Measures of Family Functioning for Research and Practice

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Preface

Originally published as a special issue of the journal *Scholarly Inquiry for Nursing Practice,* the compendium you are about to peruse, read, and certainly go back to, is the best I have seen in my 25 years as a practitioner and teacher of psychometrics. It is incisive, comprehensive, intelligible, scholarly, and current. It can be read to locate and select the particular measure you really need, with all the background work done for you. It can be read as an overview of this area and its manifest problems. It can be read to convince you to create your own measure, knowing full well the task you have set before you.

Reading through the measures gives one a sense of chronicity. In the main, the movement from well-established to moderately established to developing measures is historical in nature. My reading from this perspective was done with a question in mind. The question was whether our construction of what a family is has changed over time. The instruments take us on a journey of 30+ years. Is the notion of family going through a reconstruction?

In obvious ways families have changed; they are more diverse, but the culture has changed as well. I think we can say that over time hope has diminished, and that fear of all kinds—fear of crime, fear of the other, fear of the environment, fear of economic viability—has escalated. Have these changed our construction of what family means? I think so. The earlier instruments concentrated on the family as an environment of growth, a kind of Petri dish of self-actualization. The current instruments have a dash of family as refuge, family as a relatively safe place, family as a corporation for financial survival. I don't think it is by chance that the *Assessment of Strategies in Families' Effectiveness* (1991) includes items such as, "Our neighborhood is bad and we have to protect ourselves from what's going on out there," and the *Comprehensive Evaluation of Family Functioning* (1990) has a subscale entitled "Financial." However, Sawin and Harrigan caution that "lack of theoretical consistency makes it difficult to compare data collected by different instruments. Researchers need to closely examine the items in the instrument to ascertain if they represent the concept they wish to study."

As we read through this compendium, the central postmodern truth, if I may use that term, becomes apparent. We, as curious, sense-making creatures, construct and reconstruct our realities. Our cultural artifacts, including our measures, must reflect our current societal constructions in order to have any validity.

PIERRE WOOG, PHD

Introduction

Nurses and other health professionals who work with families must make several decisions. What data from families will they collect? Are they interested in an individual's perception of the family or multiple perceptions? What conceptual underpinnings are important to working with families? Will they use self-report data, observational data, or a combination of both? Will they use an established qualitative instrument to assess family functioning or will a structured interview meet their needs? If they choose an instrument to assess family functioning, which instruments evaluate dimensions that are appropriate for nursing research and interventions? Which instruments can be used for clinical applications, research, or both?

The purpose of this Introduction is to present an overview and a critique of selected measures of family functioning available to the clinician and researcher. These include self-report instruments, a structured interview, and clinician rating scales. Because the family is a complex social system, numerous variables can be identified that explain family functioning. Having an array of options that operationalize family dynamics allows the researcher or clinician to select those measures most critical to the families of interest.

This work was undertaken because existing reviews of family instruments were found lacking in one or more of the following areas. Either they: (1) did not include the most recent family assessment instruments developed by nursing researchers (Berkey & Hanson, 1991; Bishop & Miller, 1988; Halvorsen, 1991; Touliatos, Perlmutter, & Strauss, 1990); (2) were not detailed enough to give researcher/clinician adequate information to choose a tool, such as providing examples of items (Berkey & Hanson, 1991; Bishop & Miller, 1988; Halvorsen, 1991); (3) did not supply information on cross-cultural usage or gender-sensitive issues, which was found to be true for all the included reviews; (4) did not report a synopsis of the major findings from nursing research using the instrument (Berkey & Hanson, 1991; Bishop & Miller, 1988; Grotevant & Carlson, 1989; Touliatos et al., 1990) or (5) were based on instrument information that was over 5 years old (Bishop & Miller, 1988; Touliatos et al., 1990; Halvorsen, 1991); and (6) did not reflect the family as the unit of analysis (Feetham, 1991a). If research questions focus on the family as the unit of analysis, as proposed by Feetham and others, information about

readability level, length of questionnaire, and cost of instruments become even more important.

