Family assessment: contemporary and cutting-edge strategies / [edited by] Len Sperry. -- 2nd ed.
   p. cm. -- (Family therapy and counseling)
   Summary: "In an era that demands ever-increasing levels of accountability and documentation, Family Assessment is a vital tool for clinicians. It covers more than one hundred assessment methods—both the most widely used strategies as well as those that are more specialized and issue specific. Techniques and instruments for assessments are summarized concisely in tables and discussed in depth in the chapters, often by the experts who developed the approaches they describe. Each chapter is also supplemented by recommended strategies for utilizing the assessment tools, as well as by case studies and observational method matrices. Readers will find the second edition of Family Assessment to provide the same comprehensive evaluation and thorough analysis as the first edition but with a fully updated focus that will invigorate the work of researchers, educators, and clinicians"—Provided by publisher.
   Includes bibliographical references and index.

RC488.53.A875 2011
616.89'1562--dc23 2011029454
# Contents

Series Editor’s Foreword ix  
Foreword xi  
Preface xv  
Contributors xvii  

Chapter 1 Family Assessment: An Overview  
*Len Sperry*  
Chapter 2 Qualitative Assessment  
*Maureen Duffy and Ronald J. Chenail*  
Chapter 3 Standardized Assessment  
*A. Rodney Nurse and Len Sperry*  
Chapter 4 Observational Assessment  
*Robert B. Hampson and W. Robert Beavers*  
Chapter 5 Ongoing Assessment of Couples and Families  
*Len Sperry*  
Chapter 6 Couples Assessment Strategy and Inventories  
*Dennis A. Bagarozzi and Len Sperry*  
Chapter 7 Child and Adolescent Assessment Strategy and Inventories  
*Alexandra Cunningham and Jack Scott*  
Chapter 8 Parent–Child and Family Assessment Strategy and Inventories  
*Lynelle C. Yingling*
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Child Custody and Divorce Assessment Strategy and Inventories</td>
<td>231</td>
</tr>
<tr>
<td></td>
<td><em>M. Sylvia Fernandez and Sloane E. Veshinski</em></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Child Abuse Assessment Strategy and Inventories</td>
<td>265</td>
</tr>
<tr>
<td></td>
<td><em>Erna Olafson and Lisa Connelly</em></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Family Assessment: Current and Future Prospects</td>
<td>309</td>
</tr>
<tr>
<td></td>
<td><em>Luciano L’Abate</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Index</td>
<td>329</td>
</tr>
</tbody>
</table>

http://www.routledgementalhealth.com/family-assessment-9780415894074
The practice of behavioral health at the onset of the 21st century is increasingly different from practice during most of the 20th century. This is largely due to the paradigm shift in behavioral health practice that has been under way since the late 1980s. This shift involves every facet of behavioral health practice, including the role of the clinician and the nature of the relationship between clinician and client, as well as clinical practice patterns. This shift has already resulted in the demystification of some basic tenets and “sacred cows” of clinical lore. Central to this paradigm shift is the increasing emphasis on quality and accountability of clinical services provided. Accordingly, quality indicators and cost effectiveness have become primary considerations in behavioral health today. Not surprisingly, clinical outcomes data, a key marker of quality and of accountability, have recently become the norm for the provision of behavioral health services.

This chapter introduces the concept of clinical outcomes assessment with couples and families. It begins with a description of the emergence of the concept of accountability and the so-called outcomes revolution and its impact on clinical practice. It then has a description of the various types and levels of outcomes assessment and its clinical implications, particularly the practice of family therapy. Therapeutic effectiveness, efficacy, and efficiency are defined, and the point is made that outcomes monitoring fosters the most important of the three concepts: therapeutic efficacy. Next is a discussion of recent developments in outcomes measurement and monitoring with couples and families, and then a description of the use of five specific measurement tools. Finally, a protocol for utilizing these tools in measuring and monitoring outcomes with couples and families is provided and illustrated with a couple therapy case example.
Clinical outcomes data and the associated outcomes revolution (Sperry, 1997) reflect a norm radically different from that in which most clinicians were trained. In the past, clinical practice was characterized by independence of clinical judgment, practice constraints, emphasis on therapeutic process, and subjective assessment of clinical progress. The recent shift in focus to an emphasis on accountability, that is, outcomes instead of process and objective assessment of clinical progress, has resulted in many clinicians’ confusion and concern about the meaning and implications of this paradigm shift imposed on the profession. Some view this emphasis on accountability and quality as an intrusion into their practice style or as actually or potentially unethical. Some have embraced this norm wholeheartedly, while others have come to accept it as inevitable (Sperry, Brill, Grisson, & Marion, 1997). Whatever their perspective, clinicians must contend with the reality that therapeutic accountability and clinical outcomes assessment in particular have become a core feature of clinical practice today and will be in the future.

