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ABSTRACT

        This chapter focuses on practical assessments for family
interventions, geared for the everyday use of counselors, therapists, and
other clinicians. Two types of assessments are addressed: process assessments
and outcomes assessments. A process assessment looks at the process of
counseling, specifically how satisfied or dissatisfied the client is during
the sessions. An outcome assessment measures progress or improvement in
client' functioning as a result of the counseling intervention. Given the
multidimensional dynamics and complex relationships involved in each family,
the author notes that a measurement instrument can help counselors sort out
and identify specific target goals for therapy, measure changes from therapy,
and provide insight for clients on what changes are needed. (Contains 15
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Assessing Family Interventions

by

Steven Benish

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The initial challenge in writing an assessment chapter is to keep counselors interested in what might seem to be a very dry subject. Having experience as a clinician in private practice, a workplace personnel consultant, and a school counselor, I understand the reluctance and apprehension that many counselors have concerning outcome and process assessment measures. It conjures up bad memories of being in graduate school statistics courses and research procedures labs, with a dizzying array of complex equations, difficult computer programs, and mind-boggling statistical analyses. Few of us normally deal with such complex computations on a daily basis, and I have yet to hear, "I'll take multivariate regression for $200, Alex."

Rest assured, this chapter will be practical and geared for the everyday use of counselors, therapists, and other clinicians. The focus will be on practical assessments, everyday language, and nothing that sounds like a complex formula more familiar to nuclear physicists than therapists. I will discuss two types of assessments in this chapter: process assessments and outcome assessments.

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A *process assessment* looks at the process of counseling, specifically how satisfied or dissatisfied the client is during the sessions. We have all had the experience of counseling someone, thinking we were doing a wonderful job, and then having had the client drop out or bluntly inform us, "You're not hearing what I want you to hear." Therefore, it is important to encourage ongoing feedback from clients about the counseling process.

The second type of assessment I will present is outcome assessment. An *outcome assessment* measures progress or improvement in clients' functioning as a result of the counseling intervention. Outcome measures can measure general happiness, interpersonal relationship improvements, or any other factors that are goals of counseling.

With the understanding that this chapter will be practical and applied, I believe that it is only fair to give you an idea of my counseling background. As I stated earlier, I have been a school counselor, workplace violence prevention consultant, marital counselor, private practice therapist, and crisis counselor. Having had no formal graduate training in family systems therapy, I dismissed this approach in my early clinical work, probably because I was overconfident in my training and abilities and was intimidated by a theoretical orientation that I did not understand. Only when I became frustrated because some clients did not make progress in individual counseling did I start to realize the impact that the family system was having on personal or family progress. A case example is a client named Jill, a 15-year-old high school sophomore who was disrupting classes, skipping school, acting out in the hallways, and using substances. A concerned teacher referred Jill to me, the school counselor. After a few sessions, Jill's conduct in school improved significantly. However, she would regress the next week by acting out again, with no plausible explanation. Finally, Jill confided that because her parents were divorced, she stayed with her mother one week and her father the next. On the weeks of her in-school disruptions, she stayed with her father whose late-night partying with friends kept Jill up until morning. Thus, she would arrive at school tired and irritable from lack of sleep and feeling angry toward her

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father. What seemed to crystallize the problem in this situation was the assessments we performed after each session. I noticed a pattern of Jill doing well, then poorly on alternate weeks. This allowed Jill and me to see the pattern of what was happening and to bring her parents into the counseling process to help her.

How Do We Know That Counseling Works?

There is ample evidence that both individual and family counseling are better than no treatment for most problems (Lambert & Bergin, 1994), and that most treated clients are better off than 80% of people who do not seek treatment (Miller, Duncan, & Hubble, 1997). These findings have been confirmed through more than 40 years of outcome research indicating that therapy does make a positive difference in families' lives. However, it is important to use an outcome measure rather than assuming automatically that counseling is working. With the advent of managed care in the 1980s, professional counselors are now called on to be more accountable for counseling outcomes. Not all counseling is effective, and not all techniques or approaches work for all clients. This is why, even though we know that counseling generally works, we need to measure outcomes for each client or family in sessions with us. We must know that our clients are satisfied and, more importantly, that they are improving. We are bound ethically to discontinue treatment if the client is not making progress, and outcome measures help us to make decisions to continue counseling, terminate treatment, or refer the client to another professional.

Why Should We Assess Outcomes?

