The Relationship Between Parental PTSD and Family Functioning Among Dutch Clinical Patients.

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Abstract

Objective: The present study aims to examine the relationship between parental posttraumatic stress disorder (PTSD) symptoms and family functioning and explore parent gender, number of children and mean age of children as moderating variables. Literature points out that parental PTSD symptoms are related to impaired family functioning. Both affect child psychosocial development and child development. Family functioning in relation to parental PTSD has thus far been studied using measures attesting single, one-way relationships within a family. The present study takes into account the family system as a whole, using a measure particularly developed for that purpose.

Methods: Participants were 102 parents (M_{age} = 43.37, SD_{age} = 7.74, 83.3% male, and 85.3% born in the Netherlands) with at least one child under age 18 seeking treatment at the outpatient clinic of a psychotrauma care centre in the Netherlands. Cross-sectional analyses were conducted on the self-reported intake questionnaires PCL-5 (parental PTSD) and SCORE-15 (family functioning).

Results: Results indicated that overall family functioning problems were higher than community norms ($t(101) = 4.85$, $p < .001$, one-tailed). No significant relationship was found between parental PTSD levels and family functioning ($F(1, 100) = 0.41$, $p = .522$), neither any significant moderators. There were however correlations between some of the PTSD subscales and family functioning scales.

Conclusion: Parental PTSD symptoms do not seem to be related to family functioning when family functioning is operated as ‘all intra-familial interactions within a family’ and when parents’ children are under age 18. The study’s methodological limitations and the results’ implications for future research and clinical practice are discussed.

Keywords: Parental PTSD, PTSD, family functioning, SCORE-15, intergenerational trauma

The Relationship between Parental PTSD and Family Functioning among Dutch Clinical Patients.

The majority of the Dutch population, between 52-81%, is exposed to at least one extremely stressful life experience in his/her lifetime (Bronner et al., 2009; De Vries & Olff, 2009). Within certain professions, like veterans, police- and ambulance personnel, people often experience shocking events. The majority of people recover within 4-6 weeks after experiencing a traumatic event and demonstrate resiliency (Boeschoten, 2016). However, about 14% of people experiencing a traumatic event develop lasting symptoms, like those belonging to posttraumatic stress disorder (PTSD; De Vries & Olff).

PTSD is characterized by the re-experiencing of the traumatic experience, avoidance of trauma-related stimuli, negative alterations in cognitions and mood, and persistent symptoms of arousal (American Psychiatric Association, 2014). These symptoms interfere with daily functioning and also with the relationships the affected has with other people.

Traumatised parents face the difficult task of both taking care of their own recovery and being available for their children. Research indicates that PTSD has an extensive impact on family relationships. A review of traumatized parents and relational patterns with their non-exposed children showed consistent negative associations between increased parental symptoms of PTSD and a reduced quality of the parent-child relationship (Van Ee, Kleber, & Jongmans, 2016). Not just parental satisfaction and parental functioning but also the perception of and satisfaction with the child was found to be negatively affected. A literature review among a military and veteran population (Creech & Misca, 2017) yields similar results: There is an association between parental PTSD symptoms in male military service members or veterans and parent-child functioning difficulties. The researchers however pose that while PTSD influences family functioning, family functioning also influences PTSD. Veterans with dependent children were 40% more likely to have a diagnosis of PTSD and single parents reported significantly greater post-deployment symptoms of PTSD. Higher levels of parent-child functioning problems are likely to amplify PTSD symptoms, particularly during times of stress. One study by Hershkowitz, Dekel, Fridkin, and Freedman (2017) examined parenting, marital satisfaction and PTSD among a civilian population. Amongst their findings was that PTSD was negatively related to parenting behaviour, and this effect was direct and not mediated by marital satisfaction. They concluded that trauma-related psychopathology is related to difficulties in family functioning.

Furthermore, parental PTSD symptoms affect child psychosocial development and child functioning (Morris, Gabert-Quillen, & Delahanty, 2012; Van Ee et al., 2016). Lambert, Holzer, and Hasbun (2014) found that this effect applies to both paternal and maternal PTSD.