The development of these instruments is very dynamic. Although several "established instruments" are either undergoing major revisions (FACES III) or are being scrutinized for problems with psychometrics (FES), several new instruments (ASF-E, FFSS, and CEFF) are in initial stages of development, and several others are in the middle of their development (FDM, FHI, and FAM III). This analysis provides a critique of family functioning instruments in all stages of development. This will be helpful to both established researchers and novices seeking to choose or further develop an instrument appropriate for their needs. The clinician needs to carefully review information on clinical validation of potential instruments when considering using an instrument in the practice setting.

Understanding families demands an interdisciplinary sensitivity. As disciplines begin working together on programs of research with families, it is critical that they become familiar with the literature and measurements in each other's scholarly literature. As a result of such collaboration, concepts are clarified, assumptions are challenged, and new visions and applications are found. Thus, the measures addressed here reflect instruments from the disciplines of nursing, psychiatry, psychology, social work, and sociology. Although the interdisciplinary nature of the study of the family is recognized and supported, a concerted effort was made to include instruments generated and tested by nursing scholars. Included in this review are four such instruments: Feetham's Family Functioning Survey (FFFS); The Family Dynamics Measure (FDM); Family Hardiness Index (FHI); and Assessment of Strategies in Families (ASF-E). Three instruments representing the Beavers System Model used by many disciplines but seldom used in nursing research are also reviewed. These are included, as they provide a clinician rating approach to family investigation that is seldom used by nursing scholars.

Instrument Selection. For the selection of instruments in this critique, family functioning was defined as a set of basic attributes about the family system that characterize and explain how a family system typically appraises, operates, and/or behaves (McCubbin, 1987, 1991). For example, instruments that measured attributes such as family problem solving, hardiness, adaptability, individuation, and cohesion fit this criterion. Instruments that focused only on individual functioning, dyadic relationships, parent/child interaction, family stress, specific coping strategies, and social support were not reviewed. Instruments were identified from published literature. Computer searches of MEDLINE, CINAHL (Cumulative Index to Nursing and Allied Health Literature), and Psychological Abstracts for the last 5 years were carried out, and a

manual search of Social Work Abstracts was done. Developers of the instruments were contacted for current materials including manuscripts in press. Drafts of critiques were sent to authors for response. Developers provided input for all instruments except in the category of early development, where the majority responded. When the author did not respond, the critique was based on published data.

Three categories of family functioning instruments were reviewed. Self-report instruments offer the opportunity to measure the perceptions of family members in a quantitative manner. Thus, they can be used to predict phenomena associated with family functioning. The other measures include observational and interview instruments, which offer several strengths. First, they organize qualitative data such as patterns of health or illness, the family within a social context, or family relationships across generations, and allow for family validation of data collected and classification of data. Second, they may offer a visual representation of individual and family system data and other variables influencing the family (for example, the relationship between subsystems within the family, and extended family relations). Finally, these instruments allow the uniqueness of a family to emerge from the data, as they are not limited totally by identified dimensions in a predetermined instrument. This allows the researcher/clinician to obtain data that explain the phenomenon of family functioning from the individual and family unit's perspective(s).

Fourteen of the instruments reviewed are self-report instruments. These were divided for this review into three groups: well established, moderately established, or newly established. Instruments were included as well established or moderately established self-report instruments if they had been used in published research other than instrument development studies in the period from January 1987 to June 1993. Studies with the main purpose of reporting reliability and validity data were classified as instrument development studies. Five instruments were classified as well established based on extensive psychometric evidence and wide use in the literature. Four instruments were classified as moderately established based on ongoing development of psychometric data and some use in the literature. Five instruments with psychometric data but with no or limited published use were classified as newly established.

Although this critique focuses on self-report instruments, the authors recognize the need to use multiple sources and methods to collect data. Instruments from the observational and interview categories give another perspective not obtainable in self-report inventories. Thus, four representative instruments are included in this review: a qualitative measure (genogram), a structured interview (McSIFF), and two clinician rating scales (Beavers Family Competence and Style Scales). Although other observational instruments exist, the Beavers scales were chosen, as the authors felt they were better

developed with more psychometric evidence than other clinician rating scales reviewed (FAM Clinical Rating Scale, McMaster Clinical Rating Scale; and Clinical Rating Scale for the Circumplex Model of Marital and Family Systems [Grotevant & Carlson, 1989]).

