwards along the process all the while to go through something like this."

Source: Adapted from Miklowitz et al. (1991). Copyright 1991 by the American Psychological Association.

form of family communication can also predict the onset of schizophrenia among young people who have yet to fully develop the disorder (Goldstein, 1987). In one such study of families with a moderately disturbed teenager, high communication deviance in the parents was strongly associated with the appearance of schizophrenia-spectrum disorders in some of the family offspring at a 15-year follow-up (Goldstein, 1985). In a similar study, disturbed high-risk adolescents were followed over a period of five years (Doane, West, Goldstein, Rodnick, & Jones, 1981). By the end of the study, approximately 10 percent of those whose parents who were low or intermediate in communication deviance went on to develop schizophrenia, whereas 56 percent of those whose parents were high in communication deviance developed schizophrenia. Family communication deviance also appears to influence the course of schizophrenia. For example, Velligan et al. (1996) followed a group of schizophrenia patients and their parents for one year. During the study, slightly over 50 percent of the patients had experienced a relapse. Parental communication deviance at the time of the patient's discharge was significantly higher in the families of those who relapsed versus those who did not. As it turns out, the parents of those patients who relapsed exhibited a dramatic increase in their communication deviance over the course of the study. This investigation indicates that returning to a home with high communication deviance will increase the likelihood of relapse.

Parental communication deviance functions as a type of stressor that affects the course and outcome of schizophrenia. When parents' communication is particularly amorphous and peculiar, children may become confused and uncertain about even basic and fundamental social realities. This confusion undoubtedly has functional significance

in the course of the schizophrenia as it is so central in the constellation of symptoms that make up the disorder. The discourse of communication deviance raises substantial questions about parents' own mental health. It is therefore understandable that when discharged into the care of such individuals, their offspring remain at risk for future relapse.

Expressed Emotion

Family expressed emotion (EE) is a pattern of criticism, overinvolvement, overprotectiveness, excessive attention, and emotional reactivity, usually communicated by parents toward their children, who are at risk as a result of the behavior. EE is assessed through the frequency of critical remarks, degree of hostility, and the degree of emotional overinvolvement expressed by a family member during an interview or family interaction. High family EE is a feature of several different mental health problems.

Perhaps the earliest research on family EE and mental health was conducted in the context of schizophrenia. EE was conceptualized as a combination of several behavioral characteristics: intrusiveness, anger and/or acute distress and anxiety, overt blame and criticism of the patient, and an intolerance of the patient's symptoms (Vaughn & Leff, 1981). One of Vaughn and Leff's early studies revealed that patients who returned to a home with high EE relatives had a nine-month relapse rate of 51 percent, whereas only 13 percent of those who returned to a low EE family relapsed (Vaughn & Leff, 1976). A review of 25 studies on family EE indicated a 50 percent relapse rate, over a period of 9–12 months, among schizophrenia patients discharged to a high EE family, but only 21 percent among those with low EE relatives (Bebbington & Kuipers, 1994). These findings indicate that the odds of relapse are increased by about 2.5 times for those patients discharged to high versus low EE relatives. In addition to being a useful and reliable predictor of relapse, EE may also be fruitfully understood as a familial risk indicator for schizophrenia (Miklowitz, 1994). Even people with no history of schizophrenia are at elevated risk for developing the disorder if reared in an environment characterized by high EE. In each case one could interpret the family EE as a stressor that promotes or exacerbates symptoms.

High family EE has also been implicated in bipolar disorder. The essential feature of bipolar disorder is an oscillation between manic and depressive affective states. A manic episode involves the experience of inflated self-esteem or grandiosity, minimal sleep, excessive and pressured speech, flight of ideas, inability to focus attention, distractibility, psychomotor agitation, and poor judgment that often takes the form of risky behaviors. Naturally, depressive episodes have most of the features of major depressive disorder. As with schizophrenia, family EE is a risk factor for relapse into bipolar episodes. Relapse rates for bipolar patients who return to high EE households have been found to be as high as 92 percent over the course of two years, compared to only 39 percent among those who returned to low EE households (Miklowitz, Simoneau, Sachs-Ericsson, Warner, & Suddath, 1996). The mean duration to relapse was only 34 weeks for those returning to high EE households compared to 52 weeks for those who lived in a low EE environment (Miklowitz et al., 1996). High EE parents of adolescents with bipolar disorder also report lower adaptability and cohesion, and higher conflict in the family environment than low EE parents (Sullivan & Miklowitz, 2010) which could also explain the ill effects of this family interaction style. It should also be noted that family EE tends to be a better predictor of depressive than manic symptoms, and can provoke

symptoms when it comes from caregiving parents or a spouse (Miklowitz & Johnson, 2009).

