

ASSESSMENT OF FAMILY FUNCTIONING AT MULTIPLE LEVELS:  
AN EXPLORATORY INVESTIGATION OF THE DYNAMIC ASSESSMENT OF  
FAMILY FUNCTIONING INVENTORY – DEMONSTRATED UNDER CLINICAL  
CONDITIONS (DAFFI-DUCC):  
HOW DESPICABLE IS THE DAFFI-DUCC?

BY

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## Abstract

Family assessments that consider multiple levels of family functioning serve to provide a more comprehensive picture of family functioning, as well as highlight those areas most in need of problem remediation and intervention. The purpose of the present study was to investigate the reliability of the Dynamic Assessment of Family Functioning Inventory – Demonstrated Under Clinical Conditions (DAFFI-DUCC; Cerio, 2009), a novel, multi-level assessment of family functioning designed for clinicians-in-training. The study had two foci: 1) to determine if raters, in general, identify the same problems, structural components, and dynamic interactions of a given family; and 2) to determine the extent to which a raters’ training and professional experience effects ratings on the DAFFI-DUCC. Results demonstrated that, in general, there were many theoretically circumscribed areas that raters, regardless of training or experience, were able to agree upon as being highly problematic. Between group differences may be attributed to differences in raters’ theoretical orientations that employ different “languages” when working with and assessing a family, or to a given rater’s lack of specificity of response (i.e., offering multiple explanations for a given phenomena). Overall, although the DAFFI-DUCC is a heuristic instrument that facilitates the acquisition of family systems concepts for the burgeoning clinician, and is capable of providing guidance for session planning and problem remediation, the current version of this assessment tool does not appear to be practical for practicing clinicians. Its qualitative format lends to subjective interpretations that, in specific DAFFI-DUCC domains, are not readily interpretable. Although there was significant agreement about certain components of family functioning, the lack of specificity/instruction in areas such as structural diagramming, as

well as the difficulty in categorizing metaphors due to their subjective relativity, make the DAFFI-DUCC an inadequate tool for assessing families without further development and revision.

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Chapter 1

**Introduction**

With an increasing awareness of contextual factors and their contribution to problems manifested at an individual level, psychologists have been given an opportunity to expand their ideological lens to encompass a broader scope. Specifically, they are presented with the task of creating methods for measuring multi-individual groups, as well as developing techniques for intervening at relational and systemic levels. However, the paradigm shift from the individual to the collective is not without its idiosyncratic and formidable challenges. Family assessment is complicated and requires psychologists studying families and family health to integrate into their newly expanded understandings of interdependent functioning equally novel assessment techniques.

Families are groups of individuals, each of whom possesses unique traits and characteristics that invariably interact with the unique traits and characteristics of other family members. What makes this particularly challenging, in terms of assessment, is attempting to account for all the pertinent interactions between component parts of the group (i.e., family members) that comprise the assessor's particular area of interest. Historically, initial approaches to family assessment included the use of measurement tools designed for individuals. Although these early assessments efforts were able to

provide useful information regarding the functioning of a given family member, they did so at the exclusion of the relational and systemic characteristics of interest to the family psychologist (e.g., the relational dynamics between two family members, between three family members, ad infinitum and how this confluence of individual, dyadic, triadic, etc., forces result in a gestalt of functioning greater than the whole of the family). Specific methodological challenges for family assessment include:

- Who should be included in the family assessment?
- Is it more important to focus on the whole or the parts?
- What measurement techniques yield the most reliable and accurate results?
- Are individual self-report measures valid indicators of relational functioning?
- Do objective observations provide a more accurate assessment of family functioning, or are insider perspectives more valid?

Recent research has indicated that self-report instruments intended to assess relational dynamics are incapable of doing so given the inability of certain scale items, or data analysis procedures, to accurately or appropriately capture this relational quality (Cook & Kenny, 2004; Manders et al., 2007). Difficulties have also been noted regarding the inability of lower level analysis (e.g., individuals) to provide insight into functioning at higher levels (e.g., families; McCall & Simmons, 1991). Finally, challenges have surfaced regarding the ability of an outside observer (i.e., clinician) to remain objective after developing a relationship with a family (Surra & Ridley, 1991), as well as an observer's ability to effectively and comprehensively ascertain the collective and individual functioning of multiple individuals within a circumscribed amount of time (Whiston, 2000). Literature in the field currently indicates that multilevel, multi-method

approaches to family assessment are paramount to obtaining the most comprehensive and accurate information about family functioning (Carlson, 1989; Cromwell & Peterson, 1983; Floyd, Weinand, & Cimmarusti, 1989; Green & Vosler, 1992; Powers, 1989). The use of multiple raters, varied assessment procedures (e.g., self-report, ratings scales, observation), and corresponding data analysis techniques is the proposed “gold standard” in family measurement.

The dictionary definition of the word “assess” is, “to estimate or judge the value, character, etc., of; evaluate: to assess one's efforts” (Dictionary.com Unabridged, n.d.). Salvia and Ysseldyke (2001) have defined assessment as “a process of collecting data for the purpose of making decisions about individuals and groups” (p. 5). Furthermore, an assessment procedure has been defined as “any method used to measure characteristics of people, programs, or objects” (*Standards for educational and psychological testing*, 1985). Explicitly, given the above definitions, family assessment practices are intended to evaluate dimensions of a family in order to draw conclusions or make decisions related to that family. More implicit is the idea that assessment entails comparison, and that some normative standard exists against which comparisons can be made. Before we can assess families we must first define what “family” is, and subsequently, examine the normative criteria used to make comparisons.

Families are complex. Defining families is equally as complicated. What makes a family a family is largely determined by who is answering the question. Family structure varies by culture and context, time and place. An assemblage of three can be a complete family in their downtown apartment, or amongst handfuls of relatives at an annual reunion. There are families of single mothers and of single fathers, as well as

two-mother and two-father families. Some families have children, while others are content living comfortably as a couple. There are families where grandparents are raising their children's children, and there are families where the children are given the task of raising their own siblings. Bloodlines define some families, whereas in other contexts, family membership is defined by proximity and engagement over time, or even mutually shared values and beliefs. Understanding the dynamism of families requires a flexible taxonomy comprehensive enough to provide adequate guidance when working with these complex entities.

When determining what is “problematic,” comparisons are made to a standard of normality. Understanding what is “normative family functioning” is important in the assessment of families – it provides a comparative basis from which we can better understand the confluence of forces impacting upon families and move towards providing families with effective and meaningful treatment. However, considerations must always be made when deciding if a family is similar to other families. In order to avoid pejorative monikers derived from passing trends in family health, as well as an evolving understanding of family dynamics, it is helpful to apply the concept of normalcy to the *process* of family development, as opposed to the *content* of a family's presentation in functioning at any one given time (Walsh, 2003a). In general, all families will experience various changes throughout their existence. Therefore, what is *normal* is partly determined by the family's developmental stage (i.e., where a family is in their developmental lifecycle). The focus on process over content allows for the incorporation of the multiple recursive influences impacting families throughout their lifespan. It also helps to de-pathologize some of the more typical family stressors encountered by families

throughout their development, embracing them as expected landmarks on the journey, as opposed to fatalistic indicators of malignancy.

In an effort to provide a general definition of healthy family functioning, Constantine (1986) has suggested that healthy, or what he termed *enabled*, families are successful in carrying out two functions: ensuring the survival of the family system, and facilitating optimal growth for individual members within the family. Walsh (2003) echoes this definition with the idea that successful family functioning depends on the compatibility, or fit, between individual *and* family needs. Furthermore, she stresses the importance of how the family “fits” within their social context. This notion of “fit” implies a synchronicity across system levels, both within and outside of the family, indicating that a family’s ability to meet the demands of a given situation is what helps constitute healthy functioning.

How does one determine whether or not a family is healthy? The fluidity of the definition of “family” – its temporal quality shifting between cultural contexts, time periods, and with the idiosyncratic attributes resulting from the coalescence of individual characteristics into the family gestalt – has led many researchers and practitioners interested in this subject to devise theories regarding the underlying mechanics of family functioning and family health. Systemic thinking has provided the foundation upon which these theories are erected.

### **General System Theory**

Scores of researchers and practitioners concerned with human well-being have attempted to define and assess family functioning. Ludwig von Bertalanffy (1969) was one of the early pioneers who challenged the idea of an individual’s functioning being

contingent solely on their own inner psychological and physiological processes (i.e., organismic reaction determined by internal drives or learned behaviors). Instead, he advocated for thinking in terms of interactions and the dynamic interdependence between phenomena. Concepts derived from von Bertalanffy's General System Theory have been applied to various, seemingly unrelated, disciplines; extending this thinking into the fields of psychology, psychiatry, engineering, social policy, and business, his ideas provided a platform from which to build a more integrated view of the human condition, as well as a more comprehensive understanding of its complexities (von Bertalanffy, 1969, 1981).

When applied to social groups and individuals, this interpsychic view of difficulties has provided information linking contextual factors to dysfunction, moving away from the decontextualized, inherent defectiveness of the individual (Nichols & Schwartz, 2006). Evidence for this interdependence has been demonstrated in the literature of parental factors and their contribution to children's development of mental health concerns (Lyons-Ruth, Zeanah, & Benoit, 2003). In general, systems theory has been integral in both the conceptualization of family systems, as well as in the development of intervention strategies for families (i.e., therapeutic schools). Two major sub-disciplines in family therapy incorporating a systemic lens are the ideological schools of Structural Family Therapy, and Strategic Therapy.

### **Structural Family Therapy**

Salvador Minuchin is the figure most regularly associated with Structural Family Therapy (SFT). His emphasis on the organizational processes of families and the problematic ramifications of specific structural arrangements and interactional patterns

has guided the training and treatment practices of professionals working with families around the world. The theory underlying SFT purports that families cannot be understood outside of their immediate contexts, including where the family is in their developmental lifespan.

According to SFT, families are seen as interdependent groups of people whose individual behaviors between one another contribute to an overall family gestalt. SFT views families as living systems in a dynamic process of change related to the unique challenges and lifecycle stages encountered by each family. In addition, families are viewed as open systems subject to influences from within and outside of the family system. Problems are viewed as resulting from imbalances and/or rigidity within the family. Specifically, when families have difficulty adapting to developmental stressors or environmental challenges, problems manifest (Minuchin, 1974).

Nichols and Schwartz (2006) outlined three core constructs of structural family theory: structure, subsystems, and boundaries. As a brief problem-solving approach, SFT provides a diagnostic lens for the practitioner to employ when observing family interactions: once a family's structure is assessed (i.e., problematic structural dynamics are identified), the practitioner then has the ability to intervene and work towards goals for structural change. Furthermore, SFT posits universal characteristics of families. These include family hierarchies, rules, and boundaries. Again, a family is considered functional when there is a good "fit" between the family's structure and the family's developmental and social needs (Walsh, 2003b).

### **Strategic Family Therapy**

Another brief problem-solving approach in family therapy is the atheoretical school of Strategic Family Therapy. Pioneered by figures such as Jay Haley (Haley, 1976) and Cloé Madanes (Madasnes, 1981), Strategic Therapy eschews theory, asserting that its use reifies problems and avoids finding solutions. Instead, strategic therapists focus on the unique context of problems. Families that are flexible in their problem-solving, that utilize a range of solutions when confronting problems, are considered functional. Families that are rigid in their application of solutions encounter more difficulty (Walsh, 2003b).

Like its structural counterpart, the Strategic approach assumes the presence of hierarchies and rules as a governing mechanism for power within the family. This theory also emphasizes the need to contextualize symptoms and for the therapist to normalize family distress as a part of the therapeutic process. According to Haley (1976), symptoms of a problem can be identified through communicative acts between individuals. A particular communication, in and of itself, is not necessarily good or bad. What is important is the degree to which that particular communicative act (usually a reinforced pattern of relating developed over time) maintains a problematic relationship among the individuals in question. Therefore, treatment from this context consists of addressing maladaptive feedback loops (i.e., patterns of verbal and non-verbal communication). Furthermore, it is incumbent on the therapist to catalyze change and to reframe/define the problem into one that is solvable by the family.

### **Family Assessment**

In terms of assessment, families have been viewed as complex systems whose functioning is a result not only of the various dyadic interactions between members, but

also on triadic interactions, power differentials, and dynamic structural patterns. The level on which a family is assessed is a point of contention in the field. The type of ratings employed, the quality of the assessment (i.e., observational coding vs. rating scales), as well as the source of the information (i.e., insider vs. outsider), each color the clinician's impression of the family, as well as the intervening strategy to be employed. Needless to say, the field is rife with decades of literature focused on the assessment of families.

In their discussion of issues for family research, Grotevant and Carlson (1989) identified three criteria for the assessment of families: 1) there should be a theoretical rationale linking the assessment strategy to the particular family theory; 2) "within family" assessments should occur on multiple levels with theoretical tenets guiding the linkages between these levels; and 3) the assessment measure should possess psychometric integrity. Overall, a comprehensive assessment of families should consist of an evaluation of both insider and outsider views of a problem, as well as micro- and macroanalyses of the family (Grotevant & Carlson, 1989).

Utilizing some of the criteria for the comprehensive, thoughtful assessment of families as set forth above, the present study is an attempt to investigate a theoretically informed, multi-level assessment of family functioning. The Dynamic Assessment of Family Functioning Inventory – Demonstrated Under Clinical Conditions (DAFFI-DUCC; Cerio, 2009) is a clinical training tool designed to evaluate seven dimensions of family functioning as posited by the Structural and Strategic schools of family therapy. Utilizing a clinician's observations of family interactions, the DAFFI-DUCC helps the clinician skeletonize these theoretically based dimensions, as well as the extent to which

certain relational arrangements, beliefs, and interactional patterns contribute to undesirable functioning within the family. The DAFFI-DUCC considers functioning at individual, dyadic, triadic, and whole family levels, while attempting to contextualize family problems within a developmental framework. Furthermore, the open-ended, qualitative nature of the assessment offers flexibility for the assessment of non-traditional family systems.

In an effort to establish the psychometric integrity of the DAFFI-DUCC, the present study has two foci: 1) to determine if raters, in general, view the same problems, structural components, and dynamic interactions of a given family; and 2) to determine the extent to which a rater's training and experience effects ratings on the DAFFI-DUCC. Determining if raters, in general, make similar assessments will help to establish the DAFFI-DUCC's external validity; examining differences between ratings based on a rater's training and/or experience helps to determine if the instrument's instructions are a prerequisite for accurate use of the DAFFI-DUCC, as well as whether ratings vary as a result of a rater's understanding and practice with family systems concepts.

## Chapter 2

### **Review of the Literature**

From its inception, family therapy has accumulated a proliferation of theoretical postulations pertaining to family dynamics, each theoretical school having its own beliefs regarding assessment and assessment practices (Nichols & Schwartz, 2006). Various approaches and methods have been devised in order to evaluate families and their functioning. In her commentary on family assessment, Powers (1989) outlines four key issues in the assessment of families: the relationship of research and clinical assessment; the linkage between theory and practice; the relationship between insiders' and outsiders' perspectives on family functioning; and the level on which a family is assessed. Additional assessment issues, such as the family's developmental level (McGoldrick & Carter, 2003), as well as the need for validating theoretical constructs pertaining to families (Street & Foot, 1990), are also considerations that cannot be overlooked. Given the complexity of the family system, it is understandable that the myriad explanations regarding how to best assess these entities has driven much debate; however, this intellectual conflict has also helped to refine assessment ideas and practices, facilitating the continuing evolution of the field as a whole.

Grotevant (1989) reports that assessment is focused on gathering data from behavioral, cognitive, and emotional domains. For researchers and clinicians in the field of psychology, the practice of evaluating persons and events is commonplace. With the charge of making decisions for individuals and institutions, the psychologist is responsible for collecting meaningful, accurate data that will assist her in subsequent planning and decision-making processes. Since some of these decisions may have a

profound and lasting impact on the client, it is important that assessment strategies be of the highest integrity and produce reliable, consistent, and valid results.

The application of assessment to the functioning of families is not only beneficial, but a necessary practice. It is linked to diagnosis, treatment planning, and monitoring of outcomes (Gladding, 2002). Assessment is helpful in identifying the issues and concerns underpinning clients' presenting problems and determining the severity of those problems. It also helps to identify client strengths and the course of therapeutic action that will be most beneficial for expiating the client's referral concerns (Whiston, 2000). Given that individuals are embedded within the context of their respective families, incorporating the assessment of system dynamics and family structures is paramount to enabling system, and concomitant individual, change (Sperry, 2004a). Finally, given the comparative viridity of family psychology and family therapy in relation to the original establishment of psychology and its individual focus, family assessment practices that build accountability into clinical work (e.g., treatment planning and rationale, documentation of service provision, and progress monitoring) help to establish both therapeutic integrity on behalf of the practitioner, as well as general credibility of responsible practices for the field of family psychology as a whole (Gladding, 2002).

With these benefits in mind, there are also challenges associated with family assessment. First, there is difficulty with the subject of measurement. Families are not static entities; they are fluid and changing. As each member naturally develops and changes, these shifts will impact the family as a whole and influence its developmental trajectory (Szapocznik & Kurtines, 1989). This dynamism is a hurdle for family researchers in that, when attempting to explain families via theoretical formulations, a

wide range of reasoning behind the etiology of family functioning has surfaced. It has been noted that there is no unified theory of family functioning (Grotevant, 1989), with most models developed on a white, middle-class population (Bray, 2004), which in turn jeopardizes the generalizability of theoretical formulations, assessment results, and treatment applications.

Second, there are challenges with methods of measurement. An assessment's level of analysis – individual, dyad/subsystem, whole family – has been a concern in the field. Given multiple levels, should assessment focus on the individual, dyads, or the whole family? If the focus is on subsystems, which subsystem should be a priority? Another measurement issue concerns data collection procedures. Whether using self-report strategies or observational methods, each procedure has benefits and costs. Accounting for the unique subjective insights of all family members is important, but may neglect some of the unconscious behaviors only available to an outside, objective observer.

In order to address some of the methodological challenges in the assessment of families, as well as to reflect the multiple levels of functioning inherent to family systems, assessment strategies that incorporate multiple levels and methods of assessment have been recommended (Bray, Maxwell, & Cole, 1995; Carlson, 1989; Chamberlain & Bank, 1989; Cromwell & Peterson, 1983). Efforts to create relational data from individual-level assessments have been proposed and include methods such as arithmetic mean, sum of scores, extreme scores, difference scores, combined scaling, multivariate approaches, as well multiple empirical combinations of these methods (Fisher, 1985). Structural equation modeling and the use of latent variable models have also been

employed to incorporate the perspectives of multiple family members when investigating the various levels of family functioning (Cook, 1994; Cook & Goldstein, 1993).

### **Theory and Assessment**

A central, and overarching, area of concern in the field of psychological assessment as a whole, and family assessment specifically, is the linkage between theory and practice. Assessment plays an integral role in the development of theory, or how we understand families. As theories are derived, measurement is used to either confirm or invalidate theoretical hypotheses about families functioning (Carlson, 1989). The recursive practice of revamping our ideas about families with the information gleaned through our work with them facilitates the development of theories that are consistent with available data (Carlson, 1989; Grotevant, 1989). Given this fact, it is imperative that a strong link exists between measurement procedures and their guiding theories. Assessments based on underdeveloped theories can produce vague results and, in turn, lead to less than ideal treatment services.

Concerns regarding the lack of continuity between theory and assessment strategy have been noted as an impediment for the development of family psychology (Carlson, 1989; Cowan, 1987; Grotevant, 1989; Grotevant & Carlson, 1989). From this concern has arisen the need for a unified theory of family functioning, requiring the explanatory power of whole-family level, as well as the triadic, dyadic, and individual levels of functioning within the family (Powers, 1989). The search for a unified theory that would lay the foundation for sound assessment practices seems like futile Pollyannaism given the complexity of families, as well as the plethora of theoretical and practical essays that attempt to deconstruct family functioning down to its simplest component parts; however,

this type of theory is a necessary precursor for a unified approach to meaningful assessment practices that help establish the credibility of family psychology.

Patterson (1997) proposed a unifying model that attempts to bring coherence to the multiple dimensions and constructs posited in the family therapy field. The basic assumption of this model is that a clinician's theoretical orientation is paramount to understanding the etiology of the client's problem, as well as the subsequent goals of treatment. How the problem is solved is secondary, and eclectic methods, even those outside of the theoretical paradigm, may be employed to achieve this end. When applied to family therapy, this idea may be helpful in guiding the clinical work of family therapists, including choosing appropriate assessments that discern the origins of the family's problem. Given that using poly-theoretical approaches makes the task of tying theory to assessment practices challenging, being mindful of the number of theories – and their concomitant assessments – utilized in working with a family will help to ensure more specific assessment practices. Careful coordination of these theories, determining their common elements, may be the best practices approach to family assessment (Powers, 1989).

### **Research Assessment and Clinical Assessment**

In considering the importance of assessment in family psychology, a distinction has been made between research and clinical assessment: the former directed towards answering research questions using the relevant research tools and participants as a means to this end; the latter focusing on identifying a presenting family's problem and creating effective intervention strategies to address treatment needs (Grotevant & Carlson, 1989; Pinsof, 1992). However, primacy cannot be given only to understanding

the underlying mechanisms and internal dynamics of family functioning (research) or deciphering relational valences reflective of some diagnostic typology thought to be contributing to a family's current malaise (clinical). Rather, a synergistic approach, linking theory and practice, has been advocated in order to procure assessment measures informed by theoretical assumptions, as well as tempering these assumptions through the assessment work done within a clinical context (Cowan, 1987; Coyne, 1987; Grotevant, 1989; Grotevant & Carlson, 1989; Powers, 1989).