In short, clinical outcomes assessment has been regarded as a necessary but unwelcome task by clinicians, particularly those conducting family therapy who are process oriented. “A focus on results rather than process has been anathema to family therapists” (Yingling, Miller, McDonald, & Galwaler, 1998, p. 49). Can this process versus outcome dilemma be resolved? Wynne (1988) suggested a potential solution, which is to “recommend that two primary baselines be given priority in family therapy research: (a) the multiple versions of the family members’ ‘initial’ presenting problem, and (b) the problem identified by consensus of family and therapist” (p. 253). Yingling and colleagues (1998) contend that using data from self-report measures of family members along with data from therapist ratings or observations (i.e., the Global Assessment of Relational Functioning [GARF]) can provide data relevant to process and outcome assessment. They also note that “discussing GARF parameters and charting progress with the client can enhance the therapeutic process … [and] the GARF can also be used as a process research tool when combined with case notes that include therapeutic interventions and reflections” (Yingling et al., 1998, p. 49).

RECENT DEVELOPMENTS IN ONGOING ASSESSMENT OF COUPLES AND FAMILIES

Since the publication of the first edition of this book, there have been a few noteworthy developments in clinical outcomes assessment in general, and
with couples in particular. Most obvious is that clinical outcomes assessment has become increasingly mainstream. This reflects the “culture of accountability” in which we live and the expectation that clinicians will utilize evidence-based treatment and demonstrate the effectiveness of the therapy they provide. A related development is that a number of new instruments and assessment devices have become available and are increasingly being utilized not only to address specific assessment questions but also to monitor progress and evaluate treatment outcomes. It is noteworthy that clinicians and researchers are effectively responding to the phenomenon of high rates of premature termination (40%–70%) by advocating the use of measuring and monitoring key therapeutic factors with brief assessment instruments (Lambert, 2010).

Particularly notable are the following developments. First is the introduction of shorter and ultra-brief instruments (often 3 or 4 items) taking only 1 to 2 minutes to complete. This contrasts with the 150 items of the Marital Satisfaction Inventory, Revised (MSI-R), which takes about 25 to 30 minutes to complete. Second, because of the limited administration time, such as for the Outcome Rating Scale, it is possible and preferable to monitor client or family progress at each session. This contrasts with the necessity to limit monitoring of progress to every fourth session or so, more commonly, before the first and after the last treatment sessions (the pre–post model of evaluation). Third, because of increasing use of these brief instruments (completed immediately before a session begins), it is now possible for client ratings to be discussed in that session. This “continuous progress feedback” strategy (Miller, Duncan, Brown, Sorrell, & Chalk, 2006) provides immediate client feedback, which facilitates the modification of the treatment process. This feedback process has been shown not only to increase treatment outcomes appreciably but also to reduce the likelihood of premature termination (Lambert, 2010).

TYPES OF OUTCOMES SYSTEMS AND THEIR CLINICAL VALUE

Most clinicians are likely to have had some experience with at least one type of outcomes system. The most common, and often the only, assessment of treatment outcomes that may be required is a simple measure of client satisfaction. Usually, client satisfaction is assessed by a short paper-and-pencil questionnaire that includes such items as how well the client thought he was treated by the therapist and how much he thought he improved during therapy. Although client satisfaction is important, it has not been shown to be an accurate assessment of treatment outcomes; in fact, it is actually a poor measure of clinical improvement. For
example, Atkisson and Zwick (1982) showed that symptom improvement explains only 10% of the variance in client satisfaction, while the relationship between clinical improvement and reported satisfaction is not statistically significant for clients still in treatment or for those who have completed treatment.

On the other hand, other outcomes measures have shown clinical utility and value. Outcomes measures and outcomes measurement systems can yield three types of benefits, one of which is its capacity to identify effective treatments. This requires pretreatment and post-treatment assessment of a client’s status to determine changes that occurred as a result of treatment. Aggregation of these data across all clients who received a specific treatment is the basis for this first benefit. A second benefit is immediate feedback to clinicians and case managers. This feedback will enable clinicians to identify clients who are improving adequately, those who have improved to a point at which treatment may no longer be necessary, and those whose lack of progress or determination suggests that their treatment should be changed. The third benefit is the ability to identify the specific changes most likely to move the unimproved client onto a more positive growth path—that is, to determine whether involvement of a spouse or family in treatment, transfer to a different therapist and different type of therapy, referral for a medication evaluation, or some other alteration in treatment is most likely to get the client well.

By incorporating feedback from an outcomes system into ongoing clinical cases, clinicians effectively supplement or support a clinician’s intuition about treatment decisions. Serial data on changes in symptoms and functioning can be utilized in modifying the course and duration of treatment in terms of focus, modality, and intervention strategies with individuals, couples, or families.

Essentially, three levels of outcomes assessment exist (Sperry, 1997):

**Outcomes measurement**—quantification or measurement of clinical and functional outcomes during a specific time period. Outcomes measures have traditionally been collected at the beginning and end of treatment. However, serial or concurrent assessment is becoming more common. Measures often include change in symptoms, well-being, functioning, and even patient satisfaction.