Critique Format. Each review includes the following sections: History (of the instrument); Overview of the Model (including the conceptual framework); Instrument Description (including readability level if available, scoring options; sample items); Psychometric Properties (reliability and validity); a description of Cross-Cultural Uses, Gender Sensitivity, and Variant Family Structures; a Summary of Studies Using the Instrument; a Critique Summary; a Source to obtain the instrument and permission for use; and a table of Selected Studies Using the Instrument. User-friendly source information was included to optimize retrieval by the reader. Delineating the conceptual framework was deemed essential to understanding the instrument assumptions. Samples used, changes in the instrument over time, and a brief history of the instrument development are presented to orient the reader. Readability, scoring options, and sample items were included to facilitate the potential user's assessment of the match between the instrument and the population of interest. Psychometric data are critical to determine which instruments can be used with assurance of maximizing validity and reliability. Specifically, data on content, discriminant, predictive, concurrent, and construct validity, as well as internal reliability (Cronbach alpha), test–retest, and inter-rater reliability are presented. Studies reported in dissertations or theses were not included in the summary tables of studies using the instrument.

Particular attention in this analysis is paid to the different cultures the instrument has been used in and an examination of the validity and reliability in each of these cultures. Nurses work with a broad range of people representing various cultural, racial, and family types. Due to the increasing diversity in the general population, attention to reliability and validity of instruments measuring family functioning in diverse populations is critical. Researchers cannot assume that establishment of psychometric evidence in one population will apply to other populations.

Use of Family Functioning Instruments in Research and Practice. Consumers of instruments that measure family functioning are interested not only in the instrument itself, but in how it has functioned in studies that address variables of concern. The critique of the following instruments includes a review of the most recent studies pertinent to nursing practice that have used the instrument. Selected studies are presented in a tabular format for easy comparison. No tables are included for the newly established self-report instruments, the McSIFF, or for the Beavers Interactional Scales, as there is a limited body of supporting research in the literature using these instruments.

The critiques of the instruments are presented first. Following the 18 critiques, issues in the use of family functioning measures are discussed. This section includes an examination of measurement and analysis issues and the role of qualitative methods in family research. Finally, a concluding synthesis addresses implications of this review.

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Contents

1

Well-Established Self-Report Instruments

THE McMASTER FAMILY ASSESSMENT DEVICE (FAD)

History

The McMaster Model originated in the Departments of Psychiatry at McGill and McMaster Universities in Canada during the 1960s and 1970s under the initial direction of Nathan B. Epstein, MD. Based on research, teaching, and clinical work, its development continues at Brown University and Butler Hospital. The present research focuses on family functioning in families responding to physical and mental illnesses. Use of the Family Assessment Device which operationalizes the McMaster Model is occurring across a range of family types and problems found not only in the United States and Canada but worldwide. Research and clinical use has been both inter- and cross-disciplinary.

Overview of the Model

The McMaster Model is based on systems, role, and communications theories, and evolved from work with nonclinical families. An important theoretical assumption is that families can report healthy functioning in some dimensions while experiencing difficulties in other(s). The model is based on the assumption that, "The primary function of today's family unit appears to be that of a laboratory for the social, psychological, and biological development and maintenance of family members" (Epstein et al., 1976, p. 1411). In order to represent the complexities of a family, the model identifies six dimensions (structural and organizational properties) of family functioning: problem solving, communication, roles, affective involvement, affective responsiveness, and behavior control. Each dimension is operationally defined so that both optimal and pathological functioning is clear. Three assessment instruments have been developed based on this model. These are the Family Assessment Device (FAD), which is reviewed here, the McMaster Clinical

Rating Scale (MCRS) (Miller et al., in press), and the McMaster Structured Interview for Family Functioning (McSIFF) also included in this review.

FAD INSTRUMENT DESCRIPTION

A 60-item self-report (paper and pencil) Family Assessment Device (FAD) operationalizes the six family functioning dimensions. The general functioning scale (12 items) can be used independently from the other scales as an over-all measure. A 4-point Likert-type scale is employed to determine a member's perception of the family. The FAD has a seventh grade, or age 12, readability level and takes approximately 15–20 minutes to complete.