Why should we use a formal intervention assessment when, as trained clinicians, we believe we know when clients are making progress? One reason is that we usually overestimate our effectiveness with clients, and a standardized client measure is the most reliable and valid means of assessing true effectiveness for change (Hubble, Duncan & Miller, 1999). A second reason for formal assessment is the changing climate in counseling and psychotherapy, including the

powerful forces of managed care. Managed care is a business that requires positive results for reimbursement of professional services, and as such, needs proof of the effectiveness of your work. Most of us who have been in private practice or worked in an agency are familiar with the difficulties of dealing with managed care companies, and utilizing a quality assessment tool is one way to show that your counseling is effective. A third reason for assessment is that evidence of progress gives the client hope, and hope in the client accounts for about 15% of therapeutic change (Lambert, 1992). A fourth reason for assessment is that it allows the client and counselor to alter course when the client is not making progress; it serves as a tool to help steer the ship of counseling. By teaming up to fix the problems, the counselor and client could create a stronger therapeutic alliance.

I had the opportunity to sit down with several managed care employees and managers and to ask them what would help a clinician become a preferred provider or receive approval for extra sessions of therapy. The insurance managers provided several answers, but the one factor that came up most often was "show us that you are an effective clinician by providing an outcome measure to quantify your effectiveness." These men and women who make decisions that affect the livelihood of counselors stated that they were far less likely to utilize the services of a counselor who did not utilize outcome measures. There are currently 400,000 mental health providers licensed to serve the American public, approximately double the number needed (Hurst, 1997). This puts counselors in the unfortunate position of competing with each other for clients, due to the oversupply of therapists. Those who are able to show a quantifiable positive result from their therapy will survive. Those who do not unfortunately will perish in the current marketplace.

In the past, insurance companies and other third-party payers looked at psychotherapy as a service and used level of training (e.g., M.A., Ph.D.), years of experience, and certification/licensure as the criteria for payment. Due to the pressure placed on insurance carriers to reduce costs, third-party payers are now looking more strongly at outcomes (Hubble et al., 1999). They are constantly asking whether

the client achieved an objective improvement in functioning. These are the reasons why we need to use empirically sound, objective assessments.

When Should We Assess Outcomes?

Because we know that most improvement in therapy occurs early in treatment (Hubble et al., 1999), it is very important to conduct assessment before treatment, during treatment and, if possible, following the closure of treatment. Most families will show improvements in overall or specific functioning within the first several sessions, or they will not improve at all. It is important to know this, because if a client has not improved, you will need to alter your approach or refer the person to a different practitioner.

Continuous assessment is vital to the process. An example is Kevin and Rachel, a married couple in their thirties. They came to counseling stating that they had "communication problems." After four sessions, my impression was that they were making great progress, and I believed that they were both happy. The process and outcome measures revealed something very different, however: Rachel was happy with the progress, but Kevin was not. When we probed the meaning of this discrepancy, we realized that Kevin and Rachel's stated goals were different and that we were not working on the issues important to Kevin. Had I not used the measurements, I would eventually have terminated therapy with both Rachel and I thinking that we had been successful and Kevin feeling dissatisfied in the marriage, thus leading to a actual result of failure in therapy. This case illustrates the advantage of using an assessment tool to measure satisfaction and change in therapy.

What Qualities Are Important in a
Family Outcome Instrument?

Several factors relate to the essential qualities of a good assessment tool: ease of use (utility), cost effectiveness, reliability, and validity.

Utility often becomes a deciding factor, because counselors are so busy counseling, getting reimbursement, and performing administrative tasks that they cannot spend an inordinate amount of time doing assessments. An assessment with high validity, high reliability, and cost effectiveness will be completely useless if no one uses it because it takes too long to administer, interpret, or score.

Cost effectiveness is also essential in the current climate of counseling. Most third-party payers do not reimburse for process or outcome measures, so the counselor has to pick up the tab. This means the assessment must be relatively cheap and reproducible without substantial cost.

The other important factors of reliability and validity are well known to most counselors. In simple terms, *reliability* refers to whether an assessment consistently produces the same results for the same situation, and *validity* refers to whether the assessment measures what its authors claim that it measures. Suffice it to say here that reliability and validity are absolutely necessary components to any assessment. They are necessary though not sufficient aspects of a quality instrument.

Which Process Assessments Are Helpful for Counseling Interventions?