Pinsof (1992) has delineated two types of problems in family psychology: problems of understanding (i.e., what are the underlying mechanisms of family functioning?) and problems of intervention (i.e., what are the clinical practices that help families to work effectively with their problems?). The two are intimately connected and underscore the reciprocal nature between clinical and research assessment: with greater understanding of how families work provided through research, effective and meaningful clinical practice will follow; through clinical work, theoretical ideas and assumptions can be refined. This reciprocity between research and practice in the field of psychology has been confirmed through anecdotal reports from professional psychologists, their clinical work, and their respective qualitative research (Gale, Chenail, Watson, & Wright, 1996). A reflexive research-practice-research model has pragmatic clinical value in that the data derived from research investigations provides practitioners with useful information to apply in their daily work with clients. It is especially relevant in terms of intervention treatment effects (Kratochwill & Stoiber, 2000).

Despite differences in intention, there are overarching motifs of interest to both clinical and research assessment. According to Bray (2004), five areas are of interest to

all family assessment practices, and include: family composition; family process; patterned relationships; family affect; and family organization. Family composition is concerned with family membership, structure, ethnic orientations and sexual orientations. Family process focuses on how family members communicate and interact, including how problems and conflicts are resolved, and the way that these patterns of interacting solidify over time into patterned relationships. These relationships can have either positive or negative effects on the family as a whole, or on individual family members. Family affect is the quality of emotional expression among family members; variations in this characteristic are mediated by a given family's culture. Finally, family organization is an assessment of the family's method(s) of governance (i.e., roles, rules, and expectations).

**Research assessment.** The question of how families work is a challenging one. The application of systems theory to the family has helped clarify some of the inner-architecture of family functioning; however, given the proliferation of theories regarding families and their functioning, a unified and comprehensive understanding of family constructs and dimensions is not yet a reality (Carlson, 1989; Cowan, 1987; Grotevant, 1989; Patterson, 1997; Powers, 1989). Reifying abstract concepts through scientific study is a goal found in all scientific disciplines (Shadish, Cook, & Campbell, 2002). Through the use of both qualitative and quantitative techniques (Sprenkle & Piercy, 2005), operationalizing theoretical concepts and constructs regarding the family is one of the two primary goals of research assessment – the other being the testing and refinement of those constructs (Carlson, 1989). In terms of psychometrics, the primary focus of research assessment is the validation of the constructs contained within a given family

assessment measurement device. Construct validity is important for research assessment because, through operationalizing constructs, theoretical bridges can be gapped via a common language and conceptual understanding between family psychologists (Carlson, 1989). However, some theoretical constructs are less likely to be clearly defined for further research investigation and legitimization due to the fact that they have been derived from clinical work with families (Powers, 1989).

An additional benefit of research assessment is its ability to establish the field's integrity through the validation of family therapy approaches (Schwartz & Breunlin, 1983). Although a therapeutic paradigm with various theoretical offshoots, research on the effectiveness of family therapy is abundant (Shadish & Baldwin, 2003; Shadish et al., 1993; Shadish, Ragsdale, Glaser, & Montgomery, 1995; Sprenkle, 2003). Positive treatment outcomes for a variety of clinical concerns addressed through systems-oriented approaches have been noted in the literature, including: affective disorders (Beach, 2003); physical disorders (Campbell, 2003); chronic usage of health care services (Law, Crane, & Berge, 2003); schizophrenia (McFarlane, Dixon, Lukens, & Luckstead, 2003); and alcohol (O'Farrell & Fals-Steward, 2003) and substance abuse (Rowe & Liddle, 2003).

**Clinical assessment.** Family assessment has been described as serving two purposes: to guide clinical interventions and evaluate clinical outcomes (Cook & Kenny, 2004). Other goals of clinical assessment include clarifying the family's presenting problem, including understanding how the problem is viewed by all of the family members, and to develop an understanding of the family's structure, the family's functioning, and the mechanisms perpetuating the family's problem (McPhatter, 1991).

In their comprehensive review of common components of family therapy, Nichols and Schwartz (2006) offer a more delineated set of family dimensions assessed by the clinician. Assessment in the treatment context is focused on the following areas: the family's presenting problem; understanding the referral route; identifying the systemic context of the problem; assessing where the family is in terms of their developmental life cycle; the structure of the family (i.e., subsystems and boundaries); family communication patterns; history or current indicators of drug and/or alcohol abuse; history or current indicators of physical and/or sexual abuse; extramarital involvements; members' gender identifications; and cultural factors contributing to or expiating the family's referral concern. The information provided from these content areas facilitates the clinician's understanding of the family, and, ideally, an effective and enduring remediation of the family's presenting problem.

Carlson (1989) provides an overview of the distinct qualities of clinical assessment. Foremost, the clinician's focus is diagnostic and concerned with differentiating between similar psychological/interactive phenomena and to determine the degree to which that phenomenon is problematic for the family and indicative of needing treatment. She also noted that clinical assessment is distinct from research assessment in that it is potentially comprised of the following phases: screening, diagnostics, treatment planning, progress monitoring, and follow-up. In addition, clinical assessment is more concerned with predictive and discriminant validity, a need for normative data, and clinical cut-off scores to help in the differentiation between clinical and non-clinical families. Finally, clinical assessments are more concerned with how well the assessment assists in helping the family overcome its presenting concerns. It is noted that, given this

concern with treatment utility, clinical assessment procedures tend to be more informal and non-quantifiable.

Given the specific theoretical proclivities of a family therapy orientation, the extent to which assessment is used, as well as the type of assessment, will vary. Bowenian family therapists or family therapists employing behaviorist strategies are prone to using formal assessment measures, including genograms, questionnaires and inventories, whereas the structural, strategic and narrative approaches use more informal methods of assessment (Nichols & Schwartz, 2006). Although there are differences in how family psychologists work with their families, there are general characteristics that family psychologists typically assess (Bray, 1995, 2004).

### **Dimensions of Assessment**

Family assessments can be differentiated in various ways. Carlson (1989) proposes that this differentiation lies along two primary dimensions: the assessment's frame of reference, and the type of data gathered by the assessment. From these two dimensions, four assessment types emerge, each with its own psychometric criteria: insider subjective (e.g., self-report measures, projective tests, semi/structured interviews); insider objective (e.g., behavioral self-report); outsider subjective (e.g., clinical rating scales, clinical observations of behavior); and outsider objective (e.g., observational coding schemes). In addition, family assessments can be differentiated by their focus, or level of measurement – whole family, triad, dyad, and individual levels of functioning (Carlson, 1989). Regardless of the intention of the assessment, or the setting in which the assessment takes place, key psychometric properties (i.e., validity, reliability) of family assessments are required to ensure the professional integrity and utility of these measures

(Sperry, 2004a). As a whole, family assessment can be delineated along three major lines: formality of assessment, level of assessment, and perspective of assessor.

**Quantitative and qualitative assessment.** Formality of family measurement can be bifurcated into quantitative and qualitative assessments. The formality of a given family assessment varies with the intended purpose of the assessment, as well as the theoretical practices of the family clinician. Narrative and constructivist family therapists tend not to engage in formal assessment due to their emphasis on subjective experience (Sperry, 2004a). Family therapists utilizing a behavioral approach will be more systematic in their assessments of family interactions, using assessments as a keystone of their practice (Nichols & Schwartz, 2006). Although different in their methods, both qualitative and quantitative measurement techniques strive to collect data in order to inform hypothesis formation and clinical strategizing, so that the result is problem remediation. In terms of process, informal (i.e., qualitative) assessment methods consist of gathering data using non-standardized means. Formal (i.e., quantitative), methods are generally field-tested instruments that have been standardized to account for consistency in administration, scoring, and interpretation.

***Quantitative assessment.*** Quantitative methods of assessment tend to be instrument-based measures that help to quantify and discern various family variables and include standardized, norm-referenced instruments utilized for the measurement of specific variables or features. Examples of quantitative measures include, self-report measures, ratings-scales, and coding schemes. A number of quantitative instruments have been developed for the assessment of family functioning (for a comprehensive review see Carlson & Grotevant, 1987; Grotevant & Carlson, 1989; Sperry, 2004b), some

guided by theory, others developed in clinical practice. Depending on the needs and resources of the clinician, measures that are not traditionally family-oriented can be utilized in the assessment process. Overall, these assessments vary in their target population (i.e., individual functioning, couple/dyadic, functioning, and family/systemic functioning) as well as the variables being measured.

Although not often employed by practitioners – despite the fact of their availability – the merits of utilizing quantitative, formal measures have been noted in the literature (Bray, 2004). Among these advantages are facilitating hypotheses about etiology and treatment, underscoring family, individual and relational strengths and weaknesses, and providing data that can help decentralize a problem in order to redefine the presenting concerns from individual to relational, interactional terms.

Aside from their lack of use, some difficulties with quantitative measures include their lack of treatment utility (Deacon & Piercy, 2001), their impediment to rapport building (Thomas, 1990), and their tendency to produce misleading results due to their inability to adequately capture the complexity of the family (Green & Vosler, 1992). It has also been noted that quantitative instruments may not be considered for use due to the training requirements needed to administer them (Thomas, 1990). Deacon and Piercy (2001) contend that when a family or family member is cognizant of the fact that information they provide the clinician will be used for their treatment, they may be less forthcoming, and/or honest, in their responses. They also mention that, given the emergence and popularity of constructivist and narrative approaches, standardized measures – based on nomothetic principles – are being eschewed for assessment approaches that emphasize the unique circumstances of the individual.

***Qualitative assessment.*** Qualitative assessment is a central strategy of many family therapies ranging from laissez-faire to intervening. Some of the most common types of qualitative assessment include the clinical interview, psychosocial histories, and client-clinician dialogue. Experiential activities that were traditionally used as primary therapeutic interventions can also serve as qualitative assessment tools (Deacon & Piercy, 2001). Such methods include observational strategies, interviewing, graphic methods, and creative and metaphor-based methods (Duffy & Chenail, 2004). Specific techniques include: enactments, structural mapping, genograms, role-playing, storytelling, metaphors, sculpting, and projective measures.

Although not considered to be sufficient on their own, these techniques can act as a useful supplement to quantitative methods and have helped clinical researchers in their practice (Gale et al., 1996). In their review of qualitative techniques in family evaluation, Deacon and Piercy (2001) discuss how, through use of these methods, family members take ownership in the therapy process, generating immediate, relevant data within a session, and mitigating perceived power differentials between client and clinician that can be maintained through a therapist's "working in secret." This, in turn, can jeopardize the rapport building required to establish the essential relationship required for effective treatment (Asay, Lambert, Hubble, Duncan, & Miller, 1999). This collaborative process can also assist in providing meaningful and relevant intervention strategies that can sometimes be overlooked through more standardized assessment procedures (Deacon & Piercy, 2001). The authors also mention that qualitative techniques need to be congruent with the client's comfort level, cognitive and creative abilities, physical abilities, and orientation to reality.

**Level of assessment.** Family assessment is unique in that it has challenged psychological researchers, who have traditionally focused solely on the functioning of the individual, to develop means of measuring the effects of contexts and multiple-person interactions, as well as how those effects play out in multiple realms of functioning. Despite some variation in the nomenclature, family constructs can be divided into three primary levels: the individual, the subsystem/dyad/triad, and the whole family (Bell & Bell, 1989; Carlson, 1989; Cromwell & Peterson, 1983; Gladding, 2002; Hayden et al., 1998; McCall & Simmons, 1991). The individual level of family assessment concerns the psychological and biological factors of an individual family member. The subsystem, or dyad, level focuses on various groupings within the family (e.g., couple, parental, sibling, and parent-child). Whole family assessment is measure of the collective components of the family (i.e., individuals, subsystems), yet it is more than a cumulative measure, and accounts for the emerging dynamic resulting from the interaction of all individual and subsystem effects (Copeland & White, 1991).

**Individual assessment.** At the individual level, the assessor is concerned with the way in which individual characteristics (e.g., cognitive ability, personality, social-emotional-behavioral qualities, respective developmental stage) impact the family and contribute to, or assuage, family problems. Individual assessment is useful in determining the need for treatment of an individual, separate from the whole family (Gladding, 2002). Examples of individual level assessments include self-report measures (e.g., Behavioral Assessment System for Children-2 [BASC-2], Reynolds & Kamphaus, 2004), observational coding schemes and rating scales (when focused on the individual), diagnostic instruments (e.g., Minnesota Multiphasic Personality Inventory-2 [MMPI-2],

Butcher et al., 2001), and cognitive and achievement assessments (e.g., Woodcock Johnson – III Tests of Cognitive Abilities and Achievement [WJ-III COG & ACH], Woodcock, McGrew, Schrank, & Mather, 2001, 2007).

Although some measures purport to assess overall family (e.g., Family Environment Scale [FES], Moos & Moos, 1981) or relational (i.e., dyadic) functioning, if the measure contains information from only one family member, then that instrument is truly focused on the individual assessment level – the level which was coded – (Copeland & White, 1991) and may not be truly indicative of higher-level family functioning. Another concern regarding individual assessment is the inevitability that individual factors are always embedded within a context whose influence is perpetually exerting itself on the individual, influencing her or his choices, behaviors, and cognitions (McCall & Simmons, 1991).

***Dyad/Subsystem assessment.*** Subsystems involve the interplay of one or more individuals comprising a subgroup of a larger unit. According to Minuchin (1974) there are three primary subsystems contained in families – the couple, the parental, and the child subsystem. Subsystems are mechanisms for family differentiation, defined by age/generation, sex, interest, or function. Minuchin asserts that individuals are subsystems, as are the various potential dyads contained within the family (e.g., mother-father, father-child, child-child). Relational mechanics within subsystems operate under principles of complementarity, where one member's role is contingent on another's role, and the unit works to achieve some mutual end (McCall & Simmons, 1991). Given that families contain multiple subsystems, and that any given family member can belong to any number of subsystems at any given time, members' roles and responsibilities shift

across context and time to accommodate the subsystem in which they are immediately engaged (Minuchin & Fishman, 1981).

In terms of measurement, assessment at the subsystem level is useful in identifying potential sources of stress or happiness within the family, helping to establish individual members' views of one another, in addition to underscoring the interaction patterns of specific family members. Furthermore, when assessing the multiple subsystems contained within a family, patterns of communication and their relative functionality can be identified, as well the consistency of relational expectations across the family (Gladding, 2002). It has also been posited that functioning in one dyad effects functioning in other dyads within a family unit (Hayden et al., 1998). Informal measurements such as the structural mapping of dyadic interactions, or of a three-child subsystem, are examples of assessments at this level. Another, more formal example includes two spouses completing rating scales on one another.

Similar to the concern regarding assessment at the individual level, subsystem assessments should provide data regarding subsystem functioning, avoiding the sole use of one family member's evaluations of the inner-workings at this level. In their discussion of level validity (i.e., measuring the construct that an assessment purports to measure, at the level it purports to measure), Cook and Kenny (2006) assert the need to recognize that higher-level (e.g., subsystems, whole-family) functioning is more than just a summation of the individual units comprising these groups. They underscore the difficulties inherent in measuring subsystem levels of family functioning, especially the problems associated with aggregation of self-report data for providing information regarding dyadic operations, and suggest the need for assessments of higher-level groups

to account for the variance of the subsumed lower-level groups. When multiple perspectives are accounted for, and statistical analyses employed that account for both the unique and shared perceptions of each self-report assessment, a more accurate reflection of subsystem functioning can be obtained.

***Whole family assessment.*** A major goal of any family system is to limit the amount of change occurring within the system so as to preserve the system's integrity while simultaneously remaining flexible enough to meet the unique and developmental needs of members over time. Minuchin (1974) states that there are two major constraints within families that facilitate this preservation tendency. The first of these two constraints are the generic, universal principles that apply to families, which help them to maintain order (e.g., varying levels of authority within a family). The second preservation mechanism deals with the unique ways in which a family negotiates its functioning in order to meet the needs of the individual members. Formed over repeated interactions, these expectations can be implicit and help to accommodate the needs of family members. However, these expectations must be flexible and change when adaptation to new contextual circumstances is required (e.g., changing the behavioral expectations of an infant when that infant reaches adolescence).

Whole family assessment attempts to identify thematic elements of families and their functioning. For example, whole family assessment may measure how close family members feel to one another; how well the family adapts to change, challenge, or crisis; how the family displays affect; how the family distributes power among its members; the effect of extra-familial supports and stressors; and the extent to which culture and cultural identification impacts the family (Gladding, 2002).

One of the most popular models of assessment for whole family functioning is the Circumplex Model of Marital and Family Systems (Olson, Sprenkle, & Russell, 1979). Originally, this model posited two main categories of family behavior: cohesion and adaptation. Updates to this model have been made and now include three main facets of family functioning, including: cohesion (i.e., the level of emotional bonding within a family), flexibility (i.e., the expression and quality of leadership and organization, role relationships, and negotiation), and communication (i.e., the positive communication skills used in family systems; Olson & Gorall, 2004). According to Olson (1989) various models have been explicated with constructs similar to cohesion and flexibility, albeit with differing terminology (e.g., affiliation and interdependence; centripetal/centrifugal and adaptability; intimacy and power).

Jacob and Windle (1999) have also offered a model for the assessment of whole family functioning. Using a latent variable approach in the study of three separate self-report measures, the authors concluded that three factors (affect, control, and activities) significantly accounted for differences between varying levels of family report. Differences and agreement between family raters also lends support to the idea that there are both common and individual perceptions of family functioning within the family unit.

***Integrating Assessment Levels.*** Is the family a collection of individuals, each with their own perspectives, or is it a unified entity with a shared common vision? Questions as to how best to assess whole family functioning are prevalent in the literature. Dakof (1996) has suggested that a family has both dimensions. Results from a study of families at-risk (i.e., having a life-time history of a diagnosable disorder from the

DSM-III) indicated that although levels of family functioning are related, they are also uniquely independent (Hayden et al., 1998).

Concerns regarding the ability of a family member to be objective about their respective family's functioning, whether certain family members have more accurate views of their family, as well as the ability of one member's report to be fully representative of overall family functioning have been identified as obstacles in the effective measurement of family functioning (Bray, 1995; Cook, 2001; Coyne, 1987; Thompson & Walker, 1982).

As with dyadic assessment, examples of whole-family measures include observational coding schemes and rating scales, as well as more informal methods such as structural mapping of whole-family functioning. One formal approach utilized in the assessment of whole family functioning has been the practice of collapsing individual, self-report data in order to produce a variable representative of the family as a whole that can be utilized for cross-family comparisons (Fisher, 1985). However, the utility of this method is somewhat limited in that aggregating data in this way can obfuscate important information about individual functioning, unique individual perspectives, as well as hide levels of intra-familial disagreement (Copeland & White, 1991). Given that system functioning is comprised of numerous converging forces and factors, it is difficult for lower-level units, such as the individual, to provide insight into higher-level functioning (Cowan, 1987; McCall & Simmons, 1991). Measures that follow this practice (e.g., Family Adaptability and Cohesion Evaluation Scales – IV [FACES-IV], Olson & Gorall, 2004), although measuring the construct of whole family functioning, fail to provide an accurate picture of the family at that level.

Another concern with conceptualizing families as both a unique collection of individuals *and* a unified entity emerges regarding the statistical analyses involved in measuring this type of duality. How does one account for the unique perspective of the individual rater? It is quite possible that the rater's assessment of the family is not indicative of family functioning, and rather is a reflection of an individual-level factor, such as an extreme personality style (Cook, 1994). These *actor effects*, when collapsed across family member self-reports, can skew statistical representations of whole-family functioning.

Given the use of multiple theoretical orientations in explaining family functioning, the importance placed on which level is deemed the most salient for evaluation purposes varies. As mentioned above, without a unified theory of family functioning, consensus regarding how to best measure that functioning is lacking (Powers, 1989). In response to this concern, the use of a multi-level, multi-method approach to family assessment has been suggested, as it more readily assesses the inherent interdependent nature of family systems (Bell & Bell, 1989; Carlson, 1989; Cromwell & Peterson, 1983; Hayden et al., 1998; McCall & Simmons, 1991; Powers, 1989; Sabatelli & Bartle, 1995).

Gladding (2002) asserts that there are various benefits for evaluating families at the individual, dyad, and family levels. Individual assessment helps determine the extent to which a given family member's emotional characteristics or behavior contributes to the overall functioning of the family. It is also useful in determining if separate treatment for an individual member is warranted. Assessing the relationship between two family members (i.e., dyads) is useful in exploring how the dyad communicates and the effect of

communication styles on the family. It can also be helpful in identifying which dyadic interactions, if any, are stressful or beneficial to the family. In addition, assessment of the couple dyad helps to determine the effectiveness and functionality of relational expectations. Assessment at the family level is important when determining how close family members feel to one another, the family's ability to adapt to changes, challenges, and crises, the external supports and stressors impinging on the family, as well as the influence of culture on family functioning.

Traditional approaches of assessing the reliability and validity of family members' reports on functioning have included correlating self-report data, as well as looking at the relationship between insider and outsider perspectives on family functioning. Aggregating the reports of individual family members was thought to reduce the number of correlations being studied and to produce more reliable estimates of family functioning (Gorman-Smith, Tolan, Zelli, & Huesmann, 1996). However, aggregate data does not account for the unique perspectives of individual family members and, due to correlational bias, may produce spurious results (Cook & Goldstein, 1993; Dakof, 1996).