**Outcomes monitoring**—serial or concurrent use of outcomes measures during the course of treatment. The goal of outcomes monitoring is comparison against a standard of expected results to monitor progress or lack of progress over the course of treatment. Monitoring can be done after each session, every third session, or on some other scheduled basis. The data are then used to alter treatment when it is off course or stagnating. They
can also be used to follow progress in a single case or summed and adjusted for risk to compare several patients or programs. Outcomes monitoring can only be accomplished with repeated or concurrent measures, and the information must be available during the treatment.

Outcomes management—ultimate utilization of monitored data in a way that allows individuals and health care systems to learn from experience. Usually, this results in reshaping or improving the overall administrative and clinical processes of services provided. Patient profiling, provider profiling, and site profiling are three common aspects of an outcomes management system.

In a sense, these three levels are developmental levels or stages, with each level a prerequisite for the next. Currently, the majority of outcomes assessment activity is occurring at the outcomes measurement and the outcomes monitoring levels. It is useful to distinguish therapeutic effectiveness and efficacy from therapeutic efficiency. Therapeutic effectiveness is the determination that a treatment has a beneficial effect and is the expected outcome for a typical client treated in common practice settings by a typical clinician. On the other hand, therapeutic efficacy is the expected outcome for clients treated under optimal conditions by highly qualified clinicians. In short, efficacy defines optimal clinical practice, while effectiveness compares actual with optimal practice (Sperry, Brill, Howard, & Grissom, 1996).

In contrast, therapeutic efficiency refers to highly beneficial treatment tailored to the unique needs of a specific client (individual, couple, or family) as they are noted—or measured—over the course of treatment. Therapeutic effectiveness and efficacy answer the question, which treatment or approach is better or best? Therapeutic efficiency answers the question, which is the best treatment for this client and how can it be optimally provided? Accordingly, ongoing monitoring of clinical treatment outcomes fosters therapeutic efficiency.

CLINICAL OUTCOMES WITH INDIVIDUALS, COUPLES, AND FAMILIES

The earliest outcomes measurement efforts were primarily focused on psychotherapy with individuals, largely because a principal focus of psychotherapy research was on treatment outcomes. In the late 1980s, two instruments for outcomes assessment with individuals, COMPASS-OP and the Outcomes Questionnaire 45.2 (OQ-45), were widely utilized.
in clinical practice to measure pre–post-treatment outcomes, rather than monitor clinical outcomes on an ongoing basis. It is true that the Dyadic Adjustment Scale (DAS) was utilized as a pre–post-treatment measure of therapeutic effectiveness in a handful of research studies over the years.

However, only recently has the use of such inventories and scales as the DAS and the MSI-R (Marital Satisfaction Inventory, Revised) been advocated for monitoring clinical outcomes of couples therapy (Jacobson, 1984; Jacobson & Follette, 1985; Latham, 1990; Prouty, Markowski, & Barnes, 2000; Snyder & Aikman, 1999).

In terms of treatment outcome measures with families, the Self-Report Family Inventory (SFI), GARF Scale, and the Systematic Assessment of Family Environment (SAFE) Scale have all been utilized as pre–post-treatment measures in clinical research studies (Hampson & Beavers, 1996a; Hampson, Prince, & Beavers, 1999; Yingling, 1996; Yingling, Miller, McDonald, & Galwalier, 1994a). As clinicians become more familiar with the GARF Scale, it has tremendous potential for monitoring clinical outcomes on a session-by-session basis with families (Yingling et al., 1998).

The next section of this chapter is a description of the use of five inventories and scales for clinical outcomes measurement and for the ongoing monitoring of clinical outcomes with couples and families: GARF, SFI, SAFE, DAS, and MSI-R.

OUTCOME MEASURES PRIMARILY FOR FAMILIES

This section includes three well-regarded instruments with considerable potential in clinical outcomes measurement and monitoring: the Global Assessment of Relationship Functioning, the Systematic Assessment of Family Environment, the Self-Report Family Inventory, as well as a new and promising instrument, the Systemic Clinical Outcomes and Routine Evaluation.

Global Assessment of Relational Functioning (GARF)

Brief description of the GARF. The GARF is a therapist-rated device for indicating functioning of a family or other ongoing relationship on a continuum ranging from a low of 1 to a high of 100. The continuum is divided into five categories: 1 to 20 = chaotic; 21 to 40 = rarely satisfactory; 41 to 60 = predominantly unsatisfactory; 61 to 80 = somewhat unsatisfactory; and 81 to 100 = satisfactory. It is the only family-oriented
measure included in the pages of the DSM-IV/DSM-IV-TR and is located in Appendix B (American Psychiatric Association, 2000). GARF is analogous to Global Assessment of Functioning Scale (GAF), which is a measure of individual symptomatic distress and functioning; both are coded on Axis V. When assessing or rating a relationship, the clinician is asked to consider three dimensions of relational functioning: problem solving, organization, and emotional climate. Recent reliability and validly data on the GARF support it as a reliable and valid measure of relational functioning whose ratings can be made quickly and reliably, particularly among clinicians and supervisors with clinical experience, and are related to depression (Denton, Nakonezny, & Burwell, 2010).

Yingling and colleagues (1998) have slightly modified the dimensions Interactional, Problem Solving, Organization, and Emotional Climate, making them subscales that are scored separately, along with an overall GARF score. The psychometric properties and additional information about GARF are discussed in Chapter 6.