Process assessments are different from outcome assessments in a number of ways. Process instruments measure the counseling relationship and the process of counseling, whereas outcome instruments measure results and changes that have occurred as a result of counseling. Process instruments focus on the dynamics occurring within counseling sessions, examining the counseling process as it unfolds in the office with clients. Process instruments give you feedback on the clients' perceptions of the counseling process, thus helping you to adjust the therapeutic process in response. You can learn how family members perceive the process differently or similarly, and then recognize patterns and alliances within the family. Using process instruments might also help you prevent early dropout from therapy by providing clients with a safe method

of giving feedback.

Four important factors in selecting an instrument were explained earlier in this chapter: ease of use (utility), cost effectiveness, reliability, and validity. Cost effectiveness and ease of use are even more important in a process assessment. If you have already spent substantial time and cost on an outcome assessment, you have even less time and money to spend on a process assessment. For these reasons, I favor using a simple assessment for measuring process.

The Session Rating Scale (SRS; Johnson & Miller, 2000) is a simple, 10-item process assessment that measures clients' experience during counseling sessions. The areas measured are acceptance by the counselor; respect from the counselor; understanding, honesty, and sincerity of the counselor; agreement on goals; agreement on tasks; agreement on treatment; pacing of the session; and feeling of hope. On a Likert-type scale from 0 to 4, the client rates his or her perceptions of the 10 processes addressed by the questions. The SRS should be given toward the end of each session to gauge any processes that are helping or hindering the counseling session.

A case example might be helpful to illustrate the use of the SRS. I was counseling a couple and their 15-year-old son, who was showing signs of oppositional-defiant disorder. The family had shown signs of improvement initially, based upon their outcome scores and their observational reports, but progress had slowed since then. The results of the SRS showed that although the parents were happy with the processes and results, their son was unhappy with the goals and tasks of treatment. Not coincidentally, his growing unhappiness with the goals and tasks of treatment coincided with the stalling of progress. In the next session, the family and I discussed this situation and changed the goals and tasks of treatment to satisfy all members of the family. After these changes were made, the family rapidly resumed progress toward their therapy goals.

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Which Outcome Assessments Are Best for Family Interventions?

Four components of family balance are most helpful cornerstones in measuring progress in family counseling: boundaries, roles, communication, and problem solving. *Boundaries* refer to one's relations with other family members and range from enmeshment to disengagement. The optimal placement for boundaries on this continuum is in the middle: interdependence without enmeshment. This placement allows both intimacy and a feeling of individual identity (individuation), and it provides emotional distance without feelings of isolation or aloneness.

Roles are defined as responsibilities that an individual takes on (voluntarily or not) to maintain homeostasis. Roles can be divided into healthy, functional roles (those that maintain a healthy homeostasis) and unhealthy, dysfunctional roles (those that make the person pay a price for maintaining the family homeostasis). Examples of healthy roles are parent, child, and in the right situation, gatekeeper. Examples of unhealthy roles are scapegoat, flag bearer, the parentified child, and when a parent takes on the role of the helpless child.

Communication is the ability to openly express feelings and thoughts directly to other family members without fear of reprisal, criticism, or other adverse reactions. Healthy communication patterns in a family are displayed through open, nonjudgmental listening and expression of thoughts and feelings without fear of this openness damaging family relationships.

Problem solving is the ability to resolve efficiently and effectively family conflicts and problems that arise within or outside of the family setting. Problem solving can be handled individually or, more effectively, as a team approach with the family members working together to solve problems.

Now that we understand the operational definitions of the four cornerstones, we can discuss the assessment that most effectively measures them. The most comprehensive and arguably the best tool for assessing these areas of the family system is called the Family

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Adaptability and Cohesion Evaluation Scale (FACES), developed by Dr. David Olson at the Department of Family Social Science at the University of Minnesota. Dr. Olson developed this instrument based on his circumplex model of marital and family systems. This model bridges the distance between research, theory, and practice (Olson, Russell, and Sprenkle, 1989). The circumplex model is often used as a relational diagnosis because it focuses on integrating the four cornerstones, which are relational in nature, and it is designed for assessment, treatment planning, and measuring outcomes (Olson, 1996).

FACES offers the advantage of solid reliability and validity. It shows high positive correlations with other well-developed inventories, such as the Self-Report Family Inventory (Beavers & Hampson, 1990), the Family Assessment Measure (Skinner, Santa-Barbara, & Steinhauer, 1983), and the McMaster Family Assessment Device (Epstein & Bishop, 1993).

