

# Administering measures to families

Prepared by the AFT Family Therapy Outcomes Advisory Group, Convener Peter Stratton

**With** Marcus Averbeck, Iris Corrales, Liz Forbat, Gill Goodwillie, Judith Lask, David Low, Nicola McCarry, Lynne McCandless, Jeanette Neden, Jan Parker, Gary Robinson, Reenee Singh, and Yang Yang Teh

This document was compiled to give guidance on issues that arise specifically when applying progress measures to families. It was created by the group for inclusion in the CAMHS Outcomes Research Consortium ([CORC](#)) and Children and Young People's Improving Access to Psychological Therapies ([CYP IAPT](#)) initiative Practitioners Guide to Forms, Feedback Tools and Outcome Measures, produced by the CAMHS Evidence Based Practice Unit (EBPU), Anna Freud Centre and University College London <http://www.ucl.ac.uk/ebpu/publications>.

## Introduction

Measuring progress and outcomes of therapy raises a number of specific issues when the therapist is working with families and other networks of care. This guidance is primarily for measurement when a number of family members are present in the session. It is also relevant when working systemically with an individual, in relation to their significant relationships, when working with members of more than one family (multi-family work), and in sessions involving family member(s) and professionals.

Most measures used in CYP-IAPT and CORC+ are designed for administration to individuals who have been referred for treatment and may be being seen on their own in therapy. Sometimes an individual child or young person is receiving individual-focused treatment for their diagnosed condition in the presence of other family members, so we need to know how to use these measures when several members of a family are present.

However, we are restricting our interest to cases in which the functioning of a number of family members is of interest. The case in which an individual child or young person is receiving treatment for their diagnosed condition in the presence of other family members, will usually be processed in the same way as individual therapy. So we are concerned with the situations when the therapeutic focus includes the family's relationships, context and functioning as relevant to the referral problems and /or to the effectiveness of therapy. i.e. when children and young people's important relationships are particularly relevant to the difficulties they are experiencing and/or to their recovery and to our therapeutic work together.

An alternative to using measures developed for use with individuals is to use one that is specifically designed for use with families. Several measures have been designed for use with families and other groups. Some, primarily those developed in the USA during the 1970s and 1980s, reflect the understandings of families and of outcome measures of that time and context. More recent measures include the STIC (Pinsof et al) in the USA and the

SCORE in the UK. Where this guidance refers to family measures, we are referring to SCORE and specifically its newer and shorter version, the SCORE-15(see <http://www.aft.org.uk/view/score.html> for details)

SCORE-15 is a measure of family functioning. It has been shown to be reliable and valid both as an indicator of the quality of interactions within the family and as a measure of therapeutic progress early in family and couples therapy. It can be administered in less than 10 minutes, is free to use, and has a variety of clinical uses as well as being usable for research and audit.

Clinicians should refer to the specific guidance in the ORS/SRS and the SCORE sections of the manual relevant to working with family groups.

Systemic family therapy works with the complexity and recursive influence of people's relationships, contexts, beliefs and experiences over generations. As such, it is often used with families experiencing serious and/or multiple problems, often over many years and/or for whom other interventions have not brought change.

While non-attendance (DNAs) are sometimes construed as an indication of a poor therapeutic alliance, there may be many more factors at play in the case of family attendance. Arrangements for getting everyone present are likely to be more complicated both in terms of practicality of fitting around other commitments, and of the expense and time demands of transport. By the time a family is referred for therapy they may be already receiving help from a number of other agencies and needing to balance these appointments with other aspects of their lives which may well include insecurity about employment or problems with schools.

### **Introducing the measures**

While this chapter is intended to be useful when using any outcome measure while working with families, the SCORE-15 is specifically designed for the purpose and the ORS and SRS are readily usable in a family context.

### **Practical guidance**

It is important that practitioners use their clinical judgement about whether it is useful and safe for the family to complete the measures in each others' presence or separately, and if, when and how their responses will be shared with other family members. Factors influencing clinical judgement include the developmental and cognitive abilities of persons answering the question, therapeutic alliance, confidentiality or safeguarding issues.

All family members, especially children and young people, may need clear and repeated assurances about the parameters of confidentiality, what is to be shared with whom. The therapist must decide beforehand whether and how the information from the measure will be used with the family so that assurances about privacy will not conflict with clinical needs.