The GARF as an outcomes measure. Considerable published research and clinical reports are available in which GARF is utilized as an outcomes measure. Most of these reports involve GARF in pretreatment and post-treatment measurement (Hampson & Beavers, 1996b; Ross & Doherty, 2001; Yingling et al., 1994a, 1994b, 1998). With regard to ongoing assessment of outcomes, Yingling and colleagues (1998) discuss five case examples of the use of GARF as a treatment outcomes monitoring measure. These couple and family cases provide session-by-session ratings of overall GARF scores and subscale ratings for therapy lasting from 7 to 10 sessions. These case discussions are particularly valuable because data from the ongoing monitoring are utilized by the therapists to modify treatment focus and interventions.

Systematic Assessment of Family Environment (SAFE)

Brief description of the SAFE. The Systematic Assessment of Family Environment (SAFE) was developed by Yingling in 1991 along with field testing of the GARF (cf. Chapter 8 for an extended discussion of this instrument). It is a 21-item global assessment instrument for measuring three relational subsystem levels of the family system using two functioning factors for each subsystem level. The three subsystems are dyadic marital–executive subsystem, parent–child subsystem, and extended family subsystem. Organizational Structure and Interactional Processes are the two factors assessed for each subsystem. Scoring yields ranges for four family types: competent, discordant, disoriented, or chaotic (Yingling, 1996). SAFE is user friendly and available in a Spanish version as well as
a cartoon version for use with children under the age of 10 (Yingling et al., 1998). Validity is reported as .74 and .82 (Yingling et al., 1998).

The SAFE as an outcomes measure. The SAFE provides information that can easily be incorporated into a treatment plan. Relatively little has been published about using SAFE for pre–post-treatment evaluation of change or ongoing monitoring of family therapy. Nevertheless, Yingling and colleagues (1998) report collecting serial data on GARF and SAFE for monitoring treatment outcomes. The ease of administration makes this instrument a valuable outcomes measure with families.

Self-Report Family Inventory (SFI)

Brief description of the SFI. The Self-Report Family Inventory (SFI) is a 36-item self-report family instrument developed by Beavers and Hampson (1990) and is based on the Beavers Systems Model of Family Functioning. It measures five family domains: health and competence, conflict resolution, cohesion, leadership, and emotional expressiveness. The SFI correlates highly with two well regarded therapist observational rating scales: the Beavers Interactional Competence Scale and the Beavers Interactional Styles Scale. Spanish and Chinese versions are also available. The psychometric properties and additional information about SFI are discussed in Chapter 5.

The SFI as an outcomes measure. Some research in which the SFI has been utilized as an outcomes measure has been published. These reports involve the SFI in pretreatment and post-treatment measurement (Hampson & Beavers, 1996a, 1996b; Hampson et al., 1999). Apparently, no research or other published reports describe the use of the SFI as an ongoing measure of clinical outcomes; however, the ease of administration and brevity of the instrument (only 36 items) make it particularly valuable for monitoring session-by-session outcomes.

SCORE 15

Brief description of the SCORE 15. The Systemic Clinical Outcome and Routine Evaluation (SCORE) was developed for the ongoing evaluation of clinical outcomes of families in therapy (Stratton, Bland, Janes, & Lask, 2010). It was originally a 40-item self-rating instrument. To make it more user friendly, it was reduced to 15 items, and factor analysis provided the basis for specifying three subscales: strengths and adaptability, overwhelmed by difficulties, and disrupted communication. The SCORE 15 as the short version is called has these reported psychometric properties:

http://www.routledgementalhealth.com/family-assessment-9780415894074
Cronbach’s alpha .89, split-half correlation .81; Guttman split-half coefficient .89. The extent to which the 15 items represent the original SCORE 40 items provided a multiple regression coefficient of .975.

The SCORE 15 as an outcomes measure. As a ongoing measure of clinical outcomes of families in therapy, the SCORE 15 is easily administered—about 2 to 4 minutes—and scored, about a minute or so. The instrument is currently available at the website of the Association for Family Therapy (www.aft.org.uk). It is in English, and it is reported that translation is underway in 12 European languages (Stratton et al., 2010).

OUTCOME MEASURES PRIMARILY FOR COUPLES

This section includes two well-regarded instruments with considerable potential in clinical outcomes measurement and monitoring: the Dyadic Adjustment Scale and the Marital Satisfaction Inventory, Revised, as well as a new and promising instrument, the Intersession Report.

Dyadic Adjustment Scale (DAS)

Brief description of the DAS. The Dyadic Adjustment Scale (DAS) is a 34-item self-report instrument for assessing dyadic or relationship adjustment. This instrument was developed by Spanier (1976) to measure the quality of adjustment of couples and other dyads. The DAS comprises four scales: Dyadic Satisfaction, Dyadic Cohesion, Dyadic Consensus, and Affectional Expression. It is one of the first and most extensively utilized relational instruments in clinical practice. A shorter, 14-item version is also available. The psychometric properties and additional information about DAS are discussed in Chapter 7. Spanier developed the instrument on the assumption that the quality of relational adjustment was the key indicator of the viability of a relationship. He defined marital quality as “how the marriage functions during its existence and how partners feel about and are influenced by such functioning” (Spanier, 1979, p. 290). The DAS has consistently distinguished couples with better adjustment from those who are more dissatisfied with their relationship, including couples with a greater likelihood of divorce (Prouty et al., 2000). Well over 1,000 research studies have been published involving the DAS. Although the instrument has evolved over the years, it remains one of the most commonly used measures of couples adjustment by researchers and clinicians.