Poor parenting practices have long-term effects on parent-child relationships and child development, and these effects in turn have a negative impact on PTSD levels (Creech & Misca, 2017; Hershkowitz et al., 2017). Therefore understanding the mechanisms by which PTSD influences family functioning is important. However, research thus far has focused merely on dyadic relationships within a family (i.e. parent-parent, parent-child). As such, measurements only include reports about an individual or a dyadic relationship. The current study sets out to take into account the family system as a whole by using an instrument designed to measure processes within a family. This contributes to a gap of knowledge in the field of psychotrauma research. Knowing more about parental PTSD in relation to family functioning can also contribute to the field of psychotrauma care in that it may have consequences for PTSD diagnostics and treatment.

The research instrument assessing family functioning in this study will be the Systemic Clinical Outcome and Routine Evaluation (SCORE-15; Stratton, Bland, Janes, & Lask, 2010) questionnaire. This questionnaire was developed to meet the increasing need for systemic therapy to demonstrate its effectiveness and until now has been used to document the level of family adjustment in clinical samples or evaluate outcome in treatment trials. The SCORE-15 yields next to overall family adjustment, indices of family strengths, family difficulties, and communication. In the Method section of this report these subscales will be discussed in further detail. Considering this study's focus on the family system as a whole and the use of the SCORE-15 measurement, the following definition to family functioning will be applied: All intra-familial interactions that contribute to the strengths, difficulties, and communication within a family.

The current study aims to: (1) examine the relationship between parental PTSD symptoms and family functioning among adults from a Dutch clinical outpatient population and (2) explore whether this relationship is moderated by parent gender, number of children and mean age of children. The study will take into account parents' perception of family adjustment and their self-reported levels of PTSD symptoms. No causal inferences will be made because this study makes use of a one-time assessment.

First of all, it is hypothesized that given the clinical background of the sample, overall family functioning problems will be higher than the criterion posed by Fay et al. (2013) (Hypothesis 1). Furthermore, traumatic stressors experienced by one member of a family (e.g., a parent) may impact all members of a closed system, resulting in a susceptibility for 'systemic dysfunction' (Figley & Kiser, 2013). It is therefore expected that as parental PTSD symptoms increase, family functioning will decrease (Hypothesis 2). Additionally it will be inquired whether this relationship exists for any of the various PTSD symptom clusters and family functioning clusters. No directional expectations will be set up for this, but for the sake of clarity this subquestion will be called Hypothesis 2a.

Next, this study looks for possible moderators in the relationship between parental PTSD and family functioning. It is hypothesized that the relationship between parental PTSD and family functioning is moderated by parent gender, number of children and mean age of children. Literature regarding the difference between paternal and maternal PTSD and its influence on family functioning is rarely available, and results regarding related concepts such as child outcome appear contradictory (Lambert et al., 2014; Morris et al., 2012). It is known however that the risk of PTSD is higher in females. This has implications for family functioning since females often take the lead in managing daily family life and caring for the children (Figley & Kiser, 2013). It is therefore expected that the relationship between PTSD and family functioning will be stronger if the parent is female (Hypothesis 3).

Because children are the recipients of family climate, moderators on child characteristics will be taken into account. Hershkowitz et al. (2017) found that the number of children in a family had a negative direct effect on parenting satisfaction and parenting behaviour in trauma-exposed parents. Since parenting behaviour highly influences family functioning (Mooren & Bala, 2016), it is expected that the relationship between parental PTSD symptoms and family functioning will be stronger when there is a larger number of children within a family (Hypothesis 4).

Creech and Misca's (2017) review on parenting with PTSD mentions that veterans with dependent children are about 40% more likely to have a diagnosis of PTSD compared to counterparts without dependent children, and that having minor children living in the home was related to increased PTSD severity. However, it is not known what an influence age has within the group of dependent children (i.e. children below 18 years of age). It is assumed that within

the group of dependent children, younger children have the most dependency on their parents. Therefore, it is expected that a lower mean age of children will strengthen the relationship between PTSD and family functioning (Hypothesis 5).