FACES operates on the basic premise that healthy couples and families are more balanced (compared to unhealthy couples and families) in three basic measures: family cohesion, flexibility, and communication. *Family cohesion* is defined as "the emotional bonding that family members have toward each other" (Olson, 1999, n.p.), which in the circumplex model covers the areas of boundaries, decision making, space, coalitions, and emotional closeness.

Cohesion is measured in terms of separateness versus togetherness and ranges from very low (disengaged) to moderate (separated) to moderate/high (connected) to high (enmeshed). The circumplex model advocates a balance between extremes. For example, if Mother, Father, Daughter, and Son are in counseling to work on family issues, the ultimate goal would be for them to have a balance of cohesion (connected to separated) rather than being at the extremes of enmeshed or disengaged. When you see scores tending toward enmeshed or disengaged showing up on the FACES report, you would then begin to work with the clients on how to bring their cohesion to a middle point and to help the family change intrafamilial patterns that interfere with healthy, balanced relating. Integrated togetherness and separateness are simultaneous goals. All

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relationships strive for closeness and intimacy without the loss of individuality. This dance of intimacy is often a fine line that ebbs and flows in a healthy relationship, righting itself through the efforts of the family members when an unbalance occurs.

Family flexibility refers to "the amount of change in its leadership, role relationships, and relationship rules" (Olson, 1999, n.p.). It encompasses roles, negotiating styles, discipline/control, and family rules. Again the goal is to achieve balance, this time between flexibility and stability. Too much flexibility will leave the members feeling that their situation is chaotic, and too little flexibility will leave them feeling confined or controlled.

The circumplex model rates the family's flexibility from very low (rigid) to moderate (structured) to moderate/high (flexible) to very high (chaotic). Again, a balance between these states is the goal. Families tend to maintain the status quo and not to allow new rules to be implemented. This rigidity may cause problems as adjustments and changes become necessary through the family life cycle. A balanced family system tends to be the most functional over time, according to the circumplex model. A balanced family has a democratic parental leadership, with some child input into the system and consistency in both roles and rule enforcement. An appropriately flexible family has an egalitarian leadership style and a democratic decision-making process that openly involves the children.

An unbalanced family situation may be either rigid or chaotic, either not surprisingly causing tension and angst for its members. The chaotic relationship has inconsistent or strangled leadership with impulsive and erratic decision making, coupled with inconsistent and undefined roles that result in confusion. In a rigid relationship, there are highly defined roles but one member is overly controlling, preventing negotiation or democratic decision making and leaving very little possibility for role changes.

The circumplex model also rates *communication,* which is seen as critical for movement on the other two dimensions of cohesion and flexibility. Because communication is viewed more as a facilitating factor, it is somewhat distinct from the other two factors and is used in a different way. The areas measured in regard to

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communication are self-disclosure, speaking skills, clarity in speaking, listening skills, and respect and regard. Self-disclosure in the circumplex model refers to sharing information and feelings about oneself and the familial relationships. Speaking skills are focused on speaking for oneself rather than others. Listening skills are measured via empathy and attentive listening, and respect and regard are measured through the affective dimensions of communication and problem solving.

The circumplex model and the FACES instrument use a three-dimensional model and linear rather than curvilinear measures, consistent with Olson's findings (Olson, 1991). Again the emphasis is on balanced scores on the three dimensions of cohesion, flexibility, and communication.

A case example might be helpful at this point to illustrate the usage of the instrument. Bob and Elaine came to counseling with their two children, complaining of hostility, incongruence, and instability in their marriage and child rearing. After examining the results of their FACES inventory, their therapist could see that their flexibility scores were too high, leading to a chaotic household. Communication was minimal, and the cohesion scale was low on emotional closeness. As the therapist worked with Bob and Elaine on these issues, the couple began to talk about their childhood experiences: Bob had a controlling, distant father whom he had hated, and Bob reacted to this upbringing by swearing not to control his kids. He was trying so hard to be non-controlling that he was leaving a power vacuum in the family and was repeating the pattern of non-communication that his parents had displayed with him. Elaine wanted more emotional closeness and would shut Bob out when he did not respond. Bob would react to her rejection by becoming more aloof, and the pattern would continue. The counselor helped Bob and Elaine to understand what they were trying to avoid in their relationship and how to communicate their intent more clearly, rather than assuming that each knew what the other was thinking.