The DAS as an outcomes measure. The DAS has a long history of use as an outcomes measure. Considerable research has been reported

http://www.routledgementalhealth.com/family-assessment-9780415894074
on its use as a pre–post-treatment assessment tool in studies of therapeutic efficacy and effectiveness with couples (Adam & Gingras, 1982; Brock & Joanning, 1983; Jacobson, 1984; Jacobson & Follette, 1985; Latham, 1990; Prouty et al., 2000). Even though neither this research nor other published reports describe the DAS as used as an ongoing measure of clinical outcomes, the brevity of the instrument—particularly the 14-item version—makes it an attractive choice for monitoring session-by-session outcomes.

Marital Satisfaction Inventory, Revised (MSI-R)

_Brief description of the MSI-R_. The Marital Satisfaction Inventory, Revised (MSI-R) is a 150-item self-report instrument developed by Snyder (1997). The earlier version, MSI (Snyder, 1981), was well regarded and one of the most often used relational inventories in research and clinical practice. The MSI-R has 13 scales:

- Global Distress
- Affective Communication
- Problem-Solving Communication
- Aggression
- Time Together
- Disagreement About Finances
- Sexual Dissatisfaction
- Role Orientation
- Family History of Distress
- Dissatisfaction With Children
- Conflict Over Child Rearing
- Inconsistency (validity scale)
- Conventionalization (validity scale)

The MSI-R is useful as a diagnostic and a therapeutic tool, as well as a screening instrument. Psychometric properties of and additional information about MSI-R are discussed in Chapter 7.

_The MSI-R as an outcomes measure_. The MSI-R is typically used in the initial phase of therapy in discussing the couple’s presenting concerns and in formulating treatment goals. However, it can also be utilized before and after therapy, in a pre–post-treatment fashion, to evaluate overall treatment outcomes (Frank, Dixon, & Grosz, 1993; Iverson & Baucom, 1988; Snyder & Berg, 1983; Snyder, Mangrum, & Wills, 1993; Snyder, Wills, & Grady-Fletcher, 1991). Snyder and
Aikman (1999) also note the value of using MSI-R serially throughout the course of treatment in the evaluation of change and for revising treatment goals and interventions. The instrument “can be readministered at multiple points during treatment to evaluate and consolidate gains that the couple has made and to identify residual areas of distress for further work. This idiographic approach to outcome evaluation emphasizes within partner change across time” (Snyder & Aikman, 1999, p. 1198).

The Intersession Report

Brief description of the Intersession Report. The Intersession Report is a recently reported short and easily administered instrument for individuals and couples as well as families (Johnson, Ketring, & Anderson, 2010). It has nine items, the first eight of which are suitable for individual clients, while the ninth item—which rates the couple’s relationship with the therapist—is added when working with couples. The Intersession Report assesses clients’ level of functioning and symptomatic distress, as well as the therapeutic alliance. Accordingly, three subscales represent Functioning, Symptoms, and Alliance. Reported psychometric properties suggest the instrument is reasonably robust. Cronbach’s alpha estimates range from .74 to .90. Convergent and discriminant validity was established by correlating it with the Outcome Questionnaire 45.2 (OQ-45.2), the Revised Dyadic Adjustment Scale (RDAS), the Experiences in Close Relationships (ECR), and the Couples Therapy Alliance Scale (CTAS). Results of exploratory factor analyses and low correlations among the three subscales of the Intersession Report suggest that the three subscales are distinct.

The Intersession Report as an outcomes measure. The instrument is administered at the beginning of each session. It takes about 2 to 3 minutes to complete and about 1 minute to review and score. The authors indicate that it provides useful ongoing feedback to the therapist. They also indicate that session-to-session use provides feedback that can decrease attrition and improve supervision (Johnson et al., 2010).

STRATEGY FOR ONGOING ASSESSMENT

The following six-step protocol can be useful in utilizing the GARF, SFI, SAFE, DAS, and MSI-R when measuring and monitoring clinical outcomes with couples and families.
1. Initially interview the couple or family.
2. Choose and administer specific inventories.
3. Collect collateral data (relevant work, school, medical records, etc.) and other interview data.
5. Monitor ongoing clinical outcomes and modify treatment accordingly.
6. Evaluate pretreatment and post-treatment outcomes, if feasible.