Method

Participants

The research involved a clinical sample of trauma-exposed adults seeking medical treatment at the outpatient clinic of a specialized psychotrauma care centre in the Netherlands. The original data file consisted of 305 participants. Eight were taken out because they were under 18 years of age, one was taken out because no PCL-5 measure was available. One hundred ninety-four cases were taken out because they either had missing data on their number of children and age of those children, or they had no children under the age of 18 living inside the home or had no children at all. This resulted in a final sample size of n = 102. Mean age was 43 years and 4 months, 83.3% was male, and 85.3% of participants was born in the Netherlands. Regarding main client group within given psychotrauma care centre, 48% belonged to 'war veterans', 14.7% belonged to 'post WWII generation', 9.8% belonged to 'occupational related trauma', and the remaining belonged to client groups with traumas of different nature. 20.6% of participants completed high school, 46.1% completed community college (i.e. mbo in Dutch), 13.7% had a university of applied sciences diploma (i.e. hbo in Dutch), and 10.8% had a bachelor's degree or higher. In Table 1, the distribution of participants' age and gender is shown. Most participants (42.2%) had one child under the age of 18 living in the household, 39.2% had two children, 12.7% had three children and the remaining had four or five children under 18 years of age. The mean of the mean age of children under age 18 years living in the household, was 9 years with a standard deviation of 4 years and 8 months.

Table 1

Participants' Gender and Age Distribution

			Age			
	Gender	*n*	*M*	*SD*	Min	Max
Total		102	43.37	7.74	29	61
	Male	85	43.19	7.93	29	61
	Female	17	44.29	6.81	33	59

Procedure

The study featured a cross-sectional design with a one-time assessment. Data were collected as part of the first measurement of Routine Outcome Monitoring (ROM). Participants automatically gave informed consent upon entry at given psychotrauma care centre. Participants either received a digital weblink to complete the questionnaires online or were administered paper versions upon their intake appointment. In both cases the data was imported in QuestManager (QM), a program that automatically scores questionnaires. An SPSS data file was subtracted from QM containing data of 305 individuals intaked at Centrum ‘45 between 12/07/2015 and 04/03/2019. This file contained data of the PCL-5, SCORE-15 and demographic info (Gender, age, patient group, country of origin, number of children, age children). Descriptive and statistical analyses were conducted with the use of International Business Machines Corporation’s (IBM) Statistical Package for the Social Sciences (SPSS) for Windows, version 23.0 (IBM Corp., 2015).

Measures

To measure PTSD symptoms, the PTSD Checklist for DSM-5 (PCL-5) was used (Weathers et al., 2013). The PCL-5 is a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. It consists of four subscales that correspond with DSM-5 (American Psychiatric Association, 2014) symptom clusters B, C, D, E: Re-experiencing of the Traumatic Experience, Avoidance of Trauma-Related Stimuli, Negative Alterations in Cognitions and Mood, and Persistent Symptoms of Arousal. The questionnaire takes approximately 5-10 minutes to complete. The PCL-5 was administered in the format without Criterion A (brief instructions and items only). Sample item: In the past month, how much were you bothered by: ‘Repeated, disturbing, and unwanted memories of the stressful experience?’ Responses were given on a 5-point Likert scale (0 = ‘Not at all’ to 4 = ‘Extremely’). All PCL-5 items can be found in Appendix A.

Family functioning was measured using the Systematic Clinical Outcome and Routine Evaluation (SCORE-15; Stratton et al., 2010). The SCORE-15 is a 15-item self-report questionnaire assessing changes in family relationships. It may be used in routine clinical practice to monitor progress and evaluate the outcome in couple and family therapy (Carr & Stratton, 2017). It includes an Overall measure of family functioning as well as subscale scores on the

following dimensions: Strengths, Difficulties, and Communication. The Strengths subscale touched on strong attributes of a family and their adaptability when things were difficult, the Difficulties subscale concerned the extent to which a family was overwhelmed by difficulties, and the Communication subscale related to disruptions in communication within a family. The questionnaire is acceptable and has strong consistency and reliability (Stratton et al., 2014). Participants were asked to rate on a 5-point Likert scale (ranging from 1 = 'Very well' to 5 = 'Not at all') to which extent an item describes his/her family. Sample item: 'In my family we talk to each other about things which matter to us.' Low scores indicated better adjustment. Some demographic factors were also obtained by the SCORE-15 (Age, gender, ethnicity, education achieved, main occupation, and people living in household). Appendix B shows all SCORE-15 items grouped into their corresponding subscales.