One example of a formal multi-level assessment has emerged from the application of the social relations model (SRM) to family functioning (Cook, 2005). One of the main arguments of this method is that the reciprocity of family members' orientations to one another cannot be assumed. This type of assumption is evident in what Cook and Kenny (2004) refer to as "double-barreled" items that ask the rater to make an assessment of a relationship with another member (e.g., My wife and I look out for each other's best interest); however, given that the rater may not have insight into the respective family

member's opinion on the matter, this type of question will not provide accurate information. Valences assigned by a single individual to dyadic relationships do not account for the multiple perspectives involved in this dynamic. This highly specific self-report method accounts for the unique views of each family member in relationship to each other by compiling "directed-relationship" items, assessing the rater's view of a given subject, across all family members, in an effort to account for the various sources of variance impacting interpersonal relationships.

Although many instruments purport to measure specific levels of a family construct (e.g., whole family functioning), there may be a mismatch between the construct level and the level actually being assessed. For example, regardless of a self-report measure's indicating its assessment of whole family functioning, the measure is actually making an assessment on the individual level. Given the nature of self-report measures, the resulting data focuses on an individual level, whereas, observational data, depending on what relational subcomponents of the family being observed, provide objective data on the corresponding level (Copeland & White, 1991).

An informal process of collecting multiple levels of information on family functioning is through structural mapping practices, as outlined in the theory of Structural Family Therapy (Minuchin, 1974; Minuchin & Fishman, 1981; Whiston, 2000). Through observational assessment and subsequent mapping of family dynamics, the structural therapist is able to gain insight into the transactional patterns among various family subsystems, individual contributions to family discord, as well as the overall functional family gestalt.

**The role of objectivity: Insider and outsider reports.** Assessments are further differentiated by who provides the information, or, the rater. Rater information can be obtained from an individual from within the family (i.e., an *insider*), or from an individual outside of the family (i.e., an *outsider*). Information culled from insiders relies on the insider's behaviors, feelings, and thoughts, and comes primarily in the self-report format; outsider information comes in the form of observations (Hampson, Beavers, & Hulgus, 1989).

Varying degrees of objectivity are involved in the role of assessment. Surra and Ridley (1991) discuss this in terms of degree of relationship to the target of observation. According to the authors, relationships can be viewed in terms of cognitive and behavioral interdependence where the degree of relationship is determined by the amount of shared meaning between the observer and the observed: objective relationships are comprised of two individuals with little to no insight into the lives of one another; subjective relationships are comprised of individuals who, over time, have developed relational schemas between one another.

Following this line of thinking, outside observers vary in their degrees of relationship with the target of observation. When observers are completely removed from the observation, mutual influence between the observer and the observed is mitigated, and the observer is able to be more objective in their assessment (Surra & Ridley, 1991). As the observer becomes more involved with the target of observation, that degree of relationship shifts and the observer becomes less objective about their assessment. In the case of the structural family therapist who conducts assessments within the session, their level of objectivity decreases with the development of the

clinician's relationship with the family. This is why it is imperative that the assessment drawn from observation occurs as soon as possible in order to preserve more objective observations (Hampson & Beavers, 2004; Nichols & Schwartz, 2006; Surra & Ridley, 1991).

Olson (1977) further delineated the type of information provided by insiders and outsiders by incorporating the dimension of subjectivity/objectivity. According to his conceptualization, data can be collected from four source types in a variety of formats. Subjective-insider methods are intrapersonal assessments that provide information on the individual or that individual's perceptions of others. Subjective-insider tools include self-report methods such as questionnaires, interviews, and standardized tests. Subjective-outsider methods are similar to their insider counterpart in that they provide subjective evaluations and descriptions from an observational standpoint. These types of assessments are generally utilized by clinicians observing families and include techniques such as structural mapping, use of enactments, interactions and clinical rating scales. In response to the subjectivity of self-report data and clinical observation, objective-insider methods were developed. These primarily include an individual's self-report of their behaviors, and avoid focusing on feelings. Finally, objective-outsider methods, generally employed in laboratory settings, are strategies that attempt to provide objective data on concrete, observable behaviors. Coding systems that utilize consensus among raters (inter-rater reliability) to validate observations are an example of an objective-outsider measurement.

**Self-report and observational assessment.** Although assessing the same sample, there is ambiguity surrounding the relationship of self-report and observational

methods. Hampson, Beavers, and Hulgus (1989) provide an overview of the findings. According to the authors, some research has demonstrated little to no correlation between corresponding self-report data and observation findings of family functioning (Coyne, 1987; Green, Kolevzon, & Vosler, 1985; Noller & Callan, 1988; Olson, 1969; Sigafos, Reiss, Rich, & Douglas, 1985), whereas other research has demonstrated high correlations when the various measures used within a study possess theoretical consistency (Hampson et al., 1989; Miller, Kabacoff, Epstein, & Bishop, 1994).

The field has interpreted these discrepancies in different ways. Congruence between insiders' and outsiders' perspectives may be supportive of some theoretical constructs; however, it has also been argued that some constructs (e.g., enmeshment) may not be perceptible to insiders (Powers, 1989), and that a discrepancy between the two reports is actually supportive of that construct. Furthermore, differences between self-reports and observer assessments may be idiosyncratic to specific family types and reveal important "between family" differences (Cowan, 1987).

*Self-report methods.* Self-report measures have been relegated to the assessment of individual family member's subjective perceptions of their family reality (Grotevant & Carlson, 1989). They are subjective means designed to assess functioning on a variety of topics and areas, including global assessments of family functioning, as well as evaluations of specific behaviors, emotions, and events of individual family members. Specifically, self-reports have been used to gain access into how family members perceive the overall functioning of their family, the feelings they have about other family members, as well as affective components of their experiences while engaged in a family activity (Bray, 1995) and are helpful in informing clinical decision making.

Self-report sources are variegated, and include standardized questionnaires, structured and informal interviews (Hayden et al., 1998), personal narratives and accounts (Burnett, 1991), retrospective methods (Metts, Sprecher, & Cupach, 1991), and diaries, logs, and letters (Duck, 1991).

A primary benefit of self-report measures is their clinical efficiency: they require less training time for the clinician (Grotevant & Carlson, 1989) and less time to administer, and provide a data artifact (Copeland & White, 1991). In addition, activities such as progress monitoring, where repeated use of a measure is required, call for a more standardized protocol for gathering information. Utilizing a measure that consistently assesses a family along the same domain(s) helps to ensure that progress is being made or that intervention strategies need to change due to a lack of progress (Bray, 1995). Further benefits include acquiring individual perceptions of events and general family life that counterbalances clinician's *outsider* perspectives, directly from the informant (Hayden et al., 1998; Olson, 1977). This subjective data is useful when it is important to compare individual family members' perceptions on relational dynamics. Self-reports also offer anonymity to the individual who may have concerns regarding voicing their opinion openly in a family session. Furthermore, certain self-report strategies (i.e., open ended interviews) allow for more elaboration into relational and individual problems and concerns (Copeland & White, 1991).

Despite their benefits, there are some drawbacks to this type of assessment. In contrast to the benefit of some self-report methodology, standardized techniques only provide data that is demanded from the assessment, and lack the ability for further elaboration (Copeland & White, 1991; Hayden et al., 1998). Furthermore, self-report

measures are limited by the cognitive processes of the reporter and clinician: information provided by the informant is subject to cognitive distortions that may not reflect the functional reality of the family; information is only useful when one knows what to do with it – the expertise of the clinician will influence how what is elicited from the self-report informs future clinical decision making (Hayden et al., 1998).

Self-report data are vulnerable to various distortions and biases. Grotevant and Carlson (1989) discuss the attitudinal, or response set, influences on the accuracy of family members' self-reports: social desirability (faking good), malingering (faking bad), acquiescence (providing all "yes" or all "no" answers), and deviation (the tendency to give odd responses). They also note that situational and semantic factors can influence a rater's response; the meaning of an item can vary by person or even within a person over time. Self-report data also entail interpretive challenges, including: how raters define the concept of family and whether the self-report questionnaire captures this; the ability of all raters to fully understand instrument questions (i.e., Are there developmental or cognitive limitations?); and the possibility that language was a barrier during the assessment (Yingling, 2004).

Yingling (2004) highlights further drawbacks to self-report assessments. Self-reports and disclosures can make a rater vulnerable. Some family members may find it difficult to report on their true feelings given that doing so may affect their physical and emotional safety within the family, and thus result in a distortion of their report. In addition, certain family members may be too young to report on what is happening in their families. Evaluations of metaphorical expression of family functioning through

stories and drawings with younger family members are subject to misinterpretation and should be used with caution.

Since self-report measures are intended to consistently measure domain specific family levels or constructs, the clinician needs to be mindful that intervention effects may manifest at levels not measured by the self-report tool (Bray, 2004). In addition self-reports lack integration among family members; it is difficult to compile unique individual perspectives into a variable representative of the whole (Yingling, 2004). Given the unique qualities of families – namely their composition of more than one member – self-report measures that provide information regarding the individual's perceptions of relationships or family functioning have been discouraged. Although subjective reporting has its place, emphasis has been given to observational strategies that provide data on the interactional qualities of people in relation to one another (Copeland & White, 1991).

***Observational methods.*** There are two primary types of observations as related to family assessment: micro-analytic observations, which focus on sequences of specific, observable behavior; and macro-analytic observations, which are concerned with global assessments of functioning. Either approach can be utilized during the time of the observation, as well as after the observation, outside of the immediate observational context, via the assistance of audio/video recordings.

Micro-observations traditionally occur in more naturalistic settings where the observer is not immediately observable to the target of observation. Micro-observational strategies are less obtrusive in nature, and therefore less prone to provide data adulterated by the reactivity of the observed (Sillars, 1991). In general, given that micro-coding is

focused on specific, smaller, and more discrete units of behavior, these observations are easier to code reliably and provide operationalized data that is easier to describe to the scientific community (Copeland & White, 1991). Furthermore, these types of observations are focused more on the process of family interactions, and are considered to be the best type of observational analysis given their precision and focus on smaller units of behavior. However, given the time taken to code such observations, this method is generally relegated to the realm of research (Bell & Bell, 1989).

In comparison, macro-analysis is an observational process where a trained observer focuses on general patterns of behavior amongst family members (Bray, 1995). Given a circumscribed amount of interactional data, macro-ratings attempts to obtain an overall sense of family functioning (Copeland & White, 1991) in a given domain. Macro-analysis is unique in that the standards for observation are generally vague, and internalized within the rater (Bell & Bell, 1989). Problems related to macro-analysis include the deterioration of certain constructs over time due to their change in social meaning, as well as the expectancy bias of the rater (Bell & Bell, 1989).

Observational strategies are the complement to subjective self-report data. Intended for more objective data retrieval, observational techniques strive to provide unbiased assessments of the interactional qualities of families. These methods range in their level of formality, from formal, standardized measures to informal, qualitative strategies. Rating scales, coding schemes, planned tasks, and structural mapping provide a sample of this methodological gamut.

The goal of standardized measures, in general, is to facilitate between-family comparisons. Given this charge, family researchers have focused on creating

standardized methods, to be employed in family situations, where observations of the family's behaviors can be made. One example of a norm-referenced assessment method based on observation of the family is rating scales.

In order to provide a more objective assessment of family functioning, rating scales are systematic methods used by both family insiders and outsiders to obtain estimates of raters' opinion of various qualities of another individual or system. Although helpful in assessment practices, various considerations are required when they are used. Such considerations include the quality of the scale, the rater's personality (in terms of response style), and the cognitive processes and abilities of the rater (Carlson & Grotevant, 1987). It is also important to determine who will rate the family. Varying degrees of subjectivity are present contingent on the level of cognitive and behavioral interdependence, and the shared history of the rater and the rated. Therefore, more objective ratings will be obtained at the *outset* of the therapy/assessment if done by the clinician, or by individuals who do not possess an intimate understanding of the rated individual, but do have enough knowledge of that individual to make a meaningful assessment (Hampson & Beavers, 2004; Surra & Ridley, 1991).

Rating scales offer a molar level of family analysis, and depending on the level of assessment, can provide a summary judgment of individual, dyad, or family functioning. Benefits of rating scales include a more standardized and objective method for observing the family, the ability to identify properties of relationships, as well as the fact that they are generally easy to construct and utilize. The primary issues related to the use of rating scales can be divided into two categories: issues related to personality/stylistic characteristics of the rater (i.e., the error of central tendency, leniency/severity effect,

contrast effect), and issues related to the rater's cognitive processes (i.e., logical error, proximity error and the halo effect; Grotevant & Carlson, 1989). Another concern with rating scales is that the onus on whether or not certain relevant theoretical constructs were present within the observation is on the observer. Therefore, the less experienced the raters, the less comprehensive and/or valid their ratings.

Informal observational strategies most often occur within a clinical setting (i.e., a family therapy session), are generally conducted without the aid of physical documentation (e.g., rating scale forms), and tend to not be standardized (Bray, 1995). Throughout these observations, the observer (i.e., clinician) may be looking for how the family distributes power, the level of autonomy within the family, and the various relationships among family members. To facilitate these assessments the clinician may employ problem-solving tasks, including having members describe their family, having the family plan an outing or event, or having the family play games or work on puzzles. An example of an informal observation technique is structural mapping. In order to determine the subsystems, boundaries, hierarchy, and interactional patterns operating within a given family, structural family therapists have developed a four stage assessment strategy (Minuchin, Nichols, & Lee, 2007) that is incorporated directly into the therapeutic process (i.e., during direct work and initial contact with the family), and does not require a distinctly separate measurement phase (Duffy & Chenail, 2004). Through clinician-directed questioning, directives, and enactments, the family therapist begins to create a mental adumbration of the various structural dynamics of a given family, a necessary precursor to effective intervention and concomitant amelioration of the family's presenting problem(s).

The objectivity of observational strategies is heralded as this method's primary strength. In comparison to self-report methods, observational strategies provide a more objective method that helps to mitigate the cognitive distortions open to self-report strategies (Hayden et al., 1998). When assessing family-level constructs, observational strategies allow the clinician to observe multiple individuals and subsystems interacting at the same time (Copeland & White, 1991). With greater objectivity comes the ability to provide assessments more representative of the family's true functioning, and with standardized observational measures of that functioning (i.e., coding schemes), more reliable and valid data can be obtained (Surra & Ridley, 1991).

Another benefit of observational strategies is their ability to cull data from family behavior that is likely unknown to the family. Behaviors under conscious control (i.e., verbal behaviors) are most likely to be reactive to the presence of an observer; however nonverbal behaviors (e.g., body posture/movements, proximity) are less likely to be influenced by observation (Sillars, 1991). Through observational methods, nonverbal data is readily available and provides the clinician with insight that is helpful in hypothesis formation and treatment of family problems (Bray, 1995). In addition, observational methods allow the clinician to observe ingrained, unconscious patterns among family members, developed and concretized over time (e.g., relational scripts – see Surra & Ridley, 1991) and important data not within the scope of an individual's self-report of family functioning (Sillars, 1991). Further benefits of observational strategies include their ability to obtain information on, and about, individuals who are unable to engage in self-report activities (e.g., children whose conceptual understanding of items is too limited, or who do not possess verbal abilities) or whose reporting accuracy may be

suspect (e.g., some individuals with mental illness, cognitive impairments; Copeland & White, 1991).

One caveat with observational strategies is that multiple forms of data need to be incorporated in order to provide a more comprehensive assessment that can better account for the family's functioning (Whiston, 2000). Whiston also states that, in terms of informal observational methods, the interpretation of results is highly subjective, and there is a greater tendency to misinterpret the dynamics in a family's interaction. She adds that, for observations in general, with greater systemic complexity (i.e., more individuals involved in the observation) comes the clinician's inability to adequately monitor the totality of interactions in a given observational segment. Furthermore, given the lack of a cohesive theoretical foundation in family therapy and assessment, it is difficult to reify family concepts, presenting a challenge for the operationalization of these constructs and their subsequent measurement (Coyne, 1987).

Observations are time-limited and may not provide a complete picture of family functioning. They omit the unique perceptions, beliefs, and feelings of individual family members (Hayden et al., 1998). Furthermore, micro-analytic assessment has been criticized due to the fact that it is primarily restricted to dyadic interactions and may not provide useful data pertaining to the therapeutic outcomes for families. It has also been noted that both micro- and macro-analytic techniques may not adequately evaluate relational gestalts, and instead focus on an individual's behavior within a relationship (Grotevant & Carlson, 1989). Finally, training in observation is always limited by the biases of training instructors, resulting in the clinician potentially not being able to identify important aspects of a family's behavior by virtue of their not being trained to

value those particular events. It is also important that clinicians be mindful of the biases that may result from their own family of origin and how that informs how they view the behaviors of the families they are observing (Yingling, 2004).

### **Summary**

Family assessment is a relatively new domain in the field of psychology posing unique challenges and considerations for the family psychologist. The continuing evolution of family assessment to produce reliable and consistent results is integral to both the development of the field of family psychology as a whole, as well as to the individual families served via psychologists dedicated to empirically validated and therapeutically sound practice. In order to accomplish this level of professional integrity, the family psychologist must strive to connect theory to their assessment strategies in the domains of both research and clinical application. Although different in their intent, the iterative interplay between research and clinical assessment, with developments in one realm informing practices in the other (and vice versa, *ad nauseum*) helps to ensure that the beneficiaries of these practices (i.e., families) are served to the greatest extent possible.

This progression towards sound family assessment has resulted in various methods and strategies, each with unique functions, benefits, and shortcomings. Family assessments can be differentiated by their frame of reference (i.e., whether they provide the clinician's objective perspective or the family's subjective conceptualization of what is going on), their level of formality (i.e., whether they procure qualitative or quantitative information), and their level of focus (i.e., assessment at the individual, dyad, triad, or whole-family level). In order to accommodate the unique attributes family systems bring

to assessment, current best practices have recommended the use of multi-level, multi-method assessment practices.

The DAFFI-DUCC is a theoretically grounded, multi-level (i.e., dyad, whole family, individual perspectives), multi-method (i.e., structural mapping, degrees of interference) diagnostic assessment tool designed for use within a clinical context and intended for family problem analysis and concomitant intervention planning. Providing information from the perspective of an outsider, the subjective interpretations of the family clinician are charted and rated in order to obtain an overview of various structural elements of a given family so that problematic areas are more readily identified and targeted for intervention. Furthermore, the DAFFI-DUCC can be viewed as a training “bridge” in that it attempts to take a systematic diagnostic process of outlining various family structures and relational patterns from a physical (i.e., diagramming and rating with paper and pencil) to a mental practice (i.e., one that can be internalized by the clinician and used without the previous buttress of paper and pencil). The purpose of the present study is to establish the psychometric integrity of the DAFFI-DUCC. This exploratory examination of the extent to which raters’ ratings of a given family differed as a function of their training and experience will help to achieve this end.

## Chapter 3

### Method

#### Research Questions

Various methods of measuring family structural and relational dynamics have been developed in an effort to better understand family functioning, as well as to help provide effective interventions for families experiencing high degrees of stress. The purpose of this study was to determine the practical value of the DAFFI-DUCC outside of a didactic setting. The two research questions related to this study were: (1) Do raters, in general, observe the same types of problems within a given family? (2) Do a raters' training and levels of experience impact the type of assessments made on the DAFFI-DUCC?

#### Participants

Participants in this study were obtained from three separate sources. The first group of participants was gathered from a mailing list of Professional affiliates of the American Association of Marital and Family Therapy (AAMFT). One thousand names were randomly selected from an AAMFT mailing list comprised of individuals who had self-reported the "Professional" status and were mailed an invitation to participate in the study (Appendix A). Of the original 1000 individuals, 49 (4.9%) responded via the email address provided in the invitation indicating that they would be willing to participate. A packet of materials, including a copy of the DAFFI-DUCC (Appendix B), a DAFFI-DUCC manual (Appendix C), a short set of instructions for the study and a consent form (Appendix D), and a user survey (Appendix E) were mailed to these 49 individuals. Sixteen sets of materials (32%) were returned completed. Demographic information

regarding these participants was limited to degree type: Doctoral (N=4); Masters (N=11); Specialist (N=1)

The second group of participants consisted of students enrolled in a family therapy graduate program in Wisconsin. A faculty member of the program who was contacted via the AAMFT mailing list, indicated that she would like to use the DAFFI-DUCC and the training video as part of her course curriculum, and would be willing to return students' responses to the researcher. Approval was given for this, resulting in a total of 10 completed DAFFI-DUCCs being returned.

The final group of participants included in this study was comprised of 32 graduate students in the school psychology and counseling programs of a university in New York State. These students were trained in the use of the DAFFI-DUCC, as well as its structural/strategic theoretical underpinnings, in a graduate course in family therapy that was required in both programs. Thus, a total of 58 participants emerged from these three groups.

Those participants who did not receive direct instruction on the DAFFI-DUCC were remunerated with a copy of the recorded family therapy session, as well as the opportunity to be placed in a raffle for an Amazon.com gift certificate. Those participants who received direct instruction participated in this study as a part of their course curriculum and training and received extra credit in the course for their participation.

**Training source.** Participants (N=58) were divided into two groups to assess the degree to which a rater's training impacted their DAFFI-DUCC endorsements. The 32 individuals who had been trained in Structural and Strategic family therapies at the New

York university comprised the first group which was labeled, “Direct Training.” The remaining participants, who had been trained in family therapy/system dynamics at through other training sources comprised the second group labeled, “Indirect Training.”

**Experience level.** In order to determine the impact of a rater’s experience on endorsements made on the DAFFI-DUCC, participants were divided into two groups. The first group consisted of the 16 Professional affiliates of the AAMFT, so labeled, “Professionals.” The second group consisted of the 42 graduate students from the two universities, thus labeled, “Students.”