## Talking about talking

In some families and in some cultures, and in some families sometimes, it is considered insulting for a child to talk about their parents with anything but praise, or to ask a child to talk about their family members. Is it ok to ask these family members to complete a questionnaire about the family, or might it be felt as disrespectful, unsafe, or blaming?

*Would you feel OK about answering these questions now?*

*Would you still feel OK if your answers are seen by other family members?*

*If you have open talks as a family now, how do you imagine things might be between you after the session has finished?*

*What might help talking together feel more easy/possible/less risky?*

*If it feels tricky to talk about together at the moment, is that a useful focus of our work together? /might an aim of our work together be to get to a point when talking as a family feels OK?*

*If open talk were possible what difference might that make to you/your family?*

This child, young person, family may need a clear reassurance that you don't have to answer any questions you don't want to. If the agency is paid according to the number of completed assessments, can this assurance be freely given? This may be one area in which routine research ethics operate to a higher standard than (monetised) clinical practice.

Specific expertise for talking with children of different ages is available especially in the literature of systemic family therapy. A sample of the literature that contributors to this chapter have found helpful is included in the references below.

## Who completes the measures

*Everybody with the capabilities to do so?* The questionnaires should be completed routinely and given to all members of the family group taking part in a therapy session. Some measures have versions for different age groups, e.g. SRS/ORS and so the relevant measure would be used. Where available, clinicians could consider using the measures that have been designed for younger children with the older age group/adults, if this is likely to be more accessible for them.

Each family member would be given their own questionnaire. Be sensitive to how much help parents are giving their children in completing the questionnaires. Their expertise on their children, means that they are likely to know how much help they need to understand what is being asked of them. However, it is important that the response is from the child/young person and not from the parent; they will have their own measure to complete.

## Measures for Younger Children

Most CYP-IAPT recommended measures are currently validated for use with children 8 years or above, and measuring behavioural or emotional changes within the children. For

younger children, especially age 5 and below, their presenting problems are usually more relational, even though problems are often located in the child at the point of referral. As such, parental change measures such as attributions and parenting style rather than/as well as child symptom change would be more helpful.

Our colleagues in the Oxleas Greenwich SureStart programme are piloting Spence Preschool Anxiety and Parenting Daily Hassles Scales in 2013. This could change based on subsequent feedback from the parents. Parent Stress Index (PSI) has been found to be very helpful for complex cases but not as an initial assessment tool as, as the name suggests, it has over hundred questions. Beck's Depression Index (BDI) is a worthwhile tool in cases with parents presenting with depression. The problem, however, is that both PSI and BDI currently do not have weekly symptoms tracking components. The team is considering adapting Spence for this purpose. As for the goals tracking measures, the team and their service users have found them very useful. However, goal setting may not always be appropriate for very sensitive cases such as little children with brain tumour or with parents with serious head injuries.

### **Issues of handling non-literacy.**

Clinicians may need to read the questionnaires to family members where there are literacy challenges and take care to check that the meaning of questions is understood. For example with scaling questions it is important to check that the family member understands which end of the scale represents a positive and which a negative response.

The issue of language is difficult; some interpreters may offer to translate the questionnaires on the spot but evidence suggests that this is rarely effective. A pre-arranged translation of the questionnaires is most likely to work.

### **Mindfully not using the measures**

In some situations it may be wholly inappropriate to introduce measures, for example where young people/parents are extremely distressed and emotionally deregulated. The clinician will use their clinical judgement to assess the situation and may decide to delay doing the measures until a later session. The reasons for not using the questionnaires should be documented and consideration given to when would be an appropriate time to introduce them to the family members. The therapeutic needs of the child/ young person will be the main focus of the session; if the clinician judges that to use the measures is likely to increase distress or disrupt therapy, and thereby outweigh any clinical benefit to using them then it would be appropriate to postpone seeking the information

### **Discussing the results and using them to inform the therapy**

Distinguish discussing results for clinical purposes from audit or research. And the issues this raises about any offering of privacy in relation to each other. Solutions include e.g. phrasing of general statements that identify hot issues but do not identify who raised them. *“an impression I get .... does this seem worth discussing?”*

How to raise the issue if results show therapy is not progressing. 1. A focus on the special issue when it is going badly for one or more family members but well for others. 2. some suggestions for productive discussions when the whole family indicates lack of progress, with ideas for ways of changing tack.