Clinical cut points have been established to separate effective and potentially clinically problematic functioning families from each other. These points can maximize sensitivity (proportion of actual "abnormal" results accurately identified by the FAD) and specificity (proportion of actual "normal" results correctly identified by the FAD) when compared to clinician ratings. Sensitivity ranged from .57 (Behavior Control) to .83 (Communication). Specificity ranged from .60 (Affective Involvement) to .79 (Problem Solving).

Scoring. The test includes both positive and negative statements that require reverse scoring. Item responses then are totaled and averaged to obtain a scale score. An easily applied tally sheet has been developed to simplify hand scoring. Computerized scoring programs are also available (see "Source" at end). Scores can be compared between family members or a family score can be computed by averaging the scores for each member for each scale.

The General Functioning Scale can be used as an overall measure of family functioning. More specific identification of family strengths and weaknesses is obtained by administering the entire instrument to obtain measures of the six dimensions.

Sample Items. (dimension represented)

"We resolve most every day problems around the house" (Problem Solving).
"When someone is upset the others know why" (Communication).
"When you ask someone to do something, you have to check that they did it" (Roles).
"We are reluctant to show our affection for each other" (Affective Responsiveness).
"If someone is in trouble, the others become too involved" (Affective Involvement).
"We know what to do in an emergency" (Behavior Control)

PSYCHOMETRIC PROPERTIES

Reliability

Internal Consistency. In the initial psychometric studies, coefficient alphas were the highest for the General Functioning Scale (.83–.86) and lowest for the Roles scale (.57–.69). For the remaining scales, the reliabilities were .74–.80 for Problem Solving; .70–.76 for Communication; .73–.75 for Affective Responsiveness; .70–.78 for Affective Involvement; and .71–.73 for Behavior Control (Epstein, Baldwin, & Bishop, 1983). Subsequent reports consistently support internal stability of all scales but the Roles scale (Harrigan, 1989; Joffe, Offord, & Boyle, 1988; Kabacoff, Miller, Bishop, Epstein, & Keitner, 1990; McKay, Murphy, Rivinus, & Maisto, 1991; Miller, Epstein, Bishop, & Keitner, 1985). In addition, the lowest reliabilities have been obtained for nonclinical samples, thus the Roles scale should be used very cautiously, particularly with nonclinical samples. Data using adolescent (Harrigan, 1989; McKay et al., 1991) and geriatric populations (Harrigan, 1989) yield comparable alphas.

Test–Retest. Reliability is based on data from a nonclinical sample of 45 individuals tested at a 1-week interval. The resultant test–retest estimates were Problem Solving (.66); Communication (.72); Roles (.75); Affective Responsiveness (.76); Affective Involvement (.67); Behavior Control (.73); and General Functioning (.71) (Miller et al., 1985). Similar test–retest data were reported by Browne, Arpin, Corey, Fitch, and Gafni (1990).

Inter-Rater Reliability. Not applicable.

Validity

Content Validity. The initial item pool for the FAD was developed from goal attainment scaling point descriptions from outcome studies. Additional items were added to cover all six dimensions, items were rewritten to ensure representation of only one dimension, and an equal number of healthy and unhealthy functioning items for each dimension was ensured. This resulted in 240 items, or six scales of 40 items each, in the first version of the FAD.

Construct Validity. Each 40-item scale was analyzed using Cronbach's alpha to result in the smallest subset of items that produced the highest reliability. At this point reliabilities ranged from .83 to .90, but the scales were highly intercorrelated. Selecting the items most highly intercorrelated resulted in the creation of a seventh General Functioning Scale, which continues to serve as an overall measure of health/pathology.