### **Measures**

**Dynamic Assessment of Family Functioning Inventory – Demonstrated Under Clinical Conditions (DAFFI-DUCC).** The Dynamic Assessment of Family Functioning Inventory – Demonstrated Under Clinical Conditions (DAFFI-DUCC; Cerio, 2009; Appendix B) is a clinical tool informed by the work of Salvador Minuchin’s Structural Family Therapy (SFT) and Jay Haley’s Strategic Therapy (ST). It was originally developed as an instructional aid for graduate students who were being trained in Structural/Strategic therapy, and eventually revised into a more structured assessment that has been used in agencies that provide family therapy services (Cerio, personal communication, November, 24, 2010). Through observations of family interactions, the clinician is able to map out and document a family’s relational structure, as well as determine the extent to which certain structural arrangements, beliefs, and interactional patterns contribute to undesirable functioning within the family. Although there is no standardized procedure for using the instrument, the DAFFI-DUCC is generally completed at the end of the first or second session, after the clinician has been given time

to formulate hypotheses about a given family's structure and functioning. The DAFFI-DUCC contains seven separate dimensions related to family functioning: Symptom Function, Developmental Stage, Subsystems, Hierarchy, Triangles, Worldviews, and Circular Patterns. Each of these areas is described below.

***Symptom Function.*** The Symptom Function dimension is anecdotal and requires the clinician to formulate hypotheses on how the symptom of the identified client helps maintain the family's current problem.

***Developmental Stage.*** The Developmental Stage dimension is used to determine the specific stage (i.e., Couples Formation, The First Child, Families with Young Children, Families with Tweens, Adolescent Families, Parents Separating from Children, and Families with Aging Parents) within which a given family is functioning.

***Subsystems.*** The Subsystems dimension, similar to structural mapping, requires the clinician to identify and draw the various subsystems operating within a family, indicating how boundaries between subsystems are defined.

***Hierarchy.*** The Hierarchy dimension requires that raters describe their perception of how power is distributed within the family.

***Triangles.*** For the Triangles dimension, the rater is given space to diagram the various triadic interactions of family relationships. In each triangle, the rater is asked to judge the valence in each dyad (i.e., positive relationship = "+"; negative relationship = "-").

***Worldviews.*** The Worldview dimension is bifurcated into worldviews of individual family members and worldviews of the entire family. The rater is asked to list the worldviews of individual family members, as well as the whole family.

***Circular Patterns.*** Finally, the Circular Pattern dimension is a space where the clinician is asked to determine and draw the hypothetical overt circular patterns currently operating within the family. The clinician is also asked to determine and list the underlying causes for these patterns.

***Ratings.*** For five of the dimensions (symptom function, developmental stage, hierarchy, triangles and circular patterns), clinicians are asked to rate the degree of interference or distress related to the area using a 0 (extreme interference or stress) to 10 (minimal interference or stress) Likert-type scale. The sixth dimension, subsystems, uses a curvilinear rating scale, with higher levels of problematic functioning at either end of the scale. Ratings range from 0 (Disengaged) to 10 (Appropriate), back to 0 (Enmeshed).

**Standard training video.** The family session video utilized in this study was developed for a training workshop by two protégés of Salvador Minuchin and a faculty member from the aforementioned western New York university graduate program. The family portrayed in the video was a real family that was being seen for family therapy. The video portrays a family – a father, mother, 20-year-old son, and 15-year-old daughter – during their initial interview with a family therapist. The family is seeking counseling in order to address academic and behavioral concerns related to the daughter. During the initial portion of the session it is reported that the father moved the family from a large urban area to a small rural town for a “better life.” After relocating, the father took a low paying job for which he was overqualified, and the mother began working for the first time in their marriage. The therapist also learns that the son had recently dropped out of college, broke up with his girlfriend, and was unemployed and living at home.

Furthermore, the family reports that the daughter had a previous history of misbehavior prior to the move, which has continued and precipitated the referral.

The presenting problem and issues of the family members were taken from the content of actual family sessions. The actors seen in the video were provided with detailed information regarding their characters and the dynamics of the family during therapy sessions. The actors were asked to use this information to deliberately portray behaviors that illustrated the constructs that are assessed in the DAFFI-DUCC. The actors rehearsed their portrayal thoroughly before the taping to make the interactions appear consistent and natural, and to adequately illustrate the presenting problem, as well as the concomitant relational dynamics and structure would be adequately portrayed.

### **Procedure**

Students from the New York university graduate program watched the videotaped session during their scheduled class times. They then completed the DAFFI-DUCC and returned it to their instructor, who then gave them to the primary researcher.

All other participants were mailed a DVD copy of the training video along with the DAFFI-DUCC, a manual that provided in-depth information on the constructs contained in the DAFFI-DUCC (Appendix C), a consent form with brief instructions on how to complete the DAFFI-DUCC for this study (Appendix D) and a brief user survey (Appendix E). After viewing the training video of the hour-long family therapy session, all raters were asked to make assessments of various structural and system dynamics related to the sample family in the recording. Once completed, these participants were instructed to return the DAFFI-DUCC in the self-addressed, stamped envelope provided in the materials mailing.

## **Analysis**

Given the qualitative nature of the DAFFI-DUCC, data from each construct was systematically deconstructed for analysis. A primary challenge in the analysis of this data was that, within each construct, many raters made multiple hypotheses and endorsements with similar ratings of problematic functioning. In an effort to simplify the complexity of the present analysis, only hypotheses with the most problematic ratings (i.e., those with lower Likert/“Extreme” ratings) were included. In cases where a rater indicated the same degree of extreme interference on multiple hypotheses within a given dimension, each similarly rated hypothesis was included in the analysis. Of the seven areas measured by the DAFFI-DUCC, all but the Circular Patterns dimension was included in this analysis. Given the diversity and quality of raters’ narrative responses within this construct, analysis of the Circular Patterns construct was deemed too complex for the present research.

Frequency counts were conducted of the raters qualitative responses for the other construct areas of the DAFFI-DUCC. The counts for each construct were then analyzed using three separate chi-square analyses to examine:

- The general likelihood of specific endorsements across all raters.
- The extent to which endorsements varied as a result of raters’ source of training (“Direct” training in family therapy at the university in New York State vs. “Indirect” training from other sources).
- The extent to which endorsements varied based on experience (“Professionals” vs. “Students”).

The Symptom Function dimension required raters to provide various hypotheses regarding the individual deemed by the family to be most problematic (i.e., the symptom bearer or identified patient) which was labeled *Symptom Bearer* for this analysis. In the video family, the potential Symptom Bearers were father, son, daughter, or mother. Raters were also asked to indicate the functional nature of the symptom bearer's problems (e.g., to divert focus from another family member's problems), which was labeled *Function of Presenting Problem*. Function of Presenting Problem refers to the individual(s) with whom the Symptom Bearer's problems are associated (e.g., a child's acting out to distract from problems in the parent subsystem).

Based on the qualitative nature of raters' endorsements, responses were divided into seven categories identifying those individuals related to the presenting problem. These seven categories were determined by the researcher to adequately incorporate the range of raters' responses, and included: 1) Problem related to parents; 2) Problem related to children; 3) Problem related to father; 4) Problem related to son; 5) Problem related to daughter; 6) Problem related to mother; and 7) Problem related to the family in general. Although focusing on the individual(s) related to the presenting problem (e.g., father; parents) did not elucidate the specific quality/content of a given raters' hypothesis (e.g., daughter acts out to mask father's drinking; daughter acts out to address parent's relationship issues), it identified the individual for whom the symptom bearer's problems were acting as a diversion. Furthermore, it allowed for the incorporation of disparate responses and facilitated analysis of this initial research. In addition, if more than one symptom bearer and/or symptom function was indicated by a rater, only the endorsement rated as presenting the greatest degree of interference (i.e., lowest Likert rating) was

included. In cases where raters provided multiple symptom bearer/symptom function endorsements with similar interference ratings, each similarly rated endorsement was included in the analysis. Frequency counts were conducted of symptom bearer endorsements, as well as endorsements of the individual(s) related to the symptom bearer's problem.

Within the Developmental Stage dimension, each rater was asked to generate hypotheses regarding the particular developmental stage at which they believed the sample family to be functioning and to rate the level of stress that a particular stage may be causing for this family. Frequency counts were taken on those hypotheses that raters indicated to be causing the greatest degree of stress on the family.

For Subsystems, frequency counts were taken on the type of subsystem (e.g., parent, couple, sibling) viewed to be most problematic. In an effort to best accommodate the range of participant responses, the following subsystem types were delineated: Parent; Couple, Parent-Child (father and son); Parent-Child (father and daughter); Parent-Child (mother and son); Parent-Child (mother and daughter); Sibling; and Other. The "Other" category was created to account for those subsystem hypotheses common to one or two raters. In addition, frequency counts were also taken on the quality (i.e., enmeshed, disengaged) of each highly problematic subsystem indicated by raters.

Raters' provided a range of hypotheses in the Hierarchy construct regarding the sample family. Although most hypotheses included the four members of the family, some responses included only one member, while others included two or three members in a variety of hierarchical arrangements. Some hypotheses included more than one member at a given position (e.g., top). In order to account for all raters' responses, and to

facilitate analysis, frequency counts were conducted only on those individuals endorsed as holding either the top or the bottom position. If more than one individual held this position, both were included separately in the frequency count.

The Triangle construct included in the DAFFI-DUCC required raters to identify various triadic relationships operating within the sample family and to identify the degree to which each identified triangle interfered with family functioning. Frequency counts were conducted on each rater's most problematic triangulated relationships. If a rater endorsed multiple triangles with the same rating, each problematic triangle was included separately in the frequency count.

Finally, raters determined the degree to which family Worldviews contributed to dysfunction. Frequency counts were conducted of the individual family members' worldviews that raters endorsed as causing the greatest degree of interference for the sample family. If a rater endorsed two member worldviews as equally problematic, each worldview (and associated member) was included separately in the frequency count.

## Chapter 4

### Results

This preliminary investigation of the DAFFI-DUCC was conducted in order to establish the psychometric properties of the instrument. Endorsements of raters within each dimension of the DAFFI-DUCC were analyzed using the chi-square goodness-of-fit test to compare the observed distribution against that predicted by the null hypothesis (i.e., that any option would be equally often selected). In addition, two separate multi-dimensional chi-square tests were conducted in order to determine the independence of (1) ratings made by Direct Training participants and ratings made by Indirect Training participants; and (2) ratings made by Students and ratings made by Professionals. Each chi-square analyzed the relationship between a particular rater's training/experience and whether or not they endorsed a particular concept as highly problematic for the family. Each dimension of the DAFFI-DUCC is addressed separately, and sequentially, beginning with the analysis of training source effects, and followed by an analysis of experience effects. Descriptive statistics and significance levels for all chi-square tests of independence are provided in Tables 1-3.

#### **Ratings Across All Raters**

**Symptom bearer.** Results for raters' endorsements of the identified patient in family (See Table 1) indicated Daughter as the primary symptom bearer by 93% of all raters,  $\chi^2(1, N = 58) = 43.103, p = .0001$ . Furthermore, the three remaining family members were endorsed as the primary symptom bearer significantly less often than would be expected: Father,  $\chi^2(1, N = 58) = 24.897, p = .0001$ ; Mother,  $\chi^2(1, N = 58) = 50.276, p = .0001$ ; and Son,  $\chi^2(1, N = 58) = 36.483, p = .0001$ . Therefore, there was

overwhelming agreement among raters that the daughter served as the family's primary symptom bearer, while other family members did not.

**Source of presenting problem.** Raters did not endorse any individual for whom the sample family's presenting problem may be serving a function to a degree any greater than chance (See Table 1). However, significantly fewer raters than expected endorsed the presenting problem as related to the children,  $\chi^2(1, N = 58) = 54.069, p = .0001$ , to the mother,  $\chi^2(1, N = 58) = 24.897, p = .0001$ , the daughter,  $\chi^2(1, N = 58) = 24.897, p = .0001$ , or the son,  $(\chi^2(1, N = 58) = 24.897, p = .0001$ . Although not statistically significant, approximately half of all raters endorsed the presenting problem as related to the parents (53%), the father (48%), or to general family issues (43%).

**Developmental stage.** Results for rater's endorsements of highly problematic developmental stages can be found in Table 1. Overall, 72% of all raters endorsed the Adolescent Families stage as the stage most problematic for the sample family,  $\chi^2(1, N = 58) = 11.655, p = .001$ . Significant findings were also discovered for the Parents Separating from Children,  $\chi^2(1, N = 58) = 15.517, p = .0001$ , and the Other,  $\chi^2(1, N = 58) = 54.069, p = .0001$ , family developmental stages. In the latter three instances, raters endorsed each respective stage as problematic less often than would be expected. Endorsement of the Couples Formation happened at a level no better than chance. Thus, a significant percentage of raters agreed that the Adolescent Families stage was the primary problematic stage for this family.

**Subsystems.** Significantly fewer raters than predicted endorsed the following subsystems as highly problematic for the sample family (See Table 1): Parent-Child (father and son),  $\chi^2(1, N = 58) = 30.414, p = .0001$ ; Parent-Child (father and daughter),

$\chi^2 (1, N = 58) = 46.621, p = .0001$ ; Parent-Child (mother and son),  $\chi^2 (1, N = 58) = 54.069, p = .0001$ ; Parent-Child (mother and daughter),  $\chi^2 (1, N = 58) = 27.586, p = .0001$ ; Siblings,  $\chi^2 (1, N = 58) = 24.897, p = .0001$ ; and Other,  $\chi^2 (1, N = 58) = 46.621, p = .0001$ . Both the Parent and the Couple subsystems were endorsed as problematic at a rate no greater than chance. Hence, it appears that it was more difficult for raters to arrive at a higher degree of agreement in this area regarding the primary subsystems that were problematic for this family.

**Subsystem quality.** Table 1 also displays results regarding raters' endorsements of the cohesiveness of highly problematic subsystems within the sample family. Analyses indicated that 95% of all raters endorsed a highly problematic subsystem as Disengaged,  $\chi^2 (1, N = 58) = 46.621, p = .0001$ . In addition, only 19% of all raters endorsed a highly problematic subsystem as Enmeshed,  $\chi^2 (1, N = 58) = 22.345, p = .0001$ . Therefore, raters generally agreed about the type of problem the family was experiencing regarding cohesiveness, in spite of the lack of agreement regarding which subsystems were disengaged.

**Hierarchy: Member in top position.** Results from analyses of endorsements of the individual holding the most power within the family, as indicated by their holding the top position of a highly problematic hierarchy, are listed in Table 1. A majority (67%) of all raters indicated that the father held the top position in a highly problematic family hierarchy,  $\chi^2 (1, N = 58) = 6.897, p = .009$ . In addition, endorsements of both the mother and the son were significantly lower than expected,  $\chi^2 (1, N = 58) = 36.483, p = .0001$ , and,  $\chi^2 (1, N = 58) = 39.724, p = .0001$ , respectively. The daughter was endorsed for this position at a rate no greater than chance.

**Hierarchy: Member in bottom position.** Table 1 also displays results of analyses of raters' endorsements of the individual holding the least amount of power within the family (i.e., rated as holding the bottom position of a highly problematic hierarchy). 64% of raters endorsed the mother as holding this position,  $\chi^2(1, N = 58) = 4.414, p = .036$ . Furthermore, the father,  $\chi^2(1, N = 58) = 24.897, p = .0001$ , daughter,  $\chi^2(1, N = 58) = 9.931, p = .002$ , and son,  $\chi^2(1, N = 58) = 13.517, p = .0001$ , were all endorsed in this bottom position significantly less often than would be expected. So, there was reasonably strong, albeit not overwhelming, agreement among the raters regarding the family members at the top and bottom positions of this family's power hierarchy. There was also reasonable agreement regarding which members were *not* in these positions.

**Triangles.** Results for raters' endorsements of problematic triangles can be found in Table 1. The Mother-Father-Daughter (MFD) triangle was endorsed as highly problematic by 86% of all raters,  $\chi^2(1, N = 58) = 30.414, p = .0001$ . Each of the remaining triangles were endorsed less often than would have been expected: Mother-Father-Son,  $\chi^2(1, N = 58) = 19.931, p = .0001$ ; Son-Daughter-Mother,  $\chi^2(1, N = 58) = 8.345, p = .004$ ; Son-Daughter-Father,  $\chi^2(1, N = 58) = 43.103, p = .0001$ ; and Other,  $\chi^2(1, N = 58) = 43.103, p = .0001$ . This indicates that there was a significant level of agreement regarding the most problematic triadic relationship impacting this family.

**Worldviews.** Analysis of endorsements of problematic worldviews (Table 1) indicated that 71% of raters endorsed the father's beliefs as contributing to a high degree of stress within the family significantly more often than would be expected,  $\chi^2(1, N = 58) = 9.931, p = .002$ . Problematic worldviews were attributed to Son,  $\chi^2(1, N = 58) =$

39.724,  $p = .0001$ , Daughter,  $\chi^2 (1, N = 58) = 4.414, p = .036$ , or Family,  $\chi^2 (1, N = 58) = 5.586, p = .018$ , significantly less often than would be expected. The mother's worldviews were rated as problematic at a level no greater than chance. Thus, raters seemed to agree that the father's belief system was most problematic to this family's functioning.

### **Effects of Training Source on Ratings**

**Symptom bearer.** Separate analyses were conducted for each family member in order to determine the extent to which raters' endorsements of a primary symptom bearer varied as a function of their training. Of the four analyses conducted, only one was considered significant. There was a significant relationship between a rater's training source and their endorsement of Daughter as the primary symptom bearer for the sample family,  $\chi^2 (1, N = 58) = 5.288, p = .035$ . It should be noted that the analysis showed that two cells had expected counts less than five, so an exact significance test was selected for this particular Pearson's chi-square. All Direct Training (100%) and a majority of Indirect Training (85%) raters indicated Daughter as the primary symptom bearer; however, Direct Training raters were more likely to make this endorsement. Rater's endorsements across the remaining three family members did not significantly differ by training (See Table 2).

**Source of presenting problem.** In addition to the identification of a symptom bearer, raters also made endorsements regarding the function of the presenting problem (See Table 2). In order to determine if ratings varied as a function of a participant's training, separate analyses were conducted on the seven aforementioned categories. Significant relationships were found in two of the seven analyses. There was a

relationship between raters' training source and their indication of the family's presenting problem serving a function for problems with Son,  $\chi^2(1, N = 58) = 9.818, p = .001$ , and Daughter,  $\chi^2(1, N = 58) = 9.818, p = .001$ . It should be noted that in each respective analysis one cell had an expected count less than five, so exact significance tests were selected for each Pearson's chi-square. Although a minority of both the Direct Training and Indirect Training raters endorsed the family's presenting problem as related to Son, Direct Training raters (31%) were more likely to make this assessment than Indirect Training raters (0%). In addition, although a minority of both the Direct Training and Indirect Training raters endorsed the family's presenting problem as being related to Daughter, Direct Training raters (31%) were more likely to make this assessment than Indirect Training raters (0%). Regarding the five remaining analyses, there were no significant differences between raters endorsements regardless of their level of training.

**Developmental stage.** Table 2 also displays the four analyses conducted on developmental stage types represented in this study (i.e., Couple Formation, Adolescent Families, Parents Separating from Children, and Other). A relationship was found between raters' training source and their endorsement of Couples Formation as a developmental stage category causing the greatest degree of family stress,  $\chi^2(1, N = 58) = 14.764, p = .0001$ . Direct Training raters (66%) were more likely to indicate that the developmental stage category, Couple Formation, was an area presenting tasks most problematic with regard to familial stress, as compared to Indirect Training raters (15%).

Another relationship was found between rater's training source and their endorsement of Parents Separating from Children as the developmental stage category causing the greatest degree of family stress,  $\chi^2(1, N = 58) = 8.496, p = .004$ . In this

instance, Indirect Training raters (42%) were more likely to indicate that the sample family experienced stress related to this developmental stage category, whereas a minority of Direct Training raters (only 9%) made this endorsement.

**Subsystems.** A range of subsystem types was utilized in this analysis (See Table 2). Of the eight analyses, only one significant relationship was discovered: between raters' training source and their rating of the Couple subsystem as highly problematic,  $\chi^2(1, N = 58) = 18.302, p = .0001$ . Among Direct Training raters, a majority (63%) indicated that highly problematic family functioning was evident in the Couple subsystem, whereas a minority (only 8%) of Indirect Training raters made this assessment.

**Subsystem quality.** Analyses were also conducted in an effort to determine the quality (i.e., enmeshed, disengaged) of highly problematic subsystems. There was a relationship between raters' training source and their endorsement of the most problematic subsystem possessing an Enmeshed quality,  $\chi^2(1, N = 58) = 4.272, p = .05$ . It should be noted that this analysis showed that one cell had an expected count less than five, so an exact significance test was selected for the Pearson's chi-square. Indirect Training raters (31%) were more likely to endorse a highly problematic subsystem as enmeshed, as compared to Direct Training raters (9%), who made this assessment.

**Hierarchy: Member in top position.** Separate analyses were conducted across family members (i.e., father, son, daughter, mother) in order to determine if they were rated as occupying the top position in a problematic hierarchical arrangement (See Table 2). A significant relationship was found between a rater's training source and their ranking Father in the top position of a problematic family hierarchy,  $\chi^2(1, N = 58) =$

9.514,  $p = .002$ . Specifically, Direct Training raters (84%) were more likely to endorse Father at the top of a highly problematic hierarchy, as compared to Indirect Training raters (46%).

**Hierarchy: Member in bottom position.** Separate analyses were conducted on each family member (i.e., father, son, daughter, mother) regarding the individual endorsed by raters as occupying the bottom position in a problematic hierarchical arrangement (See Table 2). There was a relationship between rater's training source and their placing the daughter at the bottom of a problematic family hierarchy,  $\chi^2(1, N = 58) = 4.411, p = .036$ . While a minority of both Direct Training (41%) and Indirect Training (15%) raters placed the daughter at the bottom of a problematic family hierarchy, Direct Training raters were more likely to make this assessment.