Whether the written answers and discussions would be best conducted separately with individuals, or with a constellation of family members and/or professionals is a matter for clinical judgment. Influencing factors to consider include developmental and cognitive abilities of persons answering the question, therapeutic alliance, confidentiality or safeguarding issues. The clinician could cross-examine the answers given with those from other questionnaires. For example, consider answers to SCORE-15 with scores of depression in RCADS by the child/young person and parents.

Consider creatively adapting measures to match clinical needs. For example, the use of drawings, play or sculpting may enhance therapeutic engagement and understanding for some clients and families.

The assessment or reviews could either take a single or multi focus lenses that would capture the background context (silent concerns), that comes along with the referred child/young person. This might include an additional component/element of the assessment or reviews, which would make visible the associated concerns that other family members bring-forth at the assessment/ review stage that the clinician has to work with.

### **Qualitative Feedback**

While tracking quantitative aspects of the outcome measures are strengths in CYP-IAPT, It is important those working with families and other networks of care invite and incorporate qualitative information where helpful. Participants' words and other communications can alert us to thicker descriptions of their experiences, struggles and resources. For example, the child/ young person, siblings and parents could be invited to insert additional comments in their Session Rating Scale (SRS) or Session Feedback (4-questions). Besides using the descriptive comments clinically, where resources are available, the descriptions could be invaluable for services to invest in qualitative analyses, which could also be shared with families and partnering professionals, as an additional levels of feedback.

### **Exploring and managing the meanings of difference**

The same event, even the same word, can mean very different things to different people. It can often be helpful to look at those differences, as often they can help us understand each other better and find ways forward. But it can also feel tricky or risky if people believe that someone having a different view means that person doesn't love or respect them... *Who could help me understand what beliefs you hold in your family about different opinions?*

### **Managing diversity:**

The social GRRACEESS. (Burnham, Palma and Whitehouse, 2008). The acronym draws attention to issues of Gender, Race, Religion, Age, Ability, Class, Culture, Ethnicity, Education, Sexuality, Spirituality. Not as an obligatory list but a systemically interacting

framework which demands attention of different aspects at different times in therapy and training.

### **Interpreting the feedback**

*How to feed back to colleagues and managers* are there specific issues in relation to families? What if any of the measures used reveal abuse especially by a member of the family who is present?

### **References**

Burnham, J, Palma, D. A., & Whitehouse, L. (2008) Learning as a context for differences and differences as a context for learning *Journal of Family Therapy* 30: 529–542

Cooklin, A: Eliciting Children's Thinking in Family Therapy

Dummett, N. (2010) Cognitive-behavioural therapy with children, young people and families: from individual to systemic therapy. *Advances in Psychiatric Treatment*, 16: 23-36.

Frosh, S. Phoenix, A. and Pattman R *Young Masculinities* Basingstoke UK

Golding, K. Dent H. Nissim, R. and Stott L (eds) (2006) *Thinking psychologically about children who are looked after and adopted space for reflection* Wiley; Chichester.

Gorell Barnes, G. (1995) The Intersubjective Mind: Family Pattern, Family Therapy and Individual Meaning in *Learning and Teaching in Social Work* ed. Yelloly and Henkel, M. London; Jessica Kingsly

Hart A. and Luckock B,(2004) *Developing Adoption Support and Therapy, New Approaches for Practice*,( Jessica Kingsley, London

Hart, A., Blicow, D. and Thomas H. (2007) *Resilient Therapy: Working with Children and Families* Routledge; Hove East Sussex. UK

Hulyer, B 'Long Term Development' in Cannan, C. and Warren C *Social Action with Children and Families*. (1997/2003Jewell, T., Carr, A., Stratton, P., Lask, J., & Eisler, I. (2013, In Press) Development of a Children's Version of the SCORE Index of Family Function and Change. *Family Process*. doi: 10.1111/famp.12044 (available in early view 26-08-13)

Johnstone L. And Dallos, R. (2006) *Formulation in Psychology and Psychotherapy, Making Sense of Peoples Problems* Routledge.

Maitra, B. 'Children, Families and Therapists: Clinical Considerations and Ethnic Minority Cultures' in Dwivedi, K.N. *Meeting the Needs of Ethnic Minority Children including Refugee, Black and Mixed Parentage Children, A Handbook for Professionals* Jessica Kingsley ; London.