Three criteria then were applied to the 240 items: (1) the items had to be written for the relevant dimension; (2) the internal consistency had to reach at

least .70 (alpha); and (3) each scale item had to correlate higher with the scale to which it was assigned than to any of the other six scales. Using a recursive method, the final scales were established when the minimal alpha level was reached while not increasing the magnitude of relationship of items with other scales. The item pool was reduced to 53 items comprising the first version of the FAD. Based on subsequent validity and reliability studies of clinical and nonclinical families, items were added to the Problem Solving (2), Communication (3), and Roles (3) scales respectively to complete the current version for the FAD (Epstein et al., 1983; Kabakoff et al., 1990). The most recent factor analysis used pooled data from nonclinical, psychiatric, and medical family samples (n=2,063). The Oblique Multiple Groups (OMG) factor analytic approach confirmed the internal structure of the six dimensions measured by the FAD. The General Functioning Scale (12 items) was omitted due to its designed correlation with the other scales. For the remaining 48 items, 44 (92%) loaded highest on the hypothesized factor. Based on two alternative factor models utilizing principal components analyses, the structure of the FAD (including the General Functioning Scale) corresponded adequately to the hypothesized (predicted) model (Kabacoff et al., 1990).

Concurrent Validity. The predicted relationships between the scales of the FAD and FACES-II, when treated linearly (Olson, Sprenkle, & Russell, 1979), and the FUI (Van der Veen & Olson, 1981; Van der Veen, Howard, & Austria, 1970) provided adequate evidence of concurrent validity for the FAD.

Regression analysis was used to test for concurrent validity of the FAD with the Philadelphia Geriatric Morale Scale (Lawton, 1972, 1975) and the Locke Wallace Marital Satisfaction Scale (Locke & Wallace, 1959). The results indicated that the FAD was a more powerful predictor than was the Locke Wallace for morale (Epstein et al., 1983).

Discriminant Validity[1]. Based on data from samples in which reporting members represented families that were clinically presenting (n=98) compared to individuals from families who did not present clinically (n = 218), 67% of the nonclinical group and 64% of the clinical group were correctly predicted by the FAD (Epstein et al., 1983; Miller et al., 1985; Perosa & Perosa, 1990; Sawyer, Sarris, Baghurst, Cross, & Kalucy, 1988; Waller, Calam, & Slade, 1989). On each of the seven scales, the nonclinical group mean was lower (more healthy) than the mean for the clinically presenting group (1983).

Predictive Validity. The FAD was found to be a better predictor of morale when compared to Locke Wallace Marital Satisfaction Scale data (Epstein et

[1]In this review, discriminant validity will refer to the ability of the measure to correlate negatively with other variables that are theoretically unrelated to the construct (Campbell & Fiske, 1959) or the ability of the measure to discriminate between criterion (known) groups (Hudson, 1982).

al., 1983). Family functioning also predicted the course of recovery for stroke victims (Evans, Halar, & Bishop, 1986). In more recent studies, functional/dysfunctional families were significantly related to major depression recovery prognosis (Keitner, Ryan, Miller, & Norman, 1992; Miller et al., 1992). Greater degrees of dysfunction in affective responsiveness and role functioning also were found to predict higher levels of substance abuse, particularly alcohol consumption (McKay et al., 1991). Finally, there is evidence that family functioning predicts psychiatric outcome in children (Maziade, Caperaa, & Laplante, 1985) and children's postdivorce adjustment (Portes, Howell, Brown, Eichenberger, & Mas, 1992).

General Scale. The majority of the studies cited above addressed only content and discriminant validity for the General Functioning Scale. However, other evidence offers support of predictive, concurrent, and construct validity of the General Scale (Byles, Byrne, Boyle, & Offord, 1988; Joffe et al., 1988; Kabacoff et al., 1990). This psychometric evidence provides ample support that this scale, composed of only 12 items, can serve as a valid and reliable measure of overall family functioning.

Other Data: Social Desirability. Correlations of the FAD with the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1964) in a university sample of 164 individuals from 72 families were uniformly low. Correlations ranged from -.06 (Behavior Control) to -.19 (Affective Involvement) (Fristad, 1989). Corrections for Social Desirability with the FAD were not supported.

CROSS-CULTURAL USES, GENDER SENSITIVITY, AND VARIANT FAMILY STRUCTURES

Much of the psychometric evidence for the FAD was obtained from university samples that had adequate gender representation but were primarily white and middle socioeconomic level samples. Although not designed for use in cross-cultural studies, the FAD has been utilized in research with samples from several countries other than the U.S.A. and Canada based on the theoretical strength of the model (Morris, 1990). The FAD is available in English, French, Hungarian, Dutch, Portuguese, Spanish, and Afrikaans. Currently Russian, Chinese, Hebrew, Haitian, and Italian versions of the FAD are being prepared. These versions have been carefully translated and back-translated but validation in the translated languages is not completed.