**Triangles.** Within the sample family, there are four primary permutations of family triads. An additional category, "Other," was added to account for hypotheses involving members not immediately present in the family session. The five triangles included: Mother-Father-Son (MFS); Mother-Father-Daughter (MFD); Son-Daughter-Father (SDF); Son-Daughter-Mother (SDM); and Other (O). Separate analyses were conducted on each of the five triads (See Table 2). No significant findings were discovered regarding a rater's training and the type of endorsement made.

**Worldviews.** Analyses were conducted to determine if a particular belief about the world/others contributed to problems in the sample family. The analyses included worldviews of each individual family member (i.e., father, son, daughter, mother), as well as general family worldviews/beliefs (See Table 2). When comparing Direct Training to Indirect Training raters, one significant relationship was discovered: there

was a relationship between raters' training source and their indicating that a general family worldview contributed to problematic family functioning,  $\chi^2(1, N = 58) = 4.852, p = .028$ . Specifically, although less than half of both training groups indicated that general family worldviews contributed to problematic family functioning, Direct Training raters (47%) were more likely than Indirect Training raters (19%) to make this assessment.

### **Effects of Experience on Ratings**

**Symptom bearer.** In order to determine the effect of a rater's level of experience (student vs. professional) on endorsements of a primary symptom bearer for the sample family, separate analyses were conducted across family members (i.e., father, son, daughter, mother). None of the four analyses conducted was considered significant, indicating that, regardless of experience, Student and Professional raters made similar endorsements across family members (See Table 3).

**Source of presenting problem.** Seven separate analyses were conducted in order to determine if ratings of the function of the presenting problem varied as a function of a participant's experience (See Table 3). Significant relationships were found for three of the seven analyses. First, there was a relationship between raters' level of experience and their indication of the family's presenting problem serving a function for Son,  $\chi^2(1, N = 58) = 4.603, p = .048$ . It should be noted that the analysis showed that one cell had an expected count less than five, so an exact significance test was selected for the Pearson's chi-square. Although a minority of both Professional and Student raters endorsed the sample family's presenting problem as being related to Son, none of the Professional raters (0%) made this assessment, as compared to Student raters (17%). A similar finding was discovered with Daughter,  $\chi^2(1, N = 58) = 4.603, p = .048$ . This analysis showed

that one cell had an expected count less than five, so an exact significance test was selected for the Pearson's chi-square. Again, although a minority of both Professional and Student raters endorsed the sample family's presenting problem as being related to Daughter, no Professional raters (0%) made this assessment as compared to Student raters (24%). In addition to Student raters being more likely to endorse the presenting problem being related to issues with Son and Daughter, Student raters (55%) were also more likely than Professionals (13%) to indicate the presenting problem as related to general issues within the family,  $\chi^2(1, N = 58) = 8.438, p = .004$ .

**Developmental stage.** Table 3 displays the results from the four analyses conducted regarding raters' experience level and their endorsements of stressful developmental stages. Only one category indicated a significant relationship: raters' experience level and their endorsement of Couples Formation as a developmental stage causing the greatest degree of family stress,  $\chi^2(1, N = 58) = 16.739, p = .0001$ . Specifically, none of the Professional raters (0%) endorsed this category as problematic for the family; Students raters (60%) were significantly more likely to make this endorsement.

**Subsystems.** Of the eight analyses conducted on a rater's experience level and their ratings of subsystems, only the Couples subsystem analysis revealed a significant relationship,  $\chi^2(1, N = 58) = 6.070, p = .014$ . Table 3 displays that Student raters (48%) were significantly more likely to indicate the Couple subsystem as producing a high degree of interference regarding healthy family functioning versus Professional raters (12%).

**Subsystem quality.** Analyses were also conducted in an effort to determine the effects of experience on endorsements regarding the quality (i.e., enmeshed, disengaged) of highly problematic subsystems (See Table 3). Results revealed a relationship between raters' level of experience and their endorsement of the most problematic subsystem possessing a disengaged quality,  $\chi^2(1, N = 58) = 8.305, p = .018$ . This analysis showed that two cells had expected counts less than five, so an exact significance test was selected for the Pearson's chi-square. Although all Student, and a majority of Professional, raters endorsed a highly problematic subsystem as disengaged, Student raters (100%) were significantly more likely to make this endorsement, as compared to Professional raters (81%).

**Hierarchy: Member in top position.** Separate analyses, based on a rater's experience level (student vs. professional), were conducted on each family member (i.e., father, son, daughter, mother) regarding their being endorsed as holding the top position in a problematic hierarchical arrangement (See Table 3). Two significant relationships were discovered. There was a relationship between raters' level of experience and their ranking Father as holding the top position in a problematic family hierarchy,  $\chi^2(1, N = 58) = 17.898, p = .0001$ : Student raters (83%) were significantly more likely to make this endorsement, as compared to Professional raters (25%). There was also a relationship between raters' level of experience and their rating the mother at the top of a problematic family hierarchy,  $\chi^2(1, N = 58) = 5.117, p = .043$ . It should be noted that this analysis showed that two cells had expected counts less than five, so an exact significance test was selected for the Pearson's chi-square. Although a minority of both professionals and students placed Mother at the top of a problematic family hierarchy, Professional raters

(25%) were significantly more likely to make this endorsement, as opposed to Student raters (5%).

**Hierarchy: Member in bottom position.** Separate analyses based on raters' experience level (student vs. professional) were conducted on each family member (i.e., father, son, daughter, mother) regarding endorsement of holding the bottom position in a problematic hierarchical arrangement (See Table 3). One significant relationship was discovered. There was a relationship between raters' level of experience and their placing Father at the bottom of a problematic family hierarchy,  $\chi^2(1, N = 58) = 10.881, p = .003$ . It should be noted that the analysis showed that one cell had an expected count less than five, so an exact significance test was selected for the Pearson's chi-square. Student raters (7%) were significantly less likely than Professional raters (44%) to assess Father at the bottom of a problematic family hierarchy.

**Triangles.** Separate analyses were conducted on each of the five possible family triads (i.e., Mother-Father-Son, Mother-Father-Daughter, Son-Daughter-Father, Son-Daughter-Mother, and Other). No significant relationships were discovered regarding raters' level of experience and the type of rating made (See Table 3).

**Worldviews.** Analyses were conducted to determine if a particular belief about the world/others contributed to problems in the sample family (See Table 3). The analyses included worldviews of each individual family member (i.e., father, son, daughter, mother), as well as general family worldviews/beliefs. When comparing Student and Professional raters, one significant relationship was discovered: there was a relationship between raters' level of experience and a rater's indicating a general family worldview contributed to problematic family functioning,  $\chi^2(1, N = 58) = 4.726, p =$

.030. Specifically, although a minority of both Professional and Student raters indicated that general family worldviews of the sample family contributed to problematic functioning, Student raters (43%) were significantly more likely than Professional raters (13%) to make this assessment.

### **Summary and Integration of Results**

**Symptom bearer.** Endorsements of *Daughter* as primary symptom bearer occurred significantly more often than would be expected (93%). These ratings were mediated by training, with Direct Training raters (100%) significantly more likely to make this endorsement than Indirect Training raters (85%) raters. These endorsements did not vary as a function of a rater's experience. *Father*, *Mother*, and *Son* were each endorsed significantly less often than would be expected (17%, 3%, and 10%, respectively). Ratings for each of the three remaining members did not vary as a function of training or experience.

**Source of presenting problem.** In general, raters did not affirmatively endorse any of the seven subcategories designated as potential sources of the family's presenting problem to a degree any greater than chance. However, the subcategories of *Related to Children* (2%), *Related to Mother* (17%), *Related to Daughter* (17%), and *Related to Son* (17%) were each endorsed significantly less often than would be expected. Ratings of *Related to Children* and *Related to Mother* did not vary as a function of training or experience. *Related to Daughter* and *Related to Son* were significantly more likely to be endorsed by Direct Training raters (31% and 31%, respectively). It should be noted that in each of these subcategories, no Indirect Training raters endorsed either of these subcategories (0% and 0%, respectively). In addition, Student raters were significantly

more likely to endorse these two categories (24% and 17%, respectively), as compared to Professional raters (0% and 0%, respectively). In terms of the *Related to Family* subcategory, Student raters (55%) were significantly more likely to endorse this category than were Professional raters (13%); ratings of this subcategory were not mediated by a rater's experience. The subcategories of *Related to Parents*, *Related to Father*, and *Related to Family* were each endorsed as frequently as would be expected by chance.

**Developmental stage.** In general, all raters endorsed *Adolescent Families* as the primary developmental stage causing the greatest distress for the sample family significantly more often than would be expected (72%). These ratings were not mediated by either training or experience, indicating that all raters were equally likely to make this endorsement. Ratings of the developmental stage subcategories of *Parents Separating from Children* and *Other* both occurred significantly less often than would be expected (24% and 2%, respectively). Although the rating of *Parents Separating from Children* was not mediated by experience, Indirect Training raters (42%) were significantly more likely to endorse this subcategory than Direct Training raters (9%). Furthermore, ratings of *Other* did not vary as a function of training or experience. In addition, although raters in general did not endorse *Couples Formation* to a degree greater than chance, ratings in this area were mediated by both training and experience: Direct Training raters (66%) were more likely to rate this as a highly problematic developmental stage, as were Student raters (60%). Professional raters made no endorsements of the *Couples Formation* subcategory (0%).

**Subsystems.** All raters endorsed the following subsystems significantly less often than would be expected: Parent-Child (Father & Son; 14%); Parent-Child (Father &

Daughter; 5%); Parent-Child (Mother & Son; 2%); Parent-Child (Mother & Daughter; 16%); Sibling (17%); and Other (5%). Furthermore, none of these category endorsements were mediated by either training or experience. In terms of the two remaining subsystems, neither *Parent* nor *Couple* was endorsed to a degree greater than would be expected by all raters. However, *Couple* was endorsed significantly more often by both Direct Training (63% vs. Indirect Training, 8%) and Student (48% vs. Professional, 13%) raters. Endorsements of the *Parent* subsystem were not mediated by either training or experience.

**Subsystem quality.** All raters rated an endorsed highly problematic subsystem as possessing a *disengaged* quality (95%) significantly more often than would be expected. Furthermore, endorsements of a highly problematic subsystem possessing an *enmeshed* quality occurred significantly less often than would be expected (19%). It should be noted that although a majority of both Student and Professional raters endorsed a highly problematic subsystem as *disengaged*, Student raters (100%) were significantly more likely to make this assessment, as compared to Professional raters (81%). And, although ratings of *disengaged* subsystems were not mediated by training, all Direct Training raters (100%) made this assessment. In terms of enmeshment, Indirect Training (31%) raters were significantly more likely to endorse a problematic subsystem as enmeshed, when compared to Direct Training raters (9%). Ratings of enmeshment were not mediated by experience.

**Hierarchy: Member in top position.** Raters, in general, endorsed Father as holding the top position of a problematic family hierarchy significantly more often than would be expected (67%). This assessment was mediated by both training and

experience, with Direct Training raters (84%) more likely to make this endorsement than Indirect Training raters (46%), and Student raters (83%) more likely to make this assessment than Professional raters (25%). Ratings of Mother and Son occurred significantly less often than would be expected by all raters (10% and 9%, respectively). In terms of Mother, although a minority of both Student (5%) and Professional (25%) raters endorsed her at the top of a problematic family hierarchy, Professional raters were more likely to make this assessment. Ratings of mother in the top position were not mediated by training. Ratings of Son as holding the top position of a problematic family hierarchy were not mediated by either training or experience. Endorsements of Daughter as holding the top position did not occur significantly more often than would be expected (52%). Moreover, endorsements of Daughter in this position did not vary as a function of training or experience.

**Hierarchy: Member in bottom position.** Raters in general endorsed Mother as holding the bottom position in a problematic family hierarchy significantly more often than would be expected (64%). These ratings were not mediated by either training or experience. Regarding the three remaining family members, each was endorsed as holding the bottom position of a problematic family hierarchy significantly less often than would be expected (Father, 17%; Daughter, 29%; and Son, 26%). Although ratings of Father in the bottom position were not mediated by training, Professional raters (44%) were significantly more likely to make this endorsement than were Student raters (7%). In terms of Daughter, Direct Training raters (41%) were significantly more likely to endorse her as holding the bottom position than were Indirect Training raters (15%); ratings of daughter were not mediated by experience. Finally, ratings of Son as holding

the bottom position of a highly problematic family hierarchy were not mediated by either training or experience.

**Triangles.** All raters endorsed the Mother-Father-Daughter triangle significantly more often than would be expected (86%). Furthermore, these ratings did not vary as a function of training or experience. In addition, each of the remaining four triangles was endorsed significantly less often than would be expected (i.e., Mother-Father-Son, 21%; Son-Daughter-Mother, 31%; Son-Daughter-Father, 7%; and Other, 7%); none of these four triads varied by training or experience.

**Worldviews.** Ratings of Father as holding a highly problematic worldview occurred significantly more often than would be expected (71%) and did not vary as a function of training or experience. Furthermore, ratings of Daughter and Son as holding highly problematic worldviews each occurred significantly less often than would be expected across raters (36% and 9%, respectively). In addition ratings for Daughter and ratings for Son did not vary as a function of a rater's training or experience.

Endorsements indicating Mother as holding a highly problematic worldview did not occur to a degree greater than would be expected, and did not vary as a function of a rater's training and/or experience. In terms of general family worldviews that contributed to high levels of family stress, endorsements of Family occurred significantly less often than would be expected (34%). It should be noted that, although a minority of raters made endorsements of general family worldviews as contributing high degrees of stress to the sample family, both Direct Training (47%) and Student (43%) raters were significantly more likely to make these endorsements than their respective group comparisons (Indirect Training, 19%; Professionals, 13%).

## Chapter 5

### Discussion

The present investigation was an exploratory study designed to determine the practical value of the DAFFI-DUCC outside of the didactic setting in which it was created. Two research questions employed in this aim were: (1) Do raters, in general, observe the same types of problems within a given family?, and (2) Do a rater's training and levels of experience impact the type of assessments made on the DAFFI-DUCC?

#### Discussion of Findings by Construct

**Symptom bearer.** On this sub-construct, the answer appears to be, yes, regardless of the source of training or experience. Raters in general agreed that *Daughter* was the primary symptom bearer for the sample family. This is further corroborated by the fact that ratings of the three remaining family members, across all raters, occurred significantly less often than would be expected, thus indicating inter-rater agreement within this DAFFI-DUCC domain. Regarding the second research question, neither a rater's training nor their experience appears to impact their rating of this construct. A rater's experience did not mediate their endorsement in this domain, with a majority of both Student and Professional raters endorsing Daughter as the sample family's primary symptom bearer. In terms of training, a majority of each group of raters identified *Daughter* as the identified client. The fact that all Direct Training raters identified her as the primary symptom bearer may be attributable to this group of participants having received direct instruction and guidance from the developer of the instrument, including specific training in the theories and concepts underlying the instrument. Variations in

ratings from participants in the Indirect Training group may be due to instruction/training in other family-systems modalities, as well as rater error.

**Source of presenting problem.** With none of the seven researcher-delineated subcategories of this domain being endorsed significantly more often than others, the answer to the first research question is, no, raters did not identify similar sources of the presenting problem. However, they did agree on which family members were *not* sources of the problem. Raters' responses within this DAFFI-DUCC dimension provided no clear indication as to what the presenting problem (i.e., daughter's misbehavior) of the sample family was masking (i.e., the "true" problems that potentially catalyzed the daughter's problems). Given that the subcategories of *Related to Children*, *Related to Mother*, *Related to Daughter*, and *Related to Son* were all endorsed significantly less often than would be expected, as well as the fact that no subcategory was endorsed significantly more often than would be expected, it is possible that raters, in general, were not able to accurately identify the source of the presenting problem. However, it does appear that raters were able to, through lack of endorsements, identify those areas that were non-problematic (i.e., not related to the presenting problem). The non-significant finding of the three remaining groups (i.e., *Related to Parents*, *Related to Father*, and *Related to Family*) may indicate that either, the researcher's categorical delineations may not have adequately accommodated raters' responses, that the researcher may not have adequately interpreted raters' responses, or that the presenting problem may be maintained by a more intricate interplay of these three non-significant categories, which cannot be adequately captured via raters' narratives or via researcher's categorization

schemes. Finally, it is also possible that this was a poorly defined category designed for research purposes with no practical value.

*Source of Presenting Problem* endorsements appear to vary as a function of a rater's training. Specifically, although only a minority of both Direct Training and Student raters endorsed *Related to Daughter* and *Related to Son*, they were significantly more likely to do so than their relative group counterparts. Neither Indirect Training nor Professional raters endorsed *Related to Daughter* or *Related to Son* as highly problematic. This increased likelihood of endorsement by Direct Training and Student raters may be due to the fact that the Direct Training group was exclusively composed of raters from the graduate institution where the DAFFI-DUCC was created, and that the Student group was comprised exclusively of students who, most likely, have had minimal exposure to, and practice working with, family systems concepts. Specifically, these raters may have demonstrated less specificity in their labeling of the severity/interference of certain subcategories in this DAFFI-DUCC domain (e.g., endorsing multiple hypotheses as equally stressful/interfering), or simply in their identification of sources of the presenting problem. This lack of specificity is also exhibited in Students being significantly more likely to endorse a more general category like *Related to Family* as highly problematic. Furthermore, it is possible that, since Indirect Training and Professional raters did not contain raters from the New York university, training differences influenced these raters' hypotheses and subsequent ratings. Thus, it does appear that the source of training and experience had some impact on raters' analyses in this area.

**Developmental stage.** Overall, it appears that a majority of all raters believed *Adolescent Families* to be the developmental stage category presenting the greatest degree of stress-inducing interference for the sample family. Thus, raters generally agreed on the primary developmental stage of the family independent of the source of their training or experience. Endorsements of two of the three remaining categories occurred significantly less often than would be expected.

In response to the second research question, there were some differences related to a rater's source of training and secondary developmental stages identified as problematic. In terms of *Parents Separating from Children*, although only a minority of both training groups endorsed this category, Indirect Training raters were significantly more likely to make this endorsement. It should be noted, however, that the endorsement of this category can be considered valid, given that Son had left the family to attend college and recently returned home, indicating potential category-related stress for the family. One possible reason for Direct Training raters being less likely to make this endorsement may lie in the specificity of their training (i.e., direct training in the theoretical constructs underpinning the instrument), as well as possible corrective feedback on the severity of alternative hypotheses of trainee assessments via the trainer during the time ratings were made (i.e., that although the endorsement of this category is viable, it wouldn't be considered as stressful as an alternative explanation). It is also possible that Indirect Training raters may be more likely to entertain the possibility of multiple, compounding issues impacting upon a family at any given time, which therefore resulted in the endorsement of multiple hypotheses of equal severity.

Differences in the endorsement of *Couples Formation* also warrant attention. Although raters in general did not endorse this category to a degree greater than chance, both Direct Training and Student raters were significantly more likely to indicate this category as causing a high degree of stress for the sample family. One possible reason for this difference may lie in confusion regarding category-specific tasks related to the *Couples Formation* stage (i.e., establishing roles for normal tasks, guidelines for displays of affection and intimacy; relationships with each partner's families of origin; and distribution of power), as well as the placement of this category in the sequential order of the developmental life-cycle of the family (i.e., its occurrence at the beginning of the life-cycle when the couple establishes a relationship, generally prior to the addition of children to the family unit). Specifically, it is apparent that, upon observing the initial family interview contained in the video, there seems to be tension between Mother and Father (i.e., the couple); however, it is difficult to pinpoint the origin of this tension and therefore difficult to determine whether raters endorsing this category as problematic based their assessments on a misinterpretation of this stage (e.g., a logic that runs like "there seems to be problems in the parents relationship, they are a couple, so there is tension in the *Couples Formation* stage"), or if they were referring to problems that existed at the beginning of the couple's relationship that have subsequently carried over into the family's current functioning. If these raters were indicating that the difficulties the family is presently experiencing are a residual of unresolved issues from when Father and Mother first met that have persisted throughout the course of their relationship (a viable possibility), then endorsements of *Couples Formation* as producing significant amounts of interference seem more valid. At face value, this seems like a more complex

hypothesis, which would require the rater to consider the interdependent nature of phenomena and the compounding/cumulative effects of relational interactions over time – something one would not necessarily attribute to the novice clinician. Given that both the Direct Training and Student raters were comprised entirely of students with limited experience working from a systemic perspective, the employment of this level of logic is unlikely, unless it was due to direct training on this type of interaction and/or raters being guided in their responses while filling out the DAFFI-DUCC. This is further supported by the fact that no Professional raters endorsed this category. Hence, an alternative, and more probable, hypothesis is that Direct Training and Student raters' lack of exposure to and experience with family-system concepts led to a misinterpretation of this category, whereas Professional raters (who also comprised a approximately half of the Indirect Training group), who potentially possessed a more informed understanding of this developmental stage, accurately interpreted the family video and subsequently refrained from endorsing it. In regards to the second research questions, to some extent, both training and experience played a role in the type of rating made in this construct area.

**Subsystems.** Within the subsystem domain of the DAFFI-DUCC, none of the eight researcher-delineated categories was endorsed significantly more often than others, indicating a lack of consensus on a single subsystem most responsible for problematic functioning within the sample family. Hence, the answer to the first research question for this domain is, raters did not agree on a particular subsystem interaction that was problematic.