The basic goals of the circumplex model are to reduce the symptoms and problems in a family that are fed by current interpersonal dynamics (Olson, 1999). A corollary goal is to teach

the couple or family how to manage change and how to restore balance in cohesion, flexibility, and communication. Many families initially may be resistant to making changes and, as many experienced counselors know, will likely desire that *other* family members change their behaviors. It is important to educate clients on the dynamics of the family system and to help family members who are resistant to change. You can accomplish this by helping a family member to understand how his or her actions affect the system and how other family members react to them. Doing this reinforces an internal locus of control over one's problems, rather than a feeling of being victimized by others' actions. Family members need to understand that systemic changes sometimes result in greater distress temporarily, as members react and adjust to others' behavioral changes; once the family has adjusted to these changes, the situation will become more stable again.

Conclusion

Inventories and measurement instruments can be helpful additions to your work with families. Given the multidimensional dynamics and complex relationships involved in each family, a measurement instrument can help you sort out and identify specific target goals for therapy, measure changes from therapy, and provide insight for clients on what changes are needed.

It is important to use instruments as tools toward positive change rather than as tools to find the "cause" of problems, because blaming problems on one family member is correlated with early dropout of clients from therapy (Wolpert, 2000). Additionally, enlisting all family members' cooperation in the interpretation of scores can add meaning to test results. The therapist-client relationship accounts for 30% of change in therapy (Miller et al., 1997, Lambert, 1992), so it is important to use a collaborative approach with the family when integrating the test results into counseling and therapy.

As counselors, we know that assessments are not panaceas but can be effective tools in helping us learn family therapy and integrate

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it into our practices. Think of assessment not as a burden that causes extra work, but as a tool to help clients achieve better results. Assessments ultimately increase the health and legitimacy of the counseling profession, because when used properly they improve clients' outcomes.

When we recall our reasons for entering the counseling field in the first place, most of us remember wanting to help people through difficult times in their lives. Many of us, idealists who wanted to improve the world through a helping career, have oscillated between achieving these goals and occasionally feeling frustrated by a lack of progress toward them. Incorporating family systems theory and using assessments in your practice will not negate the frustrations you face as a counselor but will give you tools to help others improve their lives. Your quest toward these goals is valid, noble, and attainable. With the appropriate tools at your disposal, you can enrich others' lives.

References

Beavers, W. B., & Hampson, R. B. (1990). *Successful families: Assessment and intervention.* New York: Norton.

Epstein, N. B., & Bishop, D. S. (1993). The McMaster Family Assessment Device (FAD). In F. Walsh (Ed.), *Normal family processes.* New York: Guilford Press.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

Hurst, M. W. (1997). *How to use emerging communication technologies to streamline and improve care management and delivery.* Paper presented at the Behavioral Informatics Tomorrow Conference.

Johnson, L. D., & Miller, S. D. (2000). The Session Rating Scale, Revised Version 2. Retrieved November 1, 2001, from http://www.talkingcure.com/measures.htm.

Lambert, M. J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. Norcross & M. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York: Basic Books.

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 143–189). New York: John Wiley and Sons.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (1997). *Escape from Babel: Toward a unifying language for psychotherapy practice.* New York: Norton.

Olson, D. H. (1991). Three dimensional (3-D) circumplex model & revised scoring of FACES. *Family Process, 30,* 74–79.

Olson, D. H. (1994). Curvilinearity survives: The world is not flat. *Family Process, 33,* 471–478.

Olson, D. H. (1996). Clinical assessment and treatment interventions using the circumplex model. In F. W. Kaslow (Ed.), *Handbook of relational diagnosis and dysfunctional family patterns* (pp. 59–80). New York: John Wiley and Sons.

Olson, D. H. (1999). Empirical approaches to family assessment [Special issue]. *Journal of Family Therapy.* Retrieved November 1, 2001, from http://www.lifeinnovations.com/studies/fip0.html.

Olson, D. H., Russell, C. S., & Sprenkle, D. H. (1989). *Circumplex model: Systemic assessment and treatment of families.* New York: Haworth Press.

Skinner, H. A., Santa-Barbara, J., & Steinhauer, P. D. (1983). The Family Assessment Measure. *Canadian Journal of Community Mental Health, 2,* 91–105.

Wolpert, M. (2000). Is anyone to blame? *Clinical Child Psychology and Psychiatry, 5,* 115–131.

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