The SCORE-15 further contains several open-ended questions of which most were not taken into account in this study. However, the research participant's number of children and mean age of children were collected by inspecting answers on SCORE-15 item 24 'People living in your household (type, such as 'daughter age 12', no names please).' When answers on this item were incomplete or unclear, the participant was excluded from further analysis. Number of children included the following: Children under 18 years of age living inside the home for at least one day a week and are under parental supervision. This included children that were seen according to a visitation agreement, stepchildren, foster children. Mean age of children was constructed by adding up all ages (in years) of children under the age of 18 living inside the home environment, and dividing that number by the number of children under the age of 18 living inside the home environment.

Analyses

Total and subscale scores for the PCL-5 had already been calculated. Mean total scores and mean subscale scores for the SCORE-15 had to be calculated into four new variables.

To compute the total scores of the SCORE-15, the total of all negative items (items 2, 4, 5, 7, 8, 9, 11, 12, 13, 14 with 'very well' as 1 and 'not at all' as 5) was subtracted from 60. The remainder was added to the total of positive items (items 1, 3, 6, 10, 15). This was divided by 15 to obtain the average. For the Strengths subscale, all item scores (items 1, 3, 6, 10, 15), were added up. No subtraction was needed because all of the items were posed positively. This was

divided by 5 to obtain the average. For the Difficulties subscale, all item scores (item 5, 7, 9, 11, 14) were added and then subtracted from 30. This was divided by 5 to obtain the average. For the Communication subscale, all item scores (items 2, 4, 8, 12, 13) were added and then subtracted from 30. This was divided by 5 to obtain the average.

For the first hypothesis a one sample t-test was conducted to test the assumption that overall family functioning problems would be higher than community norms. Due to the lack of Dutch norms, Irish norms constructed by Fay et al. (2013) were used. They constructed a cut-off score with the best balance between sensitivity and specificity for identifying families of children scoring above the clinical cut-off on the total problem scale of the Strengths and Difficulties Questionnaire (SDQ): 1.9. This cut-off score is used as the comparative mean to test the current hypothesis.

Results

To start with, the data was checked for the assumption of normality. Through exploratory statistics Shapiro-Wilk's test showed that the mean total score of the SCORE-15 met the assumption of normality ($p = .061$). The assumption of normality was not met for the total PCL-5 score variable ($p = .001$). However, transformations did not yield any improvement, so the original variable was used.

As for Hypothesis 1, a one sample t-test was conducted to determine if mean total scores of the SCORE-15 from current sample were significantly higher than community norms. Dutch clinical patients reported a higher mean total score of the SCORE-15 ($M = 2.23$, $SD = 0.69$) compared to the community norms, $t(101) = 4.85$, $p < .001$, one-tailed.

A linear regression was run to test the Hypothesis 2 its claim that as parental PTSD symptoms increase, family functioning will decrease. Family functioning was entered as the dependent variable; parental PTSD as the independent variable. Results did not show a relationship between parental PTSD symptoms and family functioning ($F(1, 100) = 0.41$, $p = .522$.

To test whether the relationship of the previous hypothesis would exist for any of the various PTSD symptom clusters and family functioning clusters, all mutual correlations between the PCL-5 scales and SCORE-15 scales were explored (Hypothesis 2a). Pearson's correlations showed that there was a significant positive correlation between the PTSD Negative Alterations

in Cognitions and Mood subscale and family functioning's Overall score, as well as the Difficulties subscale and the Communication subscale. There was a significant negative correlation between the PTSD Avoidance subscale and family functioning's Strengths subscale. In Table 2 all correlations are listed.

Table 2

Pearson r's for the Associations Between Subscales of the PCL-5 and SCORE-15 (n = 102)

Measure	FF-Overall	FF-Strengths	FF-Difficulties	FF-Communication
PTSD-Overall	.064	-.088	.164	.083
PTSD-B	-.047	-.159	.051	-.027
PTSD-C	-.093	-.206*	.025	-.081
PTSD-D	.215*	.058	.273**	.235*
PTSD-E	.040	-.092	.136	.051

Note. PTSD = Posttraumatic Stress Disorder; PTSD-B = Re-experiencing of the traumatic experience; PTSD-C = Avoidance of trauma-related stimuli; PTSD-D = Negative alterations in cognitions and mood; PTSD-E = Persistent symptoms of arousal; FF = Family Functioning. ** $p < .01$. * $p < .05$.