Since there were significantly fewer than expected endorsements across raters, as well as similarities in the frequency of endorsement by training and experience, it appears

that all raters agreed that subsystems related to parent-child interactions (as interpreted by the researcher), the sibling subsystem, or any other hypothesized subsystem were *not* candidates for the most problematic/stress-inducing subsystem related to the sample family. This may be interpreted as raters indicating where the problem is not. Another explanation involves the nature of the data. Specifically, the researcher-delineated categories related to Parent-Child interactions were driven by rater responses. One explanation as to why they were endorsed significantly less frequently may be due to the fact that very few hypotheses (less than 18% in all cases) regarding problematic parent-child relationships were posited. In other words, either raters did not feel that inappropriate relationships between parent and child were present in the sample family (e.g., the mother being enmeshed with the daughter), or they felt that these types of relationships, while potentially stress-producing/stress-sustaining, were not the *most* stressful or causing the *most* interference for the family.

An explanation as to why there was no clearly identified subsystem contributing to problematic family functioning may be that the categories developed by the researcher did not adequately accommodate hypotheses created by raters. It is also possible that, given the qualitative nature of the responses, data provided by raters was not accurately interpreted by the researcher. Another explanation is that subsystem functioning may be too complex to adequately quantify or that, given the range in quality of raters' responses, the parameters around structural mapping of subsystems were not made explicit in the DAFFI-DUCC instructions, resulting in inconsistent diagramming across raters, as well as making analysis of these wide-ranging responses difficult.

Given the low frequency of endorsement related to parent-child or sibling subsystems, a review of the two adult-related subsystems is in order. Although neither the Parent nor Couple subsystems were endorsed as problematic significantly more often than would be expected, they were endorsed more frequently relative to the six remaining categories (48% and 38%, respectively); however, these endorsements did not happen at a rate greater than would be expected by chance. It should be noted that endorsements of the *Parent* subsystem did not vary as a function of a rater's training or experience, whereas endorsements of the *Couple* subsystem were significantly more likely to be made by both Direct Training and Student raters; very few Indirect Training (less than 8%) and Professional (less than 13%) raters endorsed this subsystem as problematic. One explanation for these differences may be related to quality of training provided to raters, where Direct Training and Student raters were more inclined to view problems between mother and father as related to imbalances or stress from intimacy/relationship issues (i.e., couples). Another explanation may be related to a lack of specificity, or a "flooding" strategy, where Direct Training and Student raters generated multiple hypotheses of equal severity in order to cover all possibilities. Finally, it is possible that, due to the researcher inadequately defining and categorizing the rater-identified subsystems included in this study, an inappropriate distinction was drawn between *Parent* and *Couple*, where raters may have used these terms interchangeably, and thus intended something different than what the researcher interpreted. In response to the second research question, ratings of the *Subsystem* construct appear to be mediated by a rater's training source and experience.

**Subsystem quality.** All raters using this instrument, regardless of training or experience, agreed that the quality of the highly problematic subsystem was disengaged. All Student raters endorsed a highly problematic subsystem as *disengaged*. A majority of Professional raters also made an endorsement of *disengaged*, but there were some who did not, suggesting that Professional raters may be more flexible in their interpretations of subsystem quality, and thus provide more sophisticated hypotheses regarding problematic functioning. It is also possible that variations in training of the professionals contributed to these differences. Training effects may also be evident for enmeshment. While a minority of both Direct Trained and Indirect Trained raters made such an endorsement, this type of assessment was more likely to be made by someone trained outside of the graduate institution where the DAFFI-DUCC was developed. Overall, in the area of subsystem quality, the answer to the first research question is, yes, raters indeed generally observed the same quality of cohesiveness of the family's problem; training and experience impacted the unanimity of these observations, with *all* Student and Direct Training raters agreeing on the quality of an identified problematic subsystem.

**Hierarchy: Member in top position.** Overall, raters were in agreement regarding the family member holding the top position of a problematic family hierarchy. All raters agreed that Father held the top position of a problematic family hierarchy. According to Structural Family Therapy theory, it is not uncommon, or problematic, for a parent member to hold the top position of a family hierarchy. Of concern in this family is that Father may be holding this position in isolation (i.e., without Mother) or that the hypothesized highly problematic hierarchies contain imbalances in the arrangements of the remaining family members (e.g., children placed above mother). Given that the

present data was analyzed by looking only at who was ranked at the top or bottom of a given problematic hierarchy, it is difficult to determine the presence of problematic rank-order arrangements. Therefore, considerations of these findings will be more meaningful when coupled with results from the *Hierarchies: Member in Bottom Position*.

In terms of the second research question, differences in ratings between both training and experience groups were evident. Ratings of Father in the top position being significantly more likely by Direct Training and Student raters may be due in part to Direct Training and Student raters being more acutely aware of problematic hierarchical imbalances where Mother is below children. However, these differences may also be due to both Direct Training and Student rater groups, who are primarily comprised of students, possessing less experience in seeing that sometimes those family members who appear the most powerful, actually possess the least amount of power in the family. This explanation is further corroborated by Professional raters being significantly more likely to endorse Mother as holding the top position of a problematic hierarchy and significantly less likely to endorse Father at the top of a problematic hierarchy, suggesting that the Professional's experience may again lead to more sophisticated hypotheses and hence differences in assessment.

It should also be noted that approximately half of all raters indicated that Daughter held the top position in a highly problematic family hierarchy. Furthermore, this rating was not mediated by training or experience, indicating general rater agreement. Although not statistically significant, this finding is interesting when taking into consideration the theoretical underpinnings of hierarchies. As mentioned above, Structural Family Therapy theory presupposes that healthy family hierarchies maintain a

power structure with parents towards the top and children towards the bottom. Given that Daughter was placed at the top of a highly problematic family hierarchy by at least half of all raters indicates some potential agreement around a problematic hierarchical arrangement for this family.

**Hierarchy: Member in bottom position.** Given the above results, it appears that raters, regardless of training or experience, placed Mother at the bottom of a highly problematic family hierarchy significantly more often than would have been expected. In addition, given that raters' endorsements of the three remaining family members as holding this bottom position occurred significantly less often than would be expected, it appears that there is general agreement that, within the sample family, the mother is most likely to be seen as having the least amount of power – a clear indication of problematic hierarchical arrangements for the sample family. In terms of Father, Professional raters were more likely than Students to place him at the bottom of a problematic hierarchy. As was mentioned in the discussion regarding members placed at the top of a family hierarchy, this may be due in part to the more experienced professional acknowledging the less obvious fact that sometimes the seemingly more powerful family members actually possess a smaller degree of influence in maintaining problematic family patterns of functioning. In terms of Daughter, it is possible that, although a minority a both training groups endorsed her as holding this bottom position, Direct Training raters were more likely to generate hypotheses where the daughter held the bottom position due to specific training effects. One such effect may include the function of the symptom bearer for the family's presenting problem. Raters in the Direct Training group may have placed Daughter at the bottom, knowing that the original symptom bearer is rarely the

most powerful, and instead serves as a “smoke-screen” for what is truly ailing the family. Other than having direct feedback from the instructor while filling out the DAFFI-DUCC, it is unclear why this effect did not carry over for professional raters, given that this type of interpretation is more likely to be made by those more experienced in family system dynamics. Furthermore, as was mentioned in the above discussion of members endorsed in the top position of a problematic family hierarchy, Structural Family Therapy theory posits that non-problematic hierarchical organizations of family members generally have parents holding top positions. Given that Mother is rated at the bottom significantly more often than would be expected, and that Father at top significantly more often than would be expected, it is likely that the sample family is experiencing an imbalance of power where the mother has been disenfranchised from having adequate amounts of influence within the family unit.

Thus for both the *Hierarchy: Member in Top Position* and *Hierarchy: Member in Bottom Position* constructs, raters generally agreed on which family members occupied these positions, indicating that all raters appear to observe a similar problematic hierarchical dynamic. This was true in spite of some differences in the Professional group, which is attributable to their more sophisticated conceptual understanding that comes with experience.

**Triangles.** Overall, given similar ratings across all raters, as well as a lack of variability in endorsements based on a rater’s training or experience, the results support the idea that there was a general consensus regarding the Mother-Father-Daughter triadic relationship causing the highest degree of stress for the sample family. Given this consensus, it appears that the triangular interaction construct may be one of the more

straightforward ones and easiest to understand independent of the training source or level of experience of the evaluator.

**Worldviews.** Overall, all rater endorsements indicated that Father possessed a worldview that interfered with family functioning, thus answering the first research question with a clear, yes. Upon further review of results, with three of the four remaining areas being endorsed significantly less often than would be expected, it appears that endorsements of Father's worldview occurred more often than any other family member, or when compared to endorsements of problematic worldviews stemming from general family worldviews. Differences between rating groups were found regarding endorsements of Family worldviews. The endorsement of general family worldviews as contributing to overall family stress were more likely to be made by both Student and Direct Training raters. One hypothesis as to why both of these groups of raters were more likely to make an endorsement of Family worldviews as causing a high degree of interference is that both of these groups were comprised exclusively of students. Raters who may be new to family systems theory and concepts may be more inclined to attribute problematic functioning to general family functioning, and/or may not as readily tease out problematic worldviews of individual family members. In addition, the selection of Father as holding the most problematic worldview may be a product of gender stereotyping and, at least within the United States, a result of more male-centered views of family that has placed the father at the head of the nuclear family-household, and imbued him with the most power. Given Father was rated at the top position of the family hierarchy, and is thus believed to hold the most power, his problematic worldviews were misappropriated to general family beliefs (this is also

possible given that Father dominated much of the discussion during the family session). Furthermore, the fact that more novice raters were more likely to endorse general family worldviews as highly problematic may be attributable to these raters creating more hypotheses due to a lack of certainty/specificity in their conceptualization of this families functioning (“flooding”).

### **Limitations**

One of the primary limitations of this study relates to its sample. The Direct Training participants were students in the graduate program in which the DAFFI-DUCC was used to facilitate the acquisition of family systems theories and concepts. This group was primarily selected out of convenience. Participants in the Professional group, while derived from a randomly generated AAMFT mailing list, were essentially self-selected by indicating their interest in participating in the study. Thus, the quality and application of their knowledge of systems principals could not be adequately controlled in the research design. In addition, there was a lack of external validity due to the small number of participants used in the sample and the uneven distribution of participants between Student and Professionals groups. This may have skewed the magnitude of differences in endorsements between each group. The small number of participants also affected the chi-square analyses. In various instances, cells in certain contingency tables had an expected frequency of less than five, making those results meaningless, and requiring that Fisher’s Exact tests be performed in order to render these results interpretable.

A second limitation in the study relates to the analysis of the qualitative data generated by raters, which included a wide-range of both written and pictorial responses to open-ended tasks. Researcher bias must be considered, given that the scoring

methodology used to analyze rater responses were limited by the researcher's frame of reference, which means that it is probable that there were alternative ways to categorize and analyze raters' responses. This was especially true for the construct areas of Symptom Function and Subsystems.

Symptom Function consisted of an open-ended directive suggesting a response framed in a metaphor. However, the analysis strategy employed in this study did not capture quality of presenting problem, and rather considered only the individual identified by the family as having the issue(s) which brought them to the initial sessions (i.e., Symptom Bearer, Identified Patient/Client), as well as the individual(s) with whom the problem was associated (i.e., family members). An analysis technique that might yield more definitive findings may require a strategy that considers the metaphor represented by the Symptom Bearer's presenting issues. It is hard to determine what important information is lost attempting to translate qualitative information to quantitative information.

Similar difficulties occurred when trying to analyze the Subsystems domain. A primary difficulty concerned analyzing rater's responses. Given the limited number of participants and responses ranging from narratives to various idiosyncratic diagrams, the lack of a common thread throughout responses limited the alternatives for categorizing and analyzing responses. In order to adequately accommodate the diversity of rater responses, the researcher attempted to interpret and identify the subsystems and respective boundaries portrayed by the raters, which resulted in eight separate categories. Follow-up interviews with respondents may have helped in clarifying any questions the researcher may have had when analyzing responses, as well as correcting any

misconceptions regarding the interpretation of subsystems and boundaries indicated within these responses.

A third limitation to the study relates to training and quality of instructions. It is difficult to determine whether those participants within the Indirect Training group read the manual and if they adequately understood how to fill out the instrument. Furthermore, Indirect Training raters were not trained by the developer of the DAFFI-DUCC and therefore potentially open to a greater range of theoretical perspectives that may have obfuscated their responses. In addition, the quality of the manual accompanying the DAFFI-DUCC may not have adequately met the needs of the present study. For example, although it provided guidelines for some of the primary subsystems operating within the family, these guidelines only suggested what a rater should look for and not *how* they should relate this information on the DAFFI-DUCC. Raters varied in how they utilized these guidelines when developing responses. Raters also varied in how they portrayed boundaries between subsystems. Overall, differences in training and quality of directions resulted in a wide range of response quality across raters, as well as possible misinterpretation of what the creator of the DAFFI-DUCC intended. Given that there were many similarities in ratings between the different training groups, it would appear that the training provided to both groups was adequate; however, more prescriptive directives in the manual may have provided the researcher with more consistency among responses leading to more easily quantifiable data and, therefore, less uncertainty in some of this study's more ambiguous results.

### **Implications for Practice**

Results from the study indicate that some of the theoretical concepts posited by systems theory in general, and Structural and Strategic Family Therapy in particular, are more readily grasped than others. Two primary areas, as indicated by this study, that demonstrated a lack of consensus among all raters were Source of Presenting Problem and Subsystems. If the equivocal nature of the results in these areas is not related to methodical issues related to organizing and analyzing data, then these results point to a need to provide further training and elucidation of these concepts.

Given that metaphors (the primary vehicle for communicating Symptom Function) are by nature multifaceted and are left to the interpreter to derive meaning, it may be that this domain of the DAFFI-DUCC is not quantifiable and, therefore, not amenable to analysis. However, more in depth training in generating and working with metaphors may improve reliability in this area and the usefulness in analyzing this construct as part of the clinical decision making process with families.

In terms of Subsystems, although there are some common structural diagramming techniques utilized in outlining family structure, they are not necessarily employed consistently across clinicians. Given that the information obtained from a family is only as useful as it is meaningful to the practitioner working with the family, an emphasis on training future clinicians with a more standardized approach may be a moot point. In terms of improving the utility of this instrument, clearer directions around what is to be diagrammed and how to diagram it may prove useful in promoting more consistent responses, which could consequently result in more accurate and meaningful data for making clinical decisions.

### **Implications for Future Research**

Results from this study can be used in the continuing refinement of the DAFFI-DUCC. Future research should be focused on creating an instrument that is more efficient, meaningful, and helpful in the development of clinician competencies. One such area to focus on in meeting this end concerns the training video. The DAFFI-DUCC, or any training tool, requires an accompanying video demonstrating family structures and relational dynamics that have been validated by experts. Once an expert-validated “key” for the sample family’s functioning is created, trainee ratings on the DAFFI-DUCC may more readily be compared with those of the experts, therefore creating a more meaningful training tool helping trainees in the field of family therapy become more effective clinicians.

Another important future study needed in the ongoing development of the DAFFI-DUCC will be to compare family ratings of a control group of raters who did not use instrument to those individual’s who did utilize the instrument. Such a study would help to determine how useful this instrument is in assisting a clinician in their conceptualization of a family’s functioning.

Including follow-up interviews with respondents in future studies that would help clarify questions and garner specific feedback may help improve the practical utility of the DAFFI-DUCC. The immediacy of the feedback and clarification is also important. Approximately half of the participants in the present study were mailed the DAFFI-DUCC manual and instrument, and consequently did not receive corrective feedback or support from the researcher. Future research may benefit from the researcher having greater, more immediate access to participants in order to more readily refine instrument

instructions and data analysis techniques. This would prove helpful in the analysis of most qualitative DAFFI-DUCC domains, including Symptom Function and Circular Patterns.

Specific to the Subsystems construct, more explicit definitions of subsystems, as well as specific mapping techniques on how to portray the nature and quality of boundaries, may improve future research efforts on the instrument.

It may also be helpful to develop a different method of analyzing Symptom Function in order to determine how raters vary in their understanding or theorizing about the maintenance of problematic family functioning. Perhaps the use of a recursive development strategy (i.e., Grounded Theory) would help in creating a method of effectively and meaningfully categorizing and rating metaphors.

Research methodologies for the analysis of hierarchies should be more integrated in future research. The current study only considered, in separate analyses, who was at the top and who was at the bottom of a problematic hierarchy. This methodology was somewhat misleading given that knowing solely who is at the top is not necessarily meaningful unless you know how the remaining family members are configured beneath that top member. For example, knowing that Father is at the top of many problematic hierarchies seems odd, given that a parent member would be expected to hold this position in most non-problematic families. What is important to know is if the mother is at the bottom when the father is at the top. Future investigations into hierarchical functioning should consider the hierarchies as a whole in order to tease out the valuable information provided through each members placement in a given hierarchy and how that contributes to a problematic gestalt of functioning.

It would also be interesting to investigate the interrelationships between DAFFI-DUCC dimensions. Understanding how Triangles relate to subsystems would help to determine redundancies in the DAFFI-DUCC, which may contribute to the user-friendliness of the instrument (more domains require more time to rate). It could also be helpful in determining aberrations in rater's responses by exposing inconsistencies in ratings between two potentially related domains. It would also be useful in determining the practical value in a clinician's considering various theoretical concepts simultaneously. For example, is it important to know about both Triadic relationships *and* subsystem functioning, or would it be just as useful for the clinician to understand one of these concepts in order to plan treatment/intervention?

Finally, it goes without saying, that future studies should include larger, random samples of family therapy trainees and family therapy professionals that are more representative of the profession, and incorporate better, more consistent methods of training participants in the constructs and use of the instrument. This is the only way that more powerful statistical analyses may be used to determine the reliability and validity of the instrument.

### **Summary**

Family assessment can be a complex and multifaceted process. In order to glean as much meaningful data from the family as possible, assessment that considers multiple levels of family functioning helps to provide a more comprehensive picture of the family, as well as highlighting those areas most in need of problem remediation and intervention. The purpose of the present study was to investigate the reliability of a novel multi-level assessment of family functioning designed for clinicians-in-training. This study has two

foci: 1) to determine if raters, in general, view the same problems, structural components, and dynamic interactions of a given family; and 2) to determine the extent to which raters' training and experience effects ratings on the DAFFI-DUCC.

Results from this study demonstrate that raters were in general agreement regarding seven constructs and disagreed in two areas related to problematic family functioning. These findings were consistent regardless of training or experience. While this suggests that the DAFFI-DUCC may have some usefulness as a clinical assessment, it is a very tentative first step in the development of the instrument.

Overall, the DAFFI-DUCC was created as a training tool for graduate students to aid in their application of systems concepts, especially those of the Structural and Strategic Family Therapy approaches. The results of this study indicate that raters, regardless of training and experience, make similar assessments in several of the DAFFI-DUCC domains. Differences that do exist may be due to differences in theoretical orientation that employ different "languages" when working with and assessing a family. They may also be due to novice raters being less specific in their assessment, thus making more hypotheses regarding functioning.

In general, it appears that the DAFFI-DUCC is a heuristic instrument that facilitates the acquisition of family systems concepts for the clinician-in-training, as well as providing guidance for session planning and problem remediation. However, the current version of the DAFFI-DUCC does not appear to be a practical family assessment. Its qualitative format leads to subjective interpretations that, in specific DAFFI-DUCC domains, are not readily interpretable. Although there was significant agreement about certain components of family functioning, the lack of specificity and instruction in areas

such as structural diagramming, as well as the difficulty in categorizing metaphors due to their subjective relativity, make the DAFFI-DUCC an inadequate tool for assessing families. If this instrument is going to have true value as a clinical assessment tool, it will require revisions in format, operational definitions, and instructions, as well as larger scale studies to establish validity and reliability. In the final analysis, this study was merely a very tentative first step in the development of this instrument.