Although only one version of the FAD exists, it appears to be applicable (based on the strength of the model and the wording and content of items) to nontraditional family structures, such as single parent households and extended family households (Harrigan, 1989). Cross-cultural family functioning comparison research has been done (Keitner et al., 1990). Research on percep-

tual differences of family functioning by gender is in process at the Family Research Program at Butler Hospital.

SUMMARY OF STUDIES USING THE FAD

Mental Health. The FAD (see Table 1.1) has been used with families responding to the demands of a wide range of psychiatric problems. These include alcohol dependence, depression, affective disorders, schizophrenia, adjustment, and bipolar disorders.

Families With Adolescents. The FAD has been used in clinical studies of families responding to adolescent suicide and other mental health issues.

Chronic Illness. The FAD has been used with families responding to the demands of a wide range of medical problems. These include systemic lupus, traumatic brain injury, stroke, rheumatoid arthritis, spinal cord injury, Parkinson's disease, and other disabilities.

CRITIQUE SUMMARY

The theoretical model for the FAD is perhaps one of the oldest and most researched (Westley & Epstein, 1969) family functioning projects. Its research credibility and clinical utility are evidenced by the multitude of applications of three measurement instruments and an intervention model with diverse populations. At least two other family functioning projects have credited the McMaster Model as the basis for their ongoing research (Lewis, Beavers, Gossett, & Phillips, 1976; Skinner, 1987).

Recent confirmation of the theoretical factor structure provides an even stronger rationale for the use of the FAD in family research (Kabacoff et al., 1990). Until the last few years, much of the research has been descriptive, with a heavy emphasis on comparison between clinical and nonclinical samples and establishment of clinical cut points. All scales except the Roles scale have demonstrated adequate reliability over time. Thus, users should either delete the Roles scale or interpret Role data with caution. A particular strength of the FAD is the number of languages in which the instrument is available, making it possible to study and compare families from a variety of cultures. The need for psychometric data to be established with different cultural populations is recognized and currently underway.

The McMaster Model of Family Functioning has been used to develop family assessment instruments other than the FAD for which the psychometric properties are presently being established. These are the McMaster Structured Interview of Family Functioning (McSIFF) included in this review and the

McMaster Clinical Rating Scale (MCRS). A problem-solving family intervention approach also has been developed (Bishop, 1981).

SOURCE

A current bibliography, FAD instrument packet, teaching videotapes, computerized scoring program, and other materials related to the McMaster Model are available by contacting Ivan W. Miller, Ph.D., Director of Research, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906, or by calling 401-455-6200.

FAMILY ADAPTABILITY AND COHESION SCALE (FACES II, III, IV)

History

The Circumplex Model originated in the late seventies in the Family Social Science Program at the University of Minnesota under the direction of David H. Olson, Ph.D., and associates. The model is aimed at bridging the gap that frequently exists between practice, theory, and research. Several instruments to measure various dimensions of marital and family functioning have been developed, and research continues to increase support for their reliability, validity, and clinical utility. FACES II, III, and IV (under development) focus on the adaptability and cohesion dimensions of family functioning, as well as perceived and ideal family functioning.

Overview of the Model

Based on the identification of over 50 concepts related to family functioning from a systems perspective, three concepts are seen as the most central and descriptive of marital and family dynamics: cohesion, adaptability, and communication. These dimensions are seen as dynamic over the course of the family life cycle, with one family type being more functional at times than at others.

Cohesion describes the emotional bonding in a family, which can have four levels: disengaged (very low), separated (low to moderate), connected (moderate to high), and enmeshed (very high). Adaptability describes the ability of a family to alter its role relationships, power structure, and relationship rules in response to situational and developmental stress. Adaptability has four levels: rigid (very low), structured (low to moderate), flexible (moderate to high), and chaotic (very high). The most functional levels for both adaptability