To test whether the effect of parental PTSD on family functioning is stronger if the parent is female (Hypothesis 3), when there is a larger number of children within the family (Hypothesis 4) and if those children have a lower mean age (Hypothesis 5), three separate moderation analyses were conducted using Hayes' (2018) PROCESS tool. For all three analyses heteroscedasticity-consistent standard errors were used. Family functioning was entered as the dependent variable, PTSD symptoms as the independent variable and parent gender, number of children and mean age of children as moderators. Results showed that parent gender ($F(3, 98) = 0.002$, $p = .908$), number of children ($F(3, 98) = -0.004$, $p = .274$), and mean age of children ($F(3, 98) = -0.002$, $p = .064$), did not influence the relationship between parental PTSD and family functioning.

Discussion

This study provided an inquiry into the relationship between parental PTSD symptoms and family functioning among adults from a Dutch clinical outpatient population and explored whether this relationship was moderated by parent gender, number of children and mean age of children.

As hypothesized, family functioning problems were higher than community norms in this study's sample consisting of Dutch clinical patients. The hypothesized relationship between parental PTSD symptoms and family functioning was not significant. Parent gender was not found to influence the hypothesized relationship between parental PTSD symptoms and family functioning. Likewise, the number of children under 18 years of age that a parent had did not influence that relationship. And lastly, a younger age of those children under 18 years of age, did not influence the relationship between parental PTSD symptoms and family functioning. However, there were significant correlations between some of the symptom clusters of parental PTSD and family functioning. PTSD avoidance symptoms had a significant negative correlation with family functioning strengths. Negative alterations in cognitions and mood belonging to PTSD, had a significant positive correlation with overall family functioning problems, family functioning difficulties and communication problems as part of family functioning. All those correlations were however weak. To answer the main questions of this study: PTSD symptoms in parents do not seem to be related to their family functioning, and this is also not influenced by parent gender, the number of children a parent has, and the mean age of those children. That is, when family functioning is operated as 'all intra-familial interactions within a family' using the SCORE-15 as a measurement instrument among a clinical Dutch outpatient population who's children are under 18 years of age.

Some explanations for the obtained results in the current study can be found in the literature. Regarding the observed correlations in current study, Sherman, Gress-Smith, Straits-Troster, Larsen, and Gewirtz (2016) report parenting difficulties that were associated with PTSD avoidance symptoms and negative alterations of cognitions and mood. They found parents describing that avoidance caused difficulties in participating in their children's activities. Similar results have been found by Creech and Misca (2017). In the current study, family strengths was about doing things together, and caring for and trusting each other. When one member of the family is avoidant, an important building block of the family is absent, which explains the decrease of family strengths.

As for the relationship between PTSD symptom cluster 'Negative alterations in cognitions and mood' and family functioning, the following has been written in scientific literature. Negative alterations cause patients to have distorted negative beliefs and expectations about themselves and the world (American Psychiatric Association, 2014; Sherman et al., 2016). Since

in this study family functioning difficulties existed of evaluations of feelings of difficulties in the family, it is not surprising that this was related to parent's negative alterations in cognitions and mood. The last was also related to communication problems in our study. Communication as a problem area was also highlighted by Sherman, Larsen, Straits-Troster, and Erbes (2015). They posed the importance of communication within a family about the parent's PTSD discourse.

The lack of support to the hypotheses could in the first place mean that there is no support for the theory and parental PTSD symptoms do in fact have no association with intra-familial relationships, but only with dyadic family relationships as established in scientific literature (Creech & Misca, 2017; Hershkowitz et al., 2017; Van Ee et al., 2016). In a study of Sherman et al. (2016) it is described that whereas parenthood with PTSD may be a risk factor for poor outcomes, it may at the same time be a source of resilience and motivation to engage in treatment. Resilience in research participants could be a reason for the lacking association in this study between parents' PTSD and family functioning problems. However, it is known that family functioning as measured by the SCORE-15 is associated with poorer global functioning (Carr & Stratton, 2017).