Well-executed interviews of the couple and family (Step 1 and Step 3) are essential in providing sufficient data and background information to develop and implement an effective treatment plan and intervention strategies. At the present time, the decision of which inventories and rating scales (Step 2) to use to measure and/or monitor clinical outcomes is much less complex than the protocols suggested by Bagarozzi (Chapter 6) or Yingling (Chapter 8). For example, Bagarozzi advocates a four-step funneling or filtering process that progresses from choosing global measures to focused measures. Because of the limited number of suitable potential inventories and scales (i.e., ease of administration and reasonable cost), the clinician might decide to utilize the SFI and GARF or the SAFE and GARF with families and use the GARF and DAS or MSI-R with couples.

Step 5 reflects the basic reason for monitoring outcomes, for example, session by session, every third session, and so forth. In this step, outcomes data transform into valuable feedback information that the clinician can utilize to modify the course and duration of treatment in terms of focus, modality, and intervention strategies. As a result of this feedback and subsequent treatment “course correction,” couple or family therapy becomes more closely tailored to couple or family need and circumstance. Presumably, this should lead to more effective and efficient treatment. Finally, the clinical value of outcomes measurement can be evaluated in Step 6 by examining overall pre–post-treatment effects on the given outcome measures, inventories, and/or scales.

CASE STUDY

Jack and Nancy, both age 33, were referred to couples therapy by Nancy’s gynecologist. During their first conjoint session (Step 1), the therapist learned that the couple had been married for 7 years and had a 2½-year-old daughter, Sybil. Sybil was their “wonder” child because she had been born after several years of unsuccessful efforts to conceive, including 2 years of painful fertility treatment. Jack had been an accountant at a
low-tech manufacturing corporation until he was laid off some 3 months previously; Nancy had worked as a nurse at a local hospital for 3 or 4 years before she married Jack. Both had known each other since college but had never really seriously dated until after graduation.

The couple presented with increased argumentativeness, social and emotional withdrawal, and decreased sexual intimacy. These issues were relatively new in their relationship, apparently beginning soon after Sybil’s birth. Nancy had been concerned about Jack’s rigidity and seeming lack of emotional expressiveness since they had married and on more than one occasion had indicated her desire for them to seek couples therapy, but Jack was not interested in talking to anyone about himself or his marriage. In the time since he had been laid off, Jack had become increasingly sullen and emotionally distant; Nancy, who had been working part time at the hospital, now felt “forced” to go full time to cover their bills. She was particularly distraught about this because it meant she had less time to care for her daughter. During a recent appointment with her gynecologist, Nancy had begun sobbing when asked how she was doing. It was at this point that the gynecologist referred Nancy for conjoint couples therapy. Both partners acknowledged a moderate level of commitment to their marriage and an even deeper commitment to Sybil, who had become, for all practical purposes, the center of their lives.

The plan was to administer the MSI-R to the couple at the end of the first conjoint session and to interview Nancy and Jack individually in the following week. Then, during their second conjoint session, extensive feedback would be provided incorporating MSI-R, GARF, and interview material to formulate a tailored treatment plan collaboratively with the couple. GARF would be evaluated at each conjoint session, and the MSI-R was to be administered after every third session and after the last session (Step 2).

Individual interviewing provided a fuller understanding of each partner, their attraction to one another, and the nature of their marital relationship. Nancy’s description of her family of origin suggested that she had experienced a warm and secure attachment style and that her early life experiences with parents, siblings, and peers were wholesome and supportive. Her parents were described as encouraging and believed in expressing affection openly. She was the oldest of three siblings and enjoyed helping her mother raise her younger sister and brother. Nancy was a very good student and a leader among her peers. Although Nancy’s depression did not meet criteria for a major depressive episode, a diagnosis of adjustment disorder with depressed mood was noted. Although her current GAF was 54, her highest level of function in the past 12 months was judged to be about 85.
On the other hand, Jack’s family of origin was less warm and less secure. His mother was described as emotionally unavailable, and his father was often critical and demanding. He was a second child and, although he was a competent student, he was no match for his older brother, who was an honor student and top athlete. Needless to say, his brother was his father’s favorite child. Jack’s fearful attachment style seemed to reflect a sense of personal unworthiness along with an expectation that others would be rejecting and untrustworthy. Jack’s current GAF was 62, although his highest level in the past year, when he was still working and quite content with his professional and family life, was probably about 72.

Not surprisingly, Jack had been wary of intimacy and tended to be socially distant and even awkward. However, he felt and acted differently when he first met Nancy. Her energetic presence seemed to make him come alive and feel hopeful about himself and the future. For her part, Nancy was attracted to Jack’s quiet, patient gentleness as well as his ruggedly handsome features. Nancy described Jack as a caring father who adored Sybil. She noted that he was certainly more patient as a parent than she and that she had no qualms about his ability to care for their daughter while she was working. Nevertheless, she was angry that she had to work full time and so could not spend much time nurturing her growing daughter. It appeared that this reasonably healthy couple’s GARF might have been in the mid-70s during the best period of their relationship but had slipped considerably in the past several months (Step 3).