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Table 1

*Percentage of endorsements across all raters: N=58*

SYMPTOM BEARER	Yes	No	<i>p</i>
Father	17.2%	82.8%	***
Mother	3.4%	96.6%	***
Daughter	93.1%	6.9%	***
Son	10.3%	89.7%	***
SOURCE OF PRESENTING PROBLEM			
Related to Parents	53.4%	46.6%	NS
Related to Children	1.7%	98.3%	***
Related to Father	48.2%	51.8%	NS
Related to Mother	17.2%	82.8%	***
Related to Daughter	17.2%	82.8%	***
Related to Son	17.2%	82.8%	***
Related to Family	43.1%	56.9%	NS
DEVELOPMENTAL STAGE			
Couples Formation	43.1%	56.9%	NS
Adolescent Families	72.4%	27.6%	**
Parents Separating from Children	24.1%	75.9%	***
Other	1.7%	98.3%	***
SUBSYSTEMS			
Parent	48.2%	51.8%	NS
Couple	37.9%	62.1%	NS
Parent-Child (Father & Son)	13.7%	86.3%	***
Parent-Child (Father & Daughter)	5.1%	94.9%	***
Parent-Child (Mother & Son)	1.7%	98.3%	***
Parent-Child (Mother & Daughter)	15.5%	84.5%	***
Sibling	17.2%	82.8%	***
Other	5.1%	94.9%	***

Table 1 (continued)

SUBSYSTEM QUALITY			
Disengaged	94.8%	5.2%	***
Enmeshed	18.9%	81.1%	***
HIERARCHY: MEMBER IN TOP POSITION			
Father	67.2%	32.8%	**
Mother	10.3%	89.7%	***
Daughter	51.7%	48.3%	NS
Son	8.6%	91.4%	***
HIERARCHY: MEMBER IN BOTTOM POSITION			
Father	17.2%	82.8%	***
Mother	63.7%	36.3%	*
Daughter	29.3%	70.7%	**
Son	25.8%	74.2%	***
TRIANGLES			
Mother-Father-Son	20.6%	79.4%	***
Mother-Father-Daughter	86.2%	13.8%	***
Son-Daughter-Mother	31.0%	69.0%	**
Son-Daughter-Father	6.8%	93.2%	***
Other	6.8%	93.2%	***
WORLDVIEWS			
Father	70.6%	29.4%	**
Mother	37.9%	62.1%	NS
Daughter	36.2%	63.8%	*
Son	8.6%	91.4%	***
Family	34.4%	65.6%	**

\*  $p < .05$ ; \*\*  $p < .005$ ; \*\*\*  $p < .0001$

Table 2

*Percentage of endorsements by training level: N=58*

SYMPTOM BEARER	Direct Training	Indirect Training	<i>p</i>
Father	15.6%	19.2%	NS
Mother	3.1%	3.8%	NS
Daughter	100.0%	84.6%	*
Son	9.4%	11.5%	NS
SOURCE OF PRESENTING PROBLEM			
Related to Parents	59.4%	46.2%	NS
Related to Children	3.1%	0%	NS
Related to Father	50%	46.2%	NS
Related to Mother	25%	7.7%	NS
Related to Daughter	31.3%	0%	**
Related to Son	31.3%	0%	**
Related to Family	53.1%	30.8%	NS
DEVELOPMENTAL STAGE			
Couples Formation	65.6%	15.4%	***
Adolescent Families	68.8%	76.9%	NS
Parents Separating from Children	9.4%	42.3%	**
Other	0%	3.8%	NS
SUBSYSTEMS			
Parent	40.6%	57.7%	NS
Couple	62.5%	7.7%	***
Parent-Child (Father & Son)	9.4%	19.2%	NS
Parent-Child (Father & Daughter)	0%	11.5%	NS
Parent-Child (Mother & Son)	0%	3.8%	NS
Parent-Child (Mother & Daughter)	12.5%	19.2%	NS
Sibling	15.6%	19.2%	NS
Other	0%	11.5%	NS

Table 2 (continued)

SUBSYSTEM QUALITY			
Disengaged	100%	88.5%	NS
Enmeshed	9.4%	30.8%	*
HIERARCHY: MEMBER IN TOP POSITION			
Father	84.4%	46.2%	**
Mother	6.3%	15.4%	NS
Daughter	50%	53.8%	NS
Son	9.4%	7.7%	NS
HIERARCHY: MEMBER IN BOTTOM POSITION			
Father	9.4%	26.9%	NS
Mother	65.6%	61.5%	NS
Daughter	41%	15.4%	*
Son	34.4%	15.4%	NS
TRIANGLES			
Mother-Father-Son	15.6%	26.9%	NS
Mother-Father-Daughter	84.6%	87.5%	NS
Son-Daughter-Mother	34.4%	26.9%	NS
Son-Daughter-Father	9.4%	3.8%	NS
Other	3.1%	11.5%	NS
WORLDVIEWS			
Father	75.0%	65.4%	NS
Mother	40.6%	34.6%	NS
Daughter	37.5%	34.6%	NS
Son	6.3%	11.5%	NS
Family	46.9%	19.2%	*

\*  $p < .05$ ; \*\*  $p < .005$ ; \*\*\*  $p < .0001$

Table 3

*Percentage of endorsements by experience level: N=58*

SYMPTOM BEARER	Students	Professionals	<i>p</i>
Father	21.4%	6.3%	NS
Mother	2.4%	6.3%	NS
Daughter	95.2%	87.5%	NS
Son	11.9%	6.3%	NS
SOURCE OF PRESENTING PROBLEM			
Related to Parents	54.8%	50%	NS
Related to Children	2.4%	0%	NS
Related to Father	52.4%	37.5%	NS
Related to Mother	19%	12.5%	NS
Related to Daughter	23.8%	0%	*
Related to Son	17.2%	0%	*
Related to Family	54.8%	12.5%	**
DEVELOPMENTAL STAGE			
Couples Formation	59.5%	0%	***
Adolescent Families	66.7%	87.5%	NS
Parents Separating from Children	19%	37.5%	NS
Other	0%	6.3%	NS
SUBSYSTEMS			
Parent	50%	43.8%	NS
Couple	47.6%	12.5%	*
Parent-Child (Father & Son)	14.3%	12.5%	NS
Parent-Child (Father & Daughter)	2.4%	12.5%	NS
Parent-Child (Mother & Son)	0%	6.3%	NS
Parent-Child (Mother & Daughter)	11.9%	25%	NS
Sibling	16.7%	18.8%	NS
Other	2.4%	12.5%	NS

Table 3 (continued)

SUBSYSTEM QUALITY			
Disengaged	100%	81.3%	*
Enmeshed	14.3%	31.3%	NS
HIERARCHY: MEMBER IN TOP POSITION			
Father	83.3%	25%	***
Mother	4.8%	25%	*
Daughter	45.2%	68.8%	NS
Son	9.5%	6.3%	NS
HIERARCHY: MEMBER IN BOTTOM POSITION			
Father	7.1%	43.8%	**
Mother	69%	50%	NS
Daughter	35.7%	12.5%	NS
Son	28.6%	18.8%	NS
TRIANGLES			
Mother-Father-Son	16.7%	31.3%	NS
Mother-Father-Daughter	90.5%	75%	NS
Son-Daughter-Mother	35.7%	18.8%	NS
Son-Daughter-Father	9.5%	0%	NS
Other	4.8%	12.5%	NS
WORLDVIEWS			
Father	76.2%	56.3%	NS
Mother	38.1%	37.5%	NS
Daughter	35.7%	37.5%	NS
Son	4.8%	18.8%	NS
Family	42.9%	12.5%	*

\*  $p < .05$ ; \*\*  $p < .005$ ; \*\*\*  $p < .0001$

## Appendix A

**HELP YOURSELF – HELP THE FIELD  
DO SOME GOOD & GET SOME GOODIES**

Dear Family Therapist:

My name is Jeremy Vose and I am a doctoral candidate conducting research on a family assessment tool. Part of this research requires the effort of knowledgeable family therapists and their assessment of a pre-recorded family therapy session. The tool, the Dynamic Assessment of Family Functioning Inventory – Demonstrated Under Clinical Conditions (DAFFI-DUCC) utilizes a structural/strategic approach to family assessment. I am asking each willing participant to make ratings of a family using this theoretical paradigm.

As I know time is valuable, I would like to offer willing participants the following compensation:

- A DVD copy of the family therapy session to use as a training tool or coaster
- The first ten individuals to return the completed DAFFI-DUCC will receive a draft copy of Cerio's book on Family Assessment
- Each participant will be entered into a raffle for a \$100 amazon.com gift card

If you are interested in participating, please email me ([jeremyvose@gmail.com](mailto:jeremyvose@gmail.com)). Your reply will serve as a confirmation of your willingness to participate. After receiving your email, a packet including the DVD and the DAFFI-DUCC will be mailed to this address (if you'd prefer an alternate address, please indicate this in your email).

Thank you in advance for your consideration of this project. I hope to hear from you soon.

Sincerely,

Jeremy Vose, MA  
Principal Researcher

## Appendix B

**DAFFI-DUCC**  
**Dynamic Assessment of Family Functioning Inventory**  
**Demonstrated Under Clinical Conditions**

by

**Jay Cerio, Ph.D.**

Directions:

- Complete this assessment after the second session with the family. Experienced family clinicians may be able to complete the instrument after one session.
- Follow the directions for each section, which include identifying specific family patterns and rating the pattern on a scale from 0 to 10.
- Compute the average rating for each section and enter that rating on the scoring summary form.
- Plot the average rating on the profile on the last page.

Family Surname \_\_\_\_\_ Date \_\_\_\_\_  
 Identified Client \_\_\_\_\_ Age \_\_\_\_\_  
 Other Family Members/Ages \_\_\_\_\_

Person Completing Form \_\_\_\_\_

***Symptom Function***

List some hypotheses on how the symptom of the identified client helps the family.  
 Consider the metaphor represented by the symptom.

**Hypothesis 1**

<u>Degree of Interference</u>											
Extreme							Moderate				Minimal
0	1	2	3	4	5	6	7	8	9	10	

**Hypothesis 2**

Extreme							Moderate				Minimal
0	1	2	3	4	5	6	7	8	9	10	

**Hypothesis 3**

Extreme							Moderate				Minimal
0	1	2	3	4	5	6	7	8	9	10	

**SF Average Degree of Interference**

***Family Developmental Stage***

List the developmental stage(s) in which the family is functioning. For each stage, describe developmental tasks and issues that are confronting the family and rate the degree of stress that the family is experiencing related to each task or issue.

**Developmental Stage 1:** \_\_\_\_\_

	<b>Extreme</b>	<b>Moderate</b>	<b>Minimal</b>								
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10

**Developmental Stage 2:** \_\_\_\_\_

	<b>Extreme</b>	<b>Moderate</b>	<b>Minimal</b>								
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10

**Developmental Stage 3:** \_\_\_\_\_

	<b>Extreme</b>	<b>Moderate</b>	<b>Minimal</b>								
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10
• <b>Task/Issue</b> _____	0	1	2	3	4	5	6	7	8	9	10

**DS Average Degree of Family Stress**

***Subsystems***

List the subsystems in the family that are evident, and who comprises these subsystems. Then list the various subsystems and rate the clarity of boundaries between subsystems.

**Degree of Cohesiveness**

**Hypothesis 1**                      Disengaged                      Appropriate                      Enmeshed  
0 1 2 3 4 5 6 7 8 9 10 9 8 7 6 5 4 3 2 1 0

**Hypothesis 2**                      Disengaged                      Appropriate                      Enmeshed  
0 1 2 3 4 5 6 7 8 9 10 9 8 7 6 5 4 3 2 1 0

**Hypothesis 3**                      Disengaged                      Appropriate                      Enmeshed  
0 1 2 3 4 5 6 7 8 9 10 9 8 7 6 5 4 3 2 1 0

**Hypothesis 4**                      Disengaged                      Appropriate                      Enmeshed  
0 1 2 3 4 5 6 7 8 9 10 9 8 7 6 5 4 3 2 1 0

**SS Average Degree of Cohesiveness**

***Hierarchy***

Provide your perception of the family members from most (top) to least (bottom) powerful. Space is provided for two possible hypotheses.

<b>Hierarchy #1</b>	<b><u>Degree of Interference</u></b>										
	Extreme			Moderate					Minimal		
	0	1	2	3	4	5	6	7	8	9	10
_____											
_____											
_____											
_____											
_____											
_____											
_____											
_____											

<b>Hierarchy #2</b>	<b><u>Degree of Interference</u></b>										
	Extreme			Moderate					Minimal		
	0	1	2	3	4	5	6	7	8	9	10
_____											
_____											
_____											
_____											
_____											
_____											
_____											
_____											

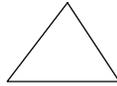


***Triangles***

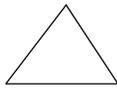
Diagram the triangles in the family by listing one family member at each point of a triangle. Then, determine the valance in each dyad (positive relationship = “+”; conflicted relationship = “-“).

**Triangle**

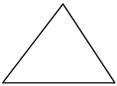
**Degree of Interference**



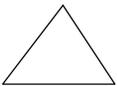
Extreme	Moderate	Minimal
0	4	9
1	5	10
2	6	
3	7	
4	8	



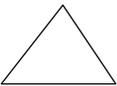
Extreme	Moderate	Minimal
0	4	9
1	5	10
2	6	
3	7	
4	8	



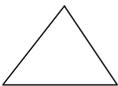
Extreme	Moderate	Minimal
0	4	9
1	5	10
2	6	
3	7	
4	8	



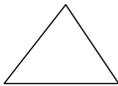
Extreme	Moderate	Minimal
0	4	9
1	5	10
2	6	
3	7	
4	8	



Extreme	Moderate	Minimal
0	4	9
1	5	10
2	6	
3	7	
4	8	



Extreme	Moderate	Minimal
0	4	9
1	5	10
2	6	
3	7	
4	8	



Extreme	Moderate	Minimal
0	4	9
1	5	10
2	6	
3	7	
4	8	

**T Average Degree of Interference**

***World Views***

List the world views of family members and rate the degree to which each view interferes with family functioning.

<u>Family Member</u>	<u>World View</u>	<u>Degree of Interference</u>										
		Extreme			Moderate				Minimal			
_____	_____	0	1	2	3	4	5	6	7	8	9	10
_____	_____	0	1	2	3	4	5	6	7	8	9	10
_____	_____	0	1	2	3	4	5	6	7	8	9	10
_____	_____	0	1	2	3	4	5	6	7	8	9	10
_____	_____	0	1	2	3	4	5	6	7	8	9	10
_____	_____	0	1	2	3	4	5	6	7	8	9	10
_____	_____	0	1	2	3	4	5	6	7	8	9	10

**World Views of the Entire Family**

_____	_____	0	1	2	3	4	5	6	7	8	9	10
_____	_____	0	1	2	3	4	5	6	7	8	9	10
_____	_____	0	1	2	3	4	5	6	7	8	9	10
_____	_____	0	1	2	3	4	5	6	7	8	9	10
_____	_____	0	1	2	3	4	5	6	7	8	9	10

**WV Average Degree of Interference**

***Circular Patterns***

List your hypotheses regarding the overt circular patterns in this family and the underlying causes for these patterns.

<b>Pattern #1</b>	<b><u>Degree of Interference</u></b>										
	Extreme			Moderate					Minimal		
	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>

<b>Pattern #2</b>	<b><u>Degree of Interference</u></b>										
	Extreme			Moderate					Minimal		
	<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>

**Pattern #3**

<u>Degree of Interference</u>										
Extreme			Moderate					Minimal		
<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>

**Pattern #4**

<u>Degree of Interference</u>										
Extreme			Moderate					Minimal		
<u>0</u>	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>

**CP Average Degree of Interference**

**Notes**

Family Surname \_\_\_\_\_ Date \_\_\_\_\_  
Identified Client \_\_\_\_\_ Age \_\_\_\_\_

**DAFFI-DUCC Score Summary**

**DS Average Degree of Family Stress** \_\_\_\_\_

**SF Average Degree of Interference** \_\_\_\_\_

**SS Average Degree of Cohesiveness** \_\_\_\_\_

**H Average Degree of Interference** \_\_\_\_\_

**T Average Degree of Interference** \_\_\_\_\_

**WV Average Degree of Interference** \_\_\_\_\_

**CP Average Degree of Interference** \_\_\_\_\_

**Total** \_\_\_\_\_

**Average Family Functioning Score**  
**(Total divided by number of areas rated.)**

Appendix C

**Dynamic Assessment of Family Functioning Inventory  
Demonstrated Under Clinical Conditions  
(DAFFI-DUCC)**

**Manual**

**Jay Cerio, Ph.D  
Jeremy C. Vose, M.A.**

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## **Part 1**

### **Introduction**

The Dynamic Assessment of Family Functioning Inventory Demonstrated Under Clinical Conditions (DAFFI-DUCC) is designed to be a tool that practicing clinicians may use to map the underlying dynamics of family interactions in order to make decisions regarding interventions that will be employed to shift dysfunctional patterns within the family. The DAFFI-DUCC is based on the structural and strategic family therapy approaches of Salvador Minuchin (Minuchin & Fishman, 1981), Jay Haley (1976), and Cloe Madanes (1981), and provides a means of operationalizing these ideas in a practical and straightforward manner. It quantifies family interactions, allowing clinicians to assess the degree of dysfunction and to map the therapeutic progress of families.

### **Structure and Format**

The DAFFI-DUCC is divided into subscales that represent the primary constructs of structural and strategic therapy: symptom function, developmental stages, subsystems and boundaries, hierarchy, triangles, world views and circular patterns. For each of these areas, the clinician can list multiple observations of family interactions that reflect each construct and then rate the observed behavior on the degree that the interaction interferes with the family's functioning. The rating scale is a 10-point (0 – 10) Likert type scale, with lower ratings indicating a higher degree of dysfunction, and higher ratings indicating a higher level of functioning. A composite score reflecting overall degree of family problems is derived from the lowest ratings on each subscale. A copy of the DAFFI-DUCC is provided in Appendix A.

This manual provides guidelines for completing the DAFFI-DUCC and explanations for the constructs that are included in the inventory. For convenience of the users, the scoring directions are provided first, followed by descriptions of the constructs. You should review the constructs before viewing the DVD and completing the DAFFI-DUCC that have been provided as part of this research project.

## Part 2

### Completing and Scoring the DAFFI-DUCC

The DAFFI-DUCC is an attempt to quantify constructs that are typically examined qualitatively. That is, we are trying to put a number on something that in reality can't be measured: theoretical concepts. These are the ideas we use to interpret the behaviors that comprise the interactions among family members. In order to do this, clinicians need to rely on their understanding of the concepts, experience with families, and cultural standards for what constitutes functional family interactions. The clinician bases his or her ratings of function on these factors.

*Step 1.* The first step in completing the instrument is to identify a behavior or situation that reflects one of the constructs. Since every family is different, the specific behaviors and situations will also be different. Write the description of the behavior on the line that is provided. This constitutes an item that will be rated. For any particular construct, you may have one item, two items, or more. It all depends on the family, and the DAFFI-DUCC is designed to be flexible enough to allow for these differences.

*Step 2.* The next step is to rate the item on the degree it interferes with the family's functioning. As stated above, the rating scale is designed for lower scores to indicate poorer functioning and higher scores, more adaptive functioning. For each individual rating, then, the rater needs to make a subjective judgment regarding how much that particular behavior is interfering with or supporting the family's functioning. Examples are provided below.

**Symptom Function:**

<b>Hypothesis 1</b>	<b><u>Degree of Interference</u></b>										
	Extreme	Moderate						Minimal			
	0	1	2	3	X 4	5	6	7	8	9	10

Johnny is refusing to go to school because he is trying to protect his mother.

[Basis for rating: Rater is basing on observation of parent’s and child’s emotional distress.]

**Developmental Stage:**

Developmental Stage 1: Families with younger children

		<b>Minimal</b>		<b>Moderate</b>			<b>Extreme</b>					
<b>Task/Issue</b>	<u>Parents agreeing on discipline</u>	0	1	2	3	4	5	X 6	7	8	9	10
<b>Task/Issue</b>	<u>Parents having time as couple</u>	0	1	2	3	4	5	6	7	8	X 9	10

**Hierarchy:**

<b>Hierarchy #1</b>	<b><u>Degree of Interference</u></b>										
	Extreme	Moderate						Minimal			
	0	1	X 2	3	4	5	6	7	8	9	10

Nancy - Youngest child assumes more power through tantrumming.

Dad – Takes over discipline when mom is ineffective.

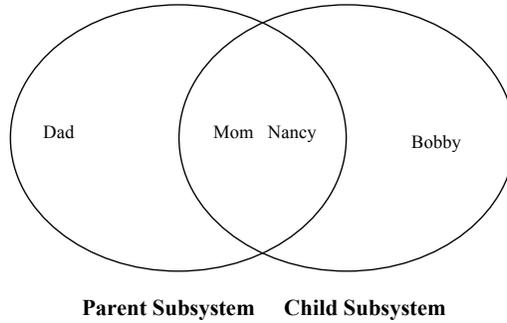
Mom – Feels like she can’t handle Nancy.

Bobby – Oldest child gets ignored because of all the attention going to Nancy.

**Subsystems:**

		<b><u>Degree of Cohesiveness</u></b>																				
		Disengaged					Appropriate					Enmeshed										
<b>Hypothesis 1</b>		0	1	2	3	4	5	6	7	8	9	10	9	8	7	6	5	4	3	2	1	0

In the following scenario, Mom seeks Dad's help when Nancy throws a tantrum, then defends Nancy when Dad disciplines her.



**World Views:**

<u>Family Member</u>	<u>World View</u>	<u>Degree of Interference</u>										
		Extreme		Moderate				Minimal				
<u>Dad</u>	<u>Spare the rod...</u>	0	1	2	3	4	5	6	7	8	9	10
		Extreme		Moderate				Minimal				
<u>Mom</u>	<u>Kids need to be understood</u>	0	1	2	3	4	5	6	7	8	9	10

**Step 3.** After listing and rating all the items in a particular area, for example, subsystems, then write the lowest rating (numerically) in the box at the bottom of the page for that area. Remember, the scale is set up so that the lower the number the more a particular behavior, interaction, or situation contributes to dysfunction in the family.

**Step 4.** Once all the areas have been rated, transfer the lowest ratings in the boxes for each area to the summary on the last page of the scale. If you didn't list and rate any items for a particular area (e.g, Circular Patterns), you leave the box for that item blank. After listing all your low ratings, add them together and then divide the sum by the number of areas that were actually rated. This is the "Average Family Functioning Score" and is designed to provide an overall picture of the healthiness of family interactions, again based on a 0 – 10 scale. A family whose average score is closer to 0 is exhibiting a higher number of interactions that interfere with the family's functioning. A family that has an average score closer to 10 is exhibiting more functional behaviors. Two examples are provided below.

**Example 1: Dysfunctional Family Record**

<b>DS Lowest Rating of Family Stress</b>	3
<b>SF Lowest Rating of Interference</b>	4
<b>SS Lowest Rating of Cohesiveness</b>	2
<b>H Lowest Rating of Interference</b>	2
<b>T Lowest Rating of Interference</b>	1
<b>WV Lowest Rating of Interference</b>	5
<b>CP Lowest Rating of Interference</b>	--
<b>Total</b>	17

Computation:  $17 \div 6 = 2.83$

**Average Family Functioning Score**  
**(Total divided by number of areas rated.)**

**2.83**

A score this low would suggest a family that is distressed and whose dynamics may be contributing to the level of distress and/or reflecting problems in coping with it.