Family expressed emotion appears to also be an important family process in the etiology and course of eating disorders (e.g., Hedlund, Fichter, Quadflieg, & Brandl, 2003). In their examination of some of the core features of EE, Kyriacou, Treasure, and Schmidt (2008) found emotional overinvolvement in 60 percent of the parents of anorexia nervosa patients, in contrast to 3 percent of control parents. They also found comparable rates of high criticism at 47 percent versus 15 percent for parents of patients versus controls, respectively. Maternal EE during family interactions with eating disordered patients is a powerful predictor of patients' eventual outcomes and responses to therapy (van Furth et al., 1996). Mothers' openly critical comments during a family interaction assessment were a better predictor of patients' outcomes than a host of other predictors such as body weight prior to onset of the disorder, duration of illness, body mass index, and age at onset (van Furth et al., 1996). Family expressed emotion may be problematic in part because it is associated with high levels of conflict and poorer levels of organization in families of people with eating disorders (Hedlund et al., 2003). The criticism element of expressed emotion appears to run rampant in families of young people with eating disorders. People at high risk for eating disorders tend to live with parents who are very critical and they are often teased by their parents and siblings about their weight (Polivy & Herman, 2002).

Family expressed emotion is a noxious and almost mean spirited communication behavior that can stress the delicate psychological landscape of a child or adolescent, or even an adult. It is evident in both the prodromal and clinical stages of various mental-health problems. Family EE clearly accelerates relapse into clinical episodes among remitted patients. High levels of family EE may be particularly troublesome because they reliably covary with other pathogenic family processes such as low adaptability and cohesion and high levels of family conflict.

Family of Orientation Antecedents and Concomitants

Family interactions continue to play a role in mental health long after most people leave their family of origin. Mental health problems can be disruptive to interactions within one's family of orientation. In some cases, dysfunctional patterns of interaction in the family of orientation can even precipitate episodes of mental illness. Research on family of orientation interactions and mental health has zeroed in on marital interaction and parenting as two classes of family of orientation relations that are disrupted by mental-health problems. In the sections that follow, dysfunctional marital interaction, emotional contagion, and parental failure are discussed as examples of family of orientation interaction processes that are associated with a variety of mental health problems.

Dysfunctional Marital Interaction

Maintaining a satisfying marriage requires good communication skills enacted with benevolent intentions, an agreeable temperament, and at least moderately positive perceptions of one's partner, among many other things. Not surprisingly, mental health problems appear to corrupt many of the fundamental components of marital quality. Although this suggests that mental health problems predate marital problems, at the same time, there is reason to believe that certain mental health problems, especially depression,

could follow decreases in marital quality. In either case, there is a strong association between poor mental health and low marital quality.

Depression is the mental health problem most studied for its relationship with dysfunctional marital interaction (see Beach, 2001 for a review). Repeatedly, this research has shown that depression and marital distress go hand in hand. As depressive symptoms worsen or improve, so too does relationship quality with the spouse (Judd et al., 2000). The communication between depressed people and their spouses is often negative in tone and tends to generate negative effect in each spouse (Gotlib & Whiffen, 1989). In the context of marriage, depression is associated with poor communication during problem solving interactions (Basco, Prager, Pite, Tamir, & Stephens, 1992), verbal aggressiveness (Segrin & Fitzpatrick, 1992), and problems in establishing intimacy (Basco et al., 1992). A history of depression is associated with less positive reciprocity in marital interactions (Johnson & Jacob, 2000). Marital conflict is a key problem for depressed spouses. Depressed wives report more frequent arguments than nondepressed wives, and that their husbands do not understand or respect them (Coyne, Thompson, & Palmer, 2002). Their husbands report frequent arguments and complain that their depressed wives blamed them for everything that goes wrong, lacked ambition, and that their wives depended too much on them. During conflict resolution interactions, there are more negative messages sent from, and directed to, the person with depression than what is seen in nondepressed married couples (Sher & Baucom, 1993). The specific communication of depressed spouses during conflict includes a lot of self-complaints, sadness, slowed speech and monotone vocal cues, whining, and despondent expressions (Jackman-Cram, Dobson, & Martin, 2006). In marriage, at least part of the negative effect of depression on marital satisfaction comes through dysfunctional conflict patterns, specifically demand–withdrawal, avoidance, and lower levels of constructive communication (Heene, Buysse, & Van Oost, 2007).