An initial MSI-R profile was derived. It was noteworthy that raw scores on Global Distress (GDS) and Affective Communication (AFC) and Problem-Solving Communication (PSC) were extremely high for Jack and Nancy (see CS-1 in Table 5.1). In line with interview data, Jack and Nancy reported considerable marital distress in their relationship (GDS) and acknowledged a high degree of dissatisfaction with the extent of affection shown each other (AFC). This was particularly evident for Nancy, which reflected Jack’s emotional distancing and lack of warmth. Similarly, the profile for both suggested their difficulty in intimate sharing, which most likely was exacerbated by their difficulty in resolving problems and conflict (PSC).

A GARF score of 52 was assessed, using Yingling’s profiling system for the GARF (1998). Subscores on Interactional (46), Organizational (56), and Emotional Climate (42), as well as an overall score of 52 were recorded (see Table 5.2). Similar to the MSI-R, their GARF profile suggested that communication was frequently inhibited by unresolved conflict, that ineffective anger and emotional deadness interfered with their
### TABLE 5.1  MSI-R Subscale Score Monitoring per Specified Conjoint Session (CS) for Female (F) and Male (M) Partners

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Gender</th>
<th>CS-1</th>
<th>CS-3</th>
<th>CS-6</th>
<th>CS-9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Distress (GDS)</td>
<td>F</td>
<td>13</td>
<td>11</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Affective Communication (AFC)</td>
<td>F</td>
<td>12</td>
<td>8</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>13</td>
<td>10</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Problem-Solving Communication (PSC)</td>
<td>F</td>
<td>13</td>
<td>13</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>12</td>
<td>11</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Aggression (AGG)</td>
<td>F</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Time Together (TTO)</td>
<td>F</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Disagreement About Finances (FIN)</td>
<td>F</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sexual Dissatisfaction (SEX)</td>
<td>F</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>13</td>
<td>13</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Role Orientation (ROR)</td>
<td>F</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Family History of Distress (FAM)</td>
<td>F</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Dissatisfaction With Children (DSC)</td>
<td>F</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Conflict Over Child Rearing (CCR)</td>
<td>F</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### TABLE 5.2  GARF Scores and Subscore Monitoring per Conjoint Session (CS)

<table>
<thead>
<tr>
<th>Subscale/global</th>
<th>CS-1</th>
<th>CS-2</th>
<th>CS-3</th>
<th>CS-4</th>
<th>CS-5</th>
<th>CS-6</th>
<th>CS-7</th>
<th>CS-8</th>
<th>CS-9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interactional</td>
<td>46</td>
<td>46</td>
<td>62</td>
<td>66</td>
<td>70</td>
<td>71</td>
<td>78</td>
<td>80</td>
<td>83</td>
</tr>
<tr>
<td>Organizational</td>
<td>56</td>
<td>56</td>
<td>62</td>
<td>65</td>
<td>65</td>
<td>75</td>
<td>78</td>
<td>81</td>
<td>86</td>
</tr>
<tr>
<td>Emotional Climate</td>
<td>42</td>
<td>45</td>
<td>51</td>
<td>55</td>
<td>60</td>
<td>60</td>
<td>65</td>
<td>70</td>
<td>80</td>
</tr>
<tr>
<td>Global therapist</td>
<td>52</td>
<td>52</td>
<td>58</td>
<td>63</td>
<td>68</td>
<td>70</td>
<td>75</td>
<td>80</td>
<td>83</td>
</tr>
</tbody>
</table>

http://www.routledgementalhealth.com/family-assessment-9780415894074
relationship, and that their decision making was intermittently effective at best. In short, ineffective communication was inhibiting intimacy, problem resolution, and decision-making processes.

Based on these clinical data, a treatment focus, goals, and intervention strategies were planned and implemented. Because this was a reasonably healthy and functional couple facing a major stressor (i.e., job loss and its relational sequelae) and the couple appeared to have some relational skill deficits, skill-focused couples therapy seemed indicated. It is also noteworthy that this couple brought some important strengths to therapy: a relatively conflict-free 7-year marriage, their positive experience as parents, and Nancy’s early secure attachment style, which implies that she possesses considerable emotional resilience. Accordingly, the goals of treatment were to increase communication and foster emotional intimacy and effective problem resolution and decision making (Step 4).

The first and second sessions initiated this emphasis on communication by focusing on increasing listening skills and learning to use the language of affect. Little change was noticed on GARF subscales after session two or on GDS, AFC, and PSC scores of the MSI-R. Accordingly, the treatment focus shifted in subsequent sessions to assertive communication and conflict resolution. For the next four sessions, the couple worked in sessions and between sessions on skill learning and practice in these two areas. Not surprisingly, Interactional, Organizational, and Emotional Climate subscales of the GARF improved (see Table 5.2), as did the AFC and PSC subscales of the MSI-R when they were assessed at the sixth session. Because overall marital distress and dissatisfaction with this couple seemed to be linked intimately to affective communication and problem-solving communication, the GDS was significantly lowered by the sixth session (see Table 5.1). Subsequent sessions—sixth through the ninth—focused even more on emotional intimacy as well as problem solving involving specific issues such as jobs and careers. Relationally, things had improved considerably, so treatment would terminate with the ninth session.