*Example 2: Functional Family Record*

DS Lowest Rating of Family Stress	<u>6</u>
SF Lowest Rating of Interference	<u>3</u>
SS Lowest Rating of Cohesiveness	<u>8</u>
H Lowest Rating of Interference	<u>9</u>
T Lowest Rating of Interference	<u>7</u>
WV Lowest Rating of Interference	<u>9</u>
CP Lowest Rating of Interference	<u>4</u>
<b>Total</b>	<b><u>46</u></b>

Computation:  $46 \div 7 = 6.57$

**Average Family Functioning Score**  
**(Total divided by number of areas rated.)**

<b>6.57</b>
-------------

This record still suggests that the family is experiencing some distress. However, the dynamics of the family appear to be functional to the extent that the family is not overwhelmed by the particular stressor.

**Please Note: For the purposes of this research project, you should only complete the ratings for each area of the scale and NOT compute the Family Functioning Score. This will be computed by the researcher.**

### Part 3

#### Structural and Strategic Constructs in the DAFFI-DUCC

##### *Symptom Function*

Strategic therapists view the identified client as the *symptom bearer* for the rest of the family. Therefore, it becomes important to hypothesize about the meaning of the symptom: that is, how the presenting problem helps the family. Often, the symptom is a way of getting the family to seek help for the identified client. Once the family is involved in counseling, the counselor can then assess what is really going that might be fueling the client's problem.

##### *Developmental Stages*

Each family passes through a sequence of stages beginning with couple formation (Minuchin & Fishman, 1981), each stage presenting a series of developmental tasks which must be accomplished. Most of these are resolved implicitly during the evolution of the family. But, inevitably, some will present obstacles that need to be addressed more openly and directly in order to be resolved. As a counselor, it is important to have a clear understanding of the stage of development at which the family is functioning.

***Couple Formation.*** Family development begins with couple formation, the period during which the new couple must renegotiate old relationships with members of their families of origin and with friends. Tasks and issues at this stage include establishing roles for normal tasks, such as housework, bill paying; parameters for displays of affection and intimacy; relationships with each partner's families of origin; and, most importantly, distribution of power, which is typically played out through financial decisions.

***The First Child.*** With the birth of the first child, all bets are off. Conflicts and developmental tasks that had been resolved in the previous stage need to be revisited and renegotiated. Changes in the couple's rules for intimacy, relationships with extended family, and friends again must be revised to meet the demands of the new nuclear family constellation. The focus of the couple now

shifts from their relationship with each other to their roles as parents, creating a new subsystem in the family. Decisions need to be made regarding care giving (Who changes diapers? Who gets up at night to feed the baby?); work and finances (Will one parent stay home to raise the child? How will this impact the family financially?); and child care, if both parents continue working? The couple has less time and energy for each other: The best form of birth control is having a child. If there were previous problems in the couple relationship, they often surface in this stage, fueled by the added stress of having a child.

***Families with Young Children.*** Whether or not more children are born, the family eventually progresses to the stage of “families with young children,” as their child or children become toddlers and elementary aged. This stage is characterized by a realignment of subsystems within the family, and a reordering of the family hierarchy, particularly in regards to the sibling subsystem. Parents must begin providing flexible boundaries between the family and new subsystems with which it must interact, such as school, church, families of children’s friends, and youth organizations. Discipline practices become important as children become more independent and able to make choices. Parents have to make decisions about such things as, family rituals (Which parent’s holiday traditions will they adopt?) and religious practices (Will they follow a particular religious belief, and, if so, which one?) Last but not least, what about the couple: Is there any time for the parents to be a couple?

***Families with Tweens.*** The aging and maturing of children moves the family on to the stage of families with pre-adolescent children. This is a more recent development in our culture. As kids are exposed to more information and technology at younger ages, some of the issues that used to be characteristic of adolescents now appear at younger ages. Specifically, this stage is characterized by a redefinition of disciplinary procedures and family rules: the parenting approaches which may have been useful with a seven-year-old are no longer appropriate with an eleven-year-old. Children begin the process of separating from their parents and challenging their values and rules. Awareness of peers, particularly differences between the families of peer’s and a child’s own family helps to fuel

some of the challenges of this stage.

***Adolescent Families.*** The family moves on to its "teenage" stage, as children enter fully into adolescence. While the primary task of the child during this stage is to establish a sense of identity, the task of the family is to establish boundaries flexible enough to allow the adolescent to become his own person while still having a sense of connectedness to the family. This is the stage in which many parents make the mistake of thinking that their kids don't need their guidance anymore, withdrawing from the responsibilities of parenting. Frustration and confusion with the things their teenagers are doing often contributes to this. However, it is more important than ever that parents serve as a safety net for their teenagers. The teen's job is to become independent. The family's job is to encourage this without rejecting the teen for some of the inappropriate ways that independence is sought.

***Parents Separating from Children.*** As teenagers become young adults, the family enters the stage of parents separating from children, the main task being "leaving home" (Haley, 1997). This is again a time when parents must support and encourage their children's independence while at the same time working through their own sense of loss and confusion regarding their roles. The focus of the parents moves back to the couple, often requiring redefinition of the couple subsystem rules for intimacy. Successful resolution of this task in particular hinges on the stability of the couple subsystem before children entered the picture and the degree to which the parents maintained a sense of "couple-hood" during their child rearing. If there were unresolved conflicts, these commonly resurface during this stage.

***Families with Aging Parents.*** Finally, the family enters the stage of families with aging parents, a time during which adult children often find themselves fulfilling caregiver roles for elderly parents. This is a stage in which elderly spouses must deal with the loss of their partner, and when children find themselves reversing roles with their parents. Issues such as moving a parent into a nursing home, selling the family home or business, and end-of-life dilemmas disrupt the family's

stability, fueling conflicts among siblings.

Both Haley (1976) and Minuchin (Minuchin & Fishman, 1981) view one aspect of family dysfunction as the family being "stuck" in a transition from one stage to another. Thus, the family engages in behaviors which may have been effective during an earlier stage, but which are no longer working. In addition, it is common for today's families *to be functioning in multiple stages at the same time*. The phenomenon of the "sandwich generation," in which parents find themselves raising a young child, dealing with a teenager, and taking care of an elderly parent, is one example of this. The recent proliferation of grandparents raising their grandchildren is another.

### ***World View***

A family's world view is another important aspect of the family system which a counselor must understand when working within a family framework. The world view is the family's filter system; that is, it is the family's construction of reality. This filter system consists of the family's culture, basic assumptions, beliefs, and experiences, some of which may be shared by all family members, while others are unique to specific individuals in the family. World views determine how family members see the family fitting into the world at large, as well as how specific family members view themselves and other family members. For instance, in my own work with families, I have found it common for parents to view the child who is symptomatic as the "bad" kid, while viewing other children in the family, who often are also misbehaving, as the "good" kids. These roles harden on the children like egg shells, making it very difficult for parents to notice instances of good behavior by the bad kid, and instances of bad behavior by the good kids. Conversely, the children understand what their roles are supposed to be and behave in a manner that confirms their parents' world view. The world view provides the counselor with another piece of the map for understanding how a particular family sees itself and how it deals with those within and outside of the family. In addition, it provides a clue about how to enter the family system through a path of least resistance.

World views usually can be summarized in a statement or euphemism that captures the

family's reality. Some of the common world views I have run into include: "spare the rod and spoil the child" (overly punitive parents); "children are to be seen and not heard" (families where communication between parents and children is problematic); "circle the wagons" (families that are closed about their activities, particularly in cases of social services involvement); "boys will be boys" (families in which there is an acting out male who the parents insulate from consequences); and "she's her mother's daughter (or father's son)" (families in which parents blame each other for a child's problems, families in which there are rigidly enforced role expectations, enmeshed families).

### ***Subsystems and Boundaries***

The strategic and structural models are also concerned with subsystems within the family, viewing the family as a network of interconnecting and/or overlapping subsystems (Madanes, 1981; Minuchin & Fishman, 1981). The most common of these are the parent subsystem (mother-father), the sibling subsystem (brothers-sisters), and subsystems which include combinations of extended family members (maternal grandmother-mother-father). With school-aged children, these subsystems often extend outside the nuclear and extended families to include peers, teachers, parents of peers, religious groups, and, social service agencies.

The aspect to consider when conceptualizing the subsystems of a specific family is the clarity and flexibility of boundaries. Subsystems are separated from other subsystems within a family by invisible boundaries--that is, the implicit rules for membership, functions, and interactions between members of different subsystems. For instance, the rules for membership in the parent subsystem are that members must be involved in *raising at least one child*, not necessarily that a member be the biological parent of the child being raised. The function of the parent subsystem is *childrearing*. The rule for membership in the sibling subsystem is that a child must have *at least one brother or sister* (again, not necessarily biologically related). The function of the sibling subsystem is *to drive the parent subsystem crazy*.

Boundaries are the way subsystems are defined by their members, and need to be firm enough

to clearly differentiate one subsystem from another, yet flexible enough to allow interactions between members of different subsystems. Overly rigid (*disengaged*) or poorly defined (*enmeshed*) boundaries may be both a symptom and contributory factor to family dysfunction (Minuchin & Fishman, 1981). For example, a family consisting of two overly protective parents and an eleven-year-old son who is not allowed to play with other children exhibits rather fuzzy boundaries between the parent and child subsystems, while having overly rigid boundaries between the child and peer subsystems. A family in which a mother constantly interrupts and speaks for her children is an example of enmeshment, where the parent and child subsystem boundaries are not well-defined.

### ***Hierarchy***

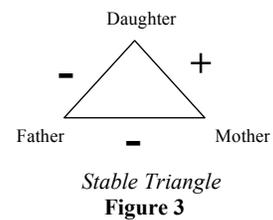
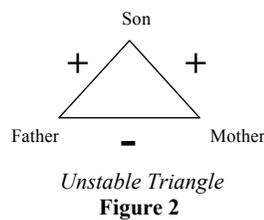
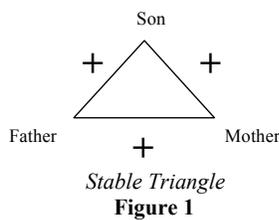
The structural concept of the family hierarchy follows along with the idea of subsystems. Minuchin (Minuchin & Fishman, 1981) believes that each family establishes a hierarchy which can facilitate or impede its functioning. The typical "normal" hierarchy is one in which the parents are on top, preferably in lateral positions, followed by the oldest child, second oldest, and so forth. Structural therapy clearly sees the parents in the *executive* position in the family. No matter how democratic or authoritative parents in a particular family want to be, they are ultimately accountable for decisions and actions that affect their children. Thus, it is important that they assume the highest position in the family hierarchy.

A hierarchy becomes dysfunctional when a family member assumes or is relegated to an inappropriate position, either higher or lower than the position in which he or she is supposed to be. An example of this is when the youngest child exerts power over his parents by making unreasonable demands on them to which they accede (special dinners, being able to stay up later than the other children). The resulting hierarchy would place the youngest child in the highest position, *above the parents*. The parents and older children in the family would then be relegated to inappropriate lower positions. Mapping the family hierarchy is a way of understanding power in the family. When a child attains a position in the family above one parent, she has more power than that parent in the family,

making it difficult for that parent to carry out normal parenting tasks, such as discipline, effectively. One parent assuming a position above the other parent can undermine the less powerful parent's authority and respect.

**Triangles**

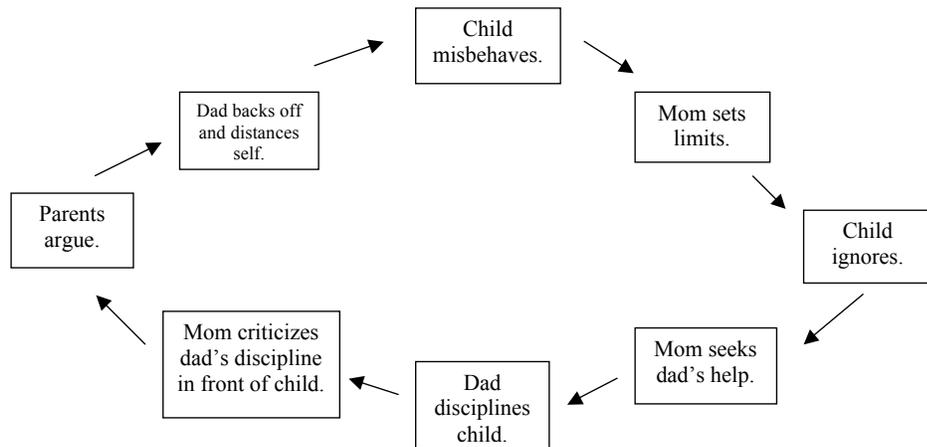
The strategic model emphasizes understanding interactions within the family in terms of triads or triangles – transactional patterns which involve three family members or subsystems (Madanes, 1981). Included in this idea is a conceptualization of the valence of each interaction within the triangle, either positive or negative, the sum of which determines the stability or instability of a triangle. A triangle consisting of father-mother-son, where the interactions are all positive is very stable, in that every relationship is basically equal with no one individual feeling threatened by the relationship between the other two individuals within the triangle (Fig. 1). However, the same triangle in which the father-mother valence is negative, and the father-son, and mother-son valences are both positive, constitutes an unstable triangle because there is competition for the son's alliance (Fig. 2). The cause of this competition is the need of each parent to strengthen his and her positions against the other parent because of a problematic relationship between mother and father. On the other hand, a triangle in which the mother-father and father-daughter valences are negative, and the mother-daughter valence is positive, is a stable triangle, as father's "outsider" status actually strengthens the mother-daughter alliance (Fig. 3). Examples of stable and unstable triangles are shown below.



***Circular (Isomorphic) Patterns***

The strategic model does not view family interactions as simple cause-effect or stimulus-response relationships. Rather, the behavior of various family members is seen as part of a rather complicated cycle of events, reactions, and reality constructs which are called isomorphic or circular patterns. These patterns typically provide the map of dysfunctional interactions, including various family members' efforts at triangulating others into family conflicts. Isomorphic patterns are actually closer to the cybernetic concept of feedback mechanisms, each component interaction leading to a subsequent interaction between individuals or sub-systems, at some point resulting in the presenting symptom in the identified patient, which brought the family into counseling in the first place. We call these patterns isomorphic because each overt or observable component of the pattern is driven by a corresponding underlying, covert issue or purpose.

Take for example a family of three (father, mother, adolescent son) in which the presenting complaint is that the child is misbehaving and not listening. In discussing how the parents enforce rules and apply discipline, the following circular pattern becomes evident:



In this pattern, the parents' underlying disagreement about discipline serves to support the child's behavior. This is the observable circular pattern. The isomorphic pattern is the therapist's hypothesis regarding the underlying dynamics that are driving the interaction. In this case, the child's acting out may be related to an underlying struggle for power between the parents. When the child frustrates the mother in her attempts to be an effective disciplinarian, she feels powerless and weak, and seeks the father's assistance. If the child responds appropriately to the father's discipline, the mother will lose power in her relationship with the father. So, she undermines and reduces the father's power by criticizing him in front of the child. This causes the power struggle between the parents to be externalized in the argument, which, distracts them from the issue with the child and allows him to continue misbehaving. Thus, the underlying power struggle interferes with the parents' effectiveness in this everyday parenting task.

Circular patterns are one of the most complex constructs for beginning family counselors to understand and apply. It goes against our tendency to reduce or simplify family interactions to simple causes, something that has become ingrained in our culture through the influence of behaviorism. While behavioral explanations might be useful in understanding discreet behaviors, there's nothing simple about how families operate because of the numerous individuals and subsystems that affect a child. Thus, it is necessary to recognize this complexity within the context of the more complicated circular relationships of family interactions.

**References**

- Haley, J. (1976). *Problem-solving therapy*. New York: Harper-Colophon Books.
- Haley, J. (1997). *Leaving home, 2<sup>nd</sup> ed.* Levittown, PA: Brunner-Mazel.
- Madanes, C. (1981). *Strategic family therapy*. San Francisco: Jossey-Bass.
- Minuchin, S., & Fishman, C. (1981). *Family therapy techniques*. Cambridge, MA: Harvard University Press.

## Appendix D

**Informed Consent Letter – Experienced Family Therapists**

Dear Family Therapist,

You are invited to participate in a research study on the Dynamic Assessment of Family Functioning – Demonstrated Under Clinical Conditions (DAFFI-DUCC), a project that I am pursuing as part of the requirements for my doctoral degree. As a working school psychologist, I know that these types of requests often seem intrusive when you have a million things to do. But, I would very much appreciate it if you would at least take a few minutes to read the information I am providing below because the research I am conducting is very practical and may provide you with another tool to assist your clinical work.

The purpose of this research is to investigate the reliability of the DAFFI-DUCC, an instrument developed by a family therapy practitioner to aid in concretely outlining the dynamics of families. You will be asked to first watch a video of a family therapy session in DVD format, and then fill out the DAFFI-DUCC based on your review of the family session. Next, you will be asked to complete a short survey based on your experience using the DAFFI-DUCC. Finally, you will be asked to mail the completed DAFFI-DUCC and questionnaires to the experimenters in the self-addressed, stamped envelope included. Your participation will take approximately two hours: one hour to review the tape; one hour to complete the DAFFI-DUCC.

There are no anticipated risks with this study, and I cannot guarantee that you will receive any direct benefits from this study. However, you will receive the DVD copy of the family session as my way of saying “thank you” for your participation.

Please understand your participation is voluntary and you have the right to withdraw your consent or discontinue participation at any time without penalty. In addition, your individual privacy will be maintained in all published and written data resulting from the study.

If you have any questions about this study, please feel free to contact one of the following individuals:

Jeremy Vose, M.A.  
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If you have read this form and decided to participate in this project, please sign the consent form provided below and return it in the pre-addressed, stamped envelope that was included in this mailing. Thank you in advanced for being kind enough to devote your time to this activity.

Sincerely,

Jeremy C. Vose, MA  
Principal Researcher

**Informed Consent Letter – Family Counseling Trainees**

Dear Graduate Student,

You are invited to participate in a research study on the Dynamic Assessment of Family Functioning – Demonstrated Under Clinical Conditions (DAFFI-DUCC), a project that I am pursuing as part of the requirements for my doctoral degree. Having been in your shoes as a graduate student, I know that these types of requests often seem intrusive when you have a million things to do. But, I would very much appreciate it if you would at least take a few minutes to read the information I am providing below because the research I am conducting is very practical and may provide you with another tool to assist your clinical work.

The purpose of this research is to investigate the reliability of the DAFFI-DUCC, an instrument developed by a family therapy practitioner to aid in concretely outlining the dynamics of families. You will be asked to first watch a video of a family therapy session in VHS format, and then fill out the DAFFI-DUCC based on your review of the family session. Next, you will be asked to complete a short survey based on your experience using the DAFFI-DUCC. When you have completed these activities, you will give the DAFFI-DUCC and survey to the research assistant in your class. Your participation will take approximately two hours: one hour to review the tape; one hour to complete the DAFFI-DUCC.

There are no anticipated risks with this study, and I cannot guarantee that you will receive any direct benefits from this study. However, students who volunteer to participate in this study will receive a 5 point bonus added to their final grades in this course. On the other hand, there will be no negative repercussions if you decide that you will not participate.

Please understand your participation is voluntary and you have the right to withdraw your consent or discontinue participation at any time without penalty. In addition, your individual privacy will be maintained in all published and written data resulting from the study.

If you have any questions about this study, please feel free to contact one of the following individuals.

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If you have read this form and decided to participate in this project, please sign the consent form provided below and return it to the graduate assistant. Thank you in advanced for being kind enough to devote your time to this activity.

Sincerely,

Jeremy Vose, M.A.  
Doctoral Candidate and  
Principal Researcher

Sincerely,

John D. Cerio  
Faculty Sponsor



Appendix E

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**DAFFI-DUCC**  
USER SURVEY  
*Trainees*

---

1) How helpful was the DAFFI-DUCC in organizing your understanding of this family's dynamics?

1-----2-----3-----4-----5  
Not Helpful                      Somewhat Helpful                      Very Helpful

2) How helpful was the DAFFI-DUCC in solidifying Structural/Strategic Family Therapy concepts?

1-----2-----3-----4-----5  
Not Helpful                      Somewhat Helpful                      Very Helpful

3) How useful was the DAFFI-DUCC in helping to plan for interventions for this family?

1-----2-----3-----4-----5  
Not Helpful                      Somewhat Helpful                      Very Helpful

4) What is the likelihood that you would use this measure in the future?

1-----2-----3-----4-----5  
Not Likely                      Somewhat Likely                      Very Likely

Suggestions/Comments:

---

**DAFFI-DUCC**

USER SURVEY

*Experienced Family Therapists*

---

- 1) Was the DAFFI-DUCC comprehensive enough in identifying the relevant family dynamics presented in the training video?

1-----2-----3-----4-----5  
 Not Comprehensive                  Somewhat Comprehensive                  Very Comprehensive

- 2) Was the DAFFI-DUCC helpful in summarizing your observation of this family?

1-----2-----3-----4-----5  
 Not Helpful                                  Somewhat Helpful                                  Very Helpful

- 3) How useful was the DAFFI-DUCC in helping to plan for interventions for this family?

1-----2-----3-----4-----5  
 Not Helpful                                  Somewhat Helpful                                  Very Helpful

- 4) What did the DAFFI-DUCC omit that would be helpful in assessing this family?

- 5) From a Structural/Strategic Family Therapy perspective, is there anything that could be added to create a more comprehensive instrument? Omitted?

- 6) Other suggestions/comments?

- 7) What is the likelihood that you would use this measure in the future?

1-----2-----3-----4-----5  
 Not Likely                                  Somewhat Likely                                  Very Likely