A range of other mental health problems also appear to create difficulties for marriage. For example, spouses of people with schizophrenia report markedly lower marital satisfaction than spouses of healthy control subjects (Hooley, Richters, Weintraub, & Neale, 1987). Anxiety disorders also appear to be associated with lower spousal reports of relationship quality, especially on days when the person with the anxiety disorder is expressing a lot of symptoms (Zaider, Heimberg, & Iida, 2010). Patients with borderline personality disorder exhibit marital distress and disruption and this is at least partially explained by an increased perpetration of both minor and severe marital violence (Whisman & Schonbrun, 2009). Patients with bipolar disorder report lower marital quality to the extent that they experience depressive symptoms, however, their spouses' ratings of poor relationship functioning appear more strongly correlated with the patient's manic symptoms (Sheets & Miller, 2010). Whisman (2007) studied the association between mental health problems (anxiety disorders, mood disorders, and substance use disorders) and marital distress in a nationally representative sample of over 2,000 respondents. The problems that were most negatively associated with marital quality, as assessed with the Dyadic Adjustment Scale, were bipolar disorder, alcohol use disorders, generalized anxiety disorder, and post traumatic stress disorder. People with these problems were anywhere between 2.3 and 3.6 times more likely than healthy controls to have significant marital distress.

Mental health problems in one or both spouses make it very difficult to maintain marital satisfaction. Problems such as depression, schizophrenia, bipolar disorder, and generalized anxiety disorder are major risk factors for marital distress. Many of these

problems may have their deleterious effect on marital quality through impaired communication processes (e.g., demand–withdrawal conflict patterns, intimate partner violence) that are otherwise known to be toxic to marriage.

Emotional Contagion

Theories of emotional contagion postulate that people will catch the intense emotional states of those with whom they interact through largely unconscious interpersonal processes (Hatfield, Cacioppo, & Rapson, 1994). This effect is predicated on the assumption and observation that people will mimic and synchronize their nonverbal behaviors with those of the people around them. This similarity in behavior is theorized to provide feedback that generates the same emotional experience as those people whose behaviors are being observed and matched. Although emotional contagion is most often observed in convergence of momentary emotional states during social interaction, there is some evidence to suggest that emotional contagion has more pronounced effects in family relationships, especially marriage. Naturally, in terms of mental health, these effects would be evident in the domain of affective disorders.

Symptoms of depression tend to be significantly and positively correlated in married couples (Benazon & Coyne, 2000; Segrin & Fitzpatrick, 1992). In couples dealing with a serious health problem or disability of one partner, symptoms of depression tend to be correlated (Goodman & Shippy, 2002), and the spouses often have symptoms of depression that are on par with those of the sick or disabled person (e.g., Segrin & Badger, 2010). Data from longitudinal investigations show that symptoms of depression in one spouse or partner predict a worsening of depression in the other partner (Joiner, 1994; Segrin et al., 2005). Comparable longitudinal studies reveal similar contagion effects for parent to child depressive symptoms (e.g., Abela, Zinck, Kryger, Zilber, & Hankink, 2009; Abela, Zuroff, Ho, Adams, & Hankin, 2006). These findings indicate that over time, the daily interactions that are part and parcel of close family relationships, especially marriages and parent–child relationships, can produce a significant exacerbation of depressive symptoms in one person as a result of those of the other.

Emotional contagion does not appear to be limited only to the experience of depression. In laboratory social interactions, emotional contagion has been documented for anxiety as well (Gump & Kulik, 1997). A longitudinal investigation of family members (mostly spouses) of women with breast cancer showed that higher levels of anxiety in the family member were predictive of a worsening of the breast cancer patients' anxiety over time (Segrin, Badger, Dorros, Meek, & Lopez, 2007). Therefore, in some situations, the anxiety of one family member can prompt increases in the anxiety of another family member.

Emotional contagion is a rather primitive process that may operate outside of human awareness. Nevertheless, there is evidence to suggest that people with symptoms of affective disorders, namely depression and anxiety, may have a deleterious influence on similar symptoms of their close family members. Presently, these contagion effects appear to operate in family relational contexts where there is otherwise a high degree of interdependence as in the case of married spouses or parents and their children.

Parental Failure

In its most effective form, parenting is a complex and skilled behavior that requires insight, patience, emotion control, and flexible communication styles to meet the ever-

changing needs of developing children. Unfortunately, mental health problems can severely corrupt these and other processes, leading to poor parenting and ultimately to significant negative child outcomes. Research on parenting and mental health has major theoretical significance for understanding familial transmission and aggregation of mental health problems.