In session eight, Jack announced he had just been offered the position of comptroller for a mid-size service corporation. Although this was the next step in a senior accountant’s career path, it was a step that Jack had avoided for the past few years, even though others had noted that he possessed the requisite skills and experience. Although he admitted to some feelings of uncertainty about whether he could handle the kinds of responsibilities associated with that position, he felt that with the recent upsurge in Nancy’s support and encouragement, he would succeed (Step 5).
Pre–post-treatment outcomes reflected the significant degree of change and growth in this marital relationship. On the MSI-R, major pre–post-treatment changes were noted on the three subscales directly related to the couple’s main concerns. On the GDS, the changes went from a 13 to a 2 for Nancy and a 12 to a 3 for Jack; with AFC, changes went from 12 to 2 for Nancy and 13 to 0 for Jack; and with PSC, changes went from 13 to 3 for Nancy and 12 to 2 for Jack. On these subscales, changes went from the highest, or most, problematic to the lowest, or least, problematic range (see Table 5.1). On the GARF, a noticeable shift in relational functioning was from occasionally unsatisfactory to highly satisfactory. More specifically, the following subscale changes were noted: Interactional subscale from 46 to 83, Organizational subscale from 56 to 86, Emotional Climate subscale from 42 to 80, and overall GARF from 52 to 83. In other words, now a greater degree of shared understanding and agreement about roles, tasks, and decision making; better problem-solving communication and negotiation; and a general atmosphere of warmth, caring, and sharing were present (Step 6; see Table 5.2).

CONCLUDING NOTE

Because the concepts covered in this chapter have only recently become a part of the conversation of assessment with couples and families, they are seldom discussed in texts on family therapy, much less books on family and couple assessment. Nevertheless, the paradigm shift in accountability in clinical practice has propelled clinical outcomes assessment to center stage. This chapter highlighted five inventories or scales that have been shown to have some clinical utility in measuring and monitoring outcomes in couples and family therapy. Presumably, other instruments exist that research and clinical practice will show have similar value (Table 5.3).

The future of ongoing assessment is bright with the promise of additional instruments. For example, the INTERSESSION STIC is a newly developed instrument for ongoing assessment of individuals, couples, and families. It is derived from the Systemic Therapy Inventory of Change (STIC) but is substantially shorter and designed to be administered to clients prior to each session following the first (Pinsof & Chambers, 2010). The psychometric properties of the STIC have already been published, with the psychometrics of INTERSESSION STIC following in a subsequent article (Pinsof et al., 2009).
<table>
<thead>
<tr>
<th>Assessment Instrument</th>
<th>Type/ Use</th>
<th>Cultural/ Language</th>
<th>Instruction/Use: T = Time to Take</th>
<th>Computerized: (a) Scoring</th>
<th>Reliability (R)</th>
<th>Validity (V)</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Assessment of Relational Functioning</td>
<td>Therapist rating/couples &amp; families</td>
<td></td>
<td>5–10 min for inquiry/scoring</td>
<td>None</td>
<td></td>
<td></td>
<td>Appendix B of DSM-IV-TR</td>
</tr>
<tr>
<td>(GARF)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Report Family Inventory (SFI)</td>
<td>Self-report/families</td>
<td>Yes, Chinese</td>
<td>Easy to administer, 5–15 min (36 items)</td>
<td>None</td>
<td>R = Test-retest</td>
<td>.30–.87 Criterion-related</td>
<td>Journal article</td>
</tr>
<tr>
<td>Systematic Assessment of Family Environment</td>
<td>Self-report/families</td>
<td>Yes, Spanish</td>
<td>(21 items)</td>
<td>a = Yes</td>
<td></td>
<td></td>
<td>Yingling et al. (1998)</td>
</tr>
<tr>
<td>(SAFE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Satisfaction Inventory, Revised</td>
<td>Self-report/couples</td>
<td>Yes, Spanish</td>
<td>25 min to administer &amp; score (150 items)</td>
<td>a = Yes b = Interpretive report</td>
<td>Factor analysis</td>
<td></td>
<td>Western Psychological Services, Inc.</td>
</tr>
<tr>
<td>(MSI-R)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dyadic Adjustment Scale (DAS)</td>
<td>Self-report/couples</td>
<td>Yes, French, Chinese</td>
<td>5–10 min (34 items; also a 14-item version)</td>
<td>a = Yes</td>
<td>R = .86–.96 V = .86–.88</td>
<td></td>
<td>Journal article; Multi-Health Systems, Inc.</td>
</tr>
<tr>
<td>SCORE 15</td>
<td>Self-report/families</td>
<td>Translations under way</td>
<td>2–5 min to administer &amp; score (15 items)</td>
<td>None</td>
<td>R = .89 alpha .88 split-half</td>
<td></td>
<td>Journal article; website</td>
</tr>
<tr>
<td>Intersession Scale</td>
<td>Self-report/individuals &amp; couples</td>
<td></td>
<td>2–5 min to administer &amp; score (9 items)</td>
<td>None</td>
<td>R = .74–.90 V = Convergent &amp; discriminant</td>
<td></td>
<td>Journal article</td>
</tr>
</tbody>
</table>
REFERENCES