Maitra, B. and Livingstone M (2010) *Does Culture Matter?* East London NHS Foundation Trust. DVD available from Dr. Maitra directly.

Minuchin S and Fishman (1981) *Family Therapy Techniques*. Harvard

Platzer, H. 2003 *Rounding up the usual suspects: towards a better understanding of factors affecting participation and research and the nature of social exclusion* . Report submitted to the Sexual Orientation Team, Women and Equality Unit , DTI

Stone Fish, L. Harvey R. (2005) *Nurturing Queer Youth, Family Therapy Transformed* Norton New York  
Stratton, P., Lask, J., Bland, J., Nowotny, E., Evans, C., Singh, R., Janes, E., & Peppiatt, A. (in press) Validation of the SCORE-15 Index of Family Functioning and Change in detecting therapeutic improvement early in therapy. *Journal of Family Therapy*. doi: 10.1111/1467-6427.12022 (available in early view 22-08-2013)  
Vetere, A. & Dallos, R. (2003) *Systemic Formulation. Working Systemically with Families: Formulation, Intervention and Evaluation*. London: H Karnac (Books) Ltd.

Wilson, J: *Child-focused practice: a collaborative systemic approach*. London, Karnac Books;

## ADHD

Nylund, D. (2000) *Treating Huckleberry Finn: A New Narrative Approach to working with kids diagnosed with ADD/ADHD* Jossey Bass San Francisco

## BEHAVIOUR AND CONDUCT PROBLEMS

Webster- Stratton C (1998) *Preventing Conduct Problems* Journal of Consulting and Clinical Psychology **62**

Faber, A. and Mazlish, E (2001) *How to talk so Kids will listen and Listen so kids will talk* Piccadilly Press, London

## USING NON VERBAL TECHNIQUES

Aldridge, F. (1998) *Chocolate or Shit: Aesthetics and Cultural Poverty in Art Therapy with Children* *Inscape* **3**, No 1, (2-9)1998.

## Appendix

Even though this Chapter concentrates on therapist activities with a family, we recommend that systemic clinicians extend its use to gather multiple perspectives. This can be done by inviting different partnering professionals, the child/young person and their family members to answer the form based on their respective views about Johnny's presenting problems. This could be done at a family session, a professional's meeting or a TAC (Team Around the Child) meeting could be convened to facilitate better understanding and clarify different persons' rating of the various levels of functioning and distress.

For example, 15-year-old Johnny, known to Social Care, was referred by the school to CAMHS for self-harming behaviour. The systemic clinician convenes an assessment session, inviting the following persons to answer about Johnny from each of their perspective:

- School teacher (referrer)
- Parents
- Allocated social worker
- 18-year-old sister

- Johnny himself

Variations to this could be incorporating circular questioning within the answers by having everyone answering the current view from another perspective:

*“I would like each of you to each imagine you are answering the questions as if you are the person sitting on your left, for example, Johnny, you will imagine you are your sister, how severe would she rate your self-harm, and Mr. Henderson (father), how would you rate Johnny’s low mood if you were your wife? As for June (school teacher), could you answer it from the Social Services’ point of view, and Anita (social worker), answer it from the school’s view? ”*

We suggest that it can be used at both assessment and 6-monthly reviews, alongside SCORE-15 and other relevant symptom measures, as together they give a broader and relational lens than what symptom-specific questionnaires alone could provide. Overtime, the systemic clinician would be able to weave the multiple perspectives (including the clinician’s personal clinical judgment) into a coherent narrative, not just around the presenting problems located within the referred child/young person, but also those located within or between the family and other contexts as well. This can then be feed back to the family and professionals to further build on the circular hypothesis. We need to however, bear in mind that *the map is not the territory*; the information is just a tool to guide us to see the problems, relationships and situations in various ways but it would not represent the entire picture of what is happening within the family, professional systems or between the systems.

While tracking quantitative aspects of the outcome measures are the strengths in CYP-IAPT, we invite systemic clinicians to creatively incorporate qualitative inputs where deemed helpful, so as to bring to the foreground thicker descriptions of the contextual issues. For example, the child/ young person, siblings and parents could be invited to insert additional comments in their Session Rating Scale (SRS) or Session Feedback (4-questions). Besides using the descriptive comments clinically, where resources are available, the descriptions could be invaluable for services to invest in qualitative analyses, which could also be shared with families and partnering professionals, as an additional levels of feedback.