Therefore the lack of supportive results to the hypotheses could also be due to methodological issues. First of all, the study only included parents with children under 18 years of age. Family functioning extends further than the interactions with minor aged children living inside a parent's home, so therefore the results could be different when children of all ages were to be included in the study. Secondly, the study lacked data on partner and child perceptions of family functioning. Because perceptions of family functioning are often different across family members (Fay et al., 2013), preferably measures of family functioning from both the parent with PTSD and their partner and children would be taken into account in future research. A further methodological weakness was the study's cross-sectional design that did not allow for comparisons to a normative population. Also, there were no multiple measurements over time. Future research requires longitudinal measurements to draw conclusions about causality.

The current study has also some implications for clinical practice. Since PTSD in parents has the potential to reverberate throughout the family system, for PTSD diagnostics it is important that clinicians systematically inquire a patient about his/her living and family situation. Information about parent's children, including their age and sex, should be systematically gathered at intake and stored at an easily accessible location in the Electronic Patient Database

(EPD). During data collection it was learned that this is not the case within the psychotrauma care centre this study was taken out. Regarding treatment, this study confirms the importance of involving the family of a PTSD patient in treatment (Mooren & Bala, 2016; Sherman et al., 2015). Researchers and clinicians will have to keep working together in creating evidence-based treatment and improving best practices for families that have been unsettled due to a parents' adversity after experiencing a traumatic event, in order to secure a safe and emotionally healthy home environment for their developing children.

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Appendix A

PTSD Checklist for DSM-5 (PCL-5) Items

Item	In the past month, how much (Not at all / A little bit / Moderately / Quite a bit / Extremely) were you bothered by:	PCL-5 subscales in which item is included
1	Repeated, disturbing, and unwanted memories of the stressful experience?	Criterion B
2	Repeated, disturbing dreams of the stressful experience?	Criterion B
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	Criterion B
4	Feeling very upset when something reminded you of the stressful experience?	Criterion B
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	Criterion B
6	Avoiding memories, thoughts, or feelings related to the stressful experience?	Criterion C
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	Criterion C
8	Trouble remembering important parts of the stressful experience?	Criterion D
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	Criterion D
10	Blaming yourself or someone else for the stressful experience or what happened after it?	Criterion D
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?	Criterion D
12	Loss of interest in activities that you used to enjoy?	Criterion D
13	Feeling distant or cut off from other people?	Criterion D
14	Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	Criterion D
15	Irritable behaviour, angry outbursts, or acting aggressively?	Criterion E
16	Taking too many risks or doing things that could cause you harm?	Criterion E
17	Being “super-alert” or watchful or on guard?	Criterion E
18	Feeling jumpy or easily startled?	Criterion E
19	Having difficulty concentrating?	Criterion E
20	Trouble falling or staying asleep?	Criterion E

Note. Criterion B = Re-experiencing of the traumatic experience; Criterion C = Avoidance of trauma-related stimuli; Criterion D = Negative alterations in cognitions and mood; Criterion E = Persistent symptoms of arousal.

Appendix B

Systematic Clinical Outcome and Routine Evaluation (SCORE-15) Items

Item	For each line, would you say this describes our family (Very well / Well / Partly / Not well / Not at all)?	SCORE-15 subscales in which item is included
1	In my family we talk to each other about the things that matter to us.	Strengths
3	Each of us gets listened to in our family.	Strengths
6	We trust each other.	Strengths
10	When one of us is upset they get looked after within the family.	Strengths
15	We are good at finding new ways to deal with things that are difficult.	Strengths
5	We find it hard to deal with everyday problems.	Difficulties
7	It feels miserable in our family.	Difficulties
9	We seem to go from one crisis to another in my family.	Difficulties
11	Things always seem to go wrong for my family.	Difficulties
14	In my family we blame each other when things go wrong.	Difficulties
2	People often don't tell each other the truth in my family.	Communication
4	It feels risky to disagree in our family.	Communication
8	When people in my family get angry they ignore each other on purpose.	Communication
12	People in the family are nasty to each other.	Communication
13	People in my family interfere too much in each other's lives.	Communication