By far, the majority of research into parenting practices of people afflicted with mental health problems has focused on depression. This is undoubtedly due to the extraordinarily high incidence of depression in the general population as well as the pervasiveness of depression as an immediate consequent of childbirth. The experience of depression goes hand in hand with a variety of dysfunctional parenting behaviors. Chiariello and Orvaschel (1995) explained that depression interferes with parenting skills by corrupting parents' capacity to relate to their children. In general, the social behavior of depressed parents is characterized by similar negativity, hostility, complaining, and poor interpersonal problem solving that is associated with their other relationships. For instance, the communication between depressed mothers and their children is more negative and less positive than that of nondepressed mothers (Foster, Garber, & Durlak, 2008; Park, Garber, Ciesla, & Ellis, 2008). The same holds for depression in fathers—they exhibit fewer positive (e.g., affectionate, sensitive, supportive, positively accepting) and more negative (e.g., hostile, coercive, intrusive, restrictive, controlling, and critical) behaviors than nondepressed fathers do (Wilson & Durbin, 2010). Family interactions with a depressed father are also marked by positivity suppression; that is the tendency for a positive message (e.g., agree, approve, smile and laugh) by one family member to be met with either a negative (e.g., criticize, disagree, put down) or problem solving (e.g., question, command, solution) message by other family members (Jacob & Johnson, 2001). The unfortunate consequent of these dysfunctional parenting practices of people with depression is that their children evidence a number of negative psychosocial outcomes of their own, including depression. As Jacob and Johnson (2001) plainly stated, "family communication could be one of the channels promoting the increased risk of depression among children of depressed parents" (p. 39).

Parenting problems are not just limited to people with depression. It is apparent that other mental health problems are equally disruptive to parenting processes. For example, mothers who have schizophrenia exhibit even lower quality social interaction with their children than do mothers with affective disorders (Wan et al., 2007). The parent–child interactions studied by Wan et al. (2007) were marked by a lack of maternal sensitivity and responsiveness, and infant avoidance of the mother. In addition to being remote and insensitive toward their children, mothers with schizophrenia also appear more intrusive and self-absorbed when interacting with their child, in comparison to mothers with affective disorders (Riordan, Appleby, & Faragher, 1999). When interacting with their children, mothers with anxiety disorders exhibit more criticism, more conflict, less sensitivity, less warmth, and more overcontrol of their children, when compared to healthy mothers (Moore, Whaley, & Sigman, 2004; Schneider et al., 2009). Observations of mother–infant interactions reveal less sensitivity and less structure in the interaction, along with less child interest and eagerness, when mothers with borderline personality disorder were compared to control mothers (Newman, Stevenson, Bergman, & Boyce, 2007). Finally, parents with bipolar disorder report more negative communication styles and less expressiveness with their children than healthy parents do (Vance, Jones, Espie, Bentall, & Tai, 2008).

Conclusion

The research on family process and mental health has documented numerous communication patterns in the family of origin that appear to be risk factors for subsequent mental health problems in offspring. Parents who are unwilling or unable to create a supportive family environment and who instead exhibit pathogenic behaviors such as affectionless control, critical expressed emotion, and extreme adaptability or cohesion increase the risk of mental health problems in their offspring. Sometimes these problems are evident while the child is still living in the family of origin (e.g., eating disorders) and in other cases the mental health problems may be slower to develop and show up later in life (e.g., personality disorders). In either case, dysfunctional family communication patterns can be viewed as stressors that either interact with psychobiological predispositions to create the disorder or that have a direct effect on creating mental health problems. Adults with mental health problems, not surprisingly, often have concomitant interpersonal problems in their family of orientation relationships. It is difficult, if not impossible, to have a spouse, parent, or sibling with a major mental health problem while otherwise maintaining a harmonious and trouble-free family environment. Psychological problems have ripple effects that invariably affect the lives of other people who are in contact with the ill person.

One of the challenges for future research is explaining why one family stressor (e.g., affectionless control) culminates in different psychological problems (e.g., eating disorders, personality disorders, depression) in different people. Although family systems theorists described this phenomenon with the concept of multifinality, it has yet to be adequately explained in the domain of family processes and mental health. A related challenge will be explaining why some people who are exposed to stressful family interactions develop certain mental health problems and others do not. The study of resilience holds great promise for informing theories of mental health maintenance, not just mental health problems. Each of these goals is being actively pursued by researchers and clinicians and will further reinforce the fact that family interaction has a major influence on the mental health of its members, and family members' mental health has an equally major influence on the nature of their interactions.

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