...ays ...aviour are expected ...the things

...ful things are said

Almost Always Usually Sometimes

Planned activities actually happen

Almost Always Usually Sometimes Ra...

...t is difficult for people to have space

Almost Always Usually Sometimes Rarely

...s are spread out equally

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...e talk to each other face-to-face when they want to say ...hing

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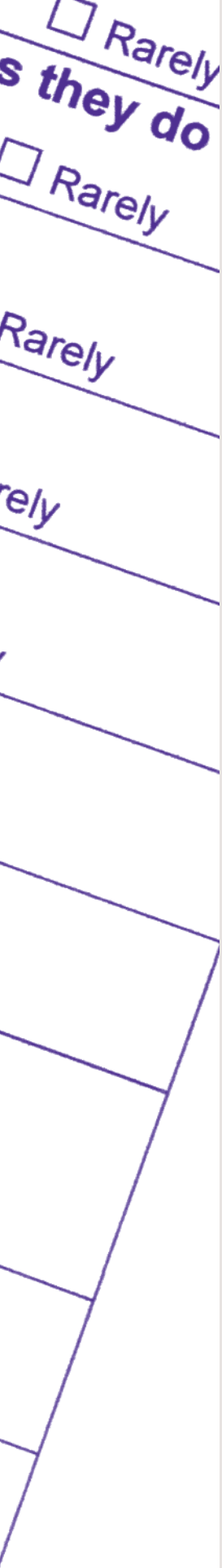


Adolescent families: a clinical tool

We asked **Paul Tiffin** to briefly introduce the rationale for the Family Perceptions Scale, a tool that enables us to look at how an adolescent's family functions

Families have been shown to play an important role in the outcome of adolescent mental health problems. Conversely, when a member is ill or distressed, family life is affected. The Family Perceptions Scale (FPS) was developed as a novel clinical tool and research instrument. The questionnaire is specifically designed to evaluate young people's views of their family functioning across a number of domains. In addition, adult family members are also able to complete the questionnaire, allowing the clinician and family to explore disparities in scores between differing individuals.

Background to the FPS

Before looking at the use of the FPS, it is worth noting why it was considered necessary. The concept of 'family functioning' is difficult to define. However, theorists argue that families cannot be understood merely by studying individual behaviour or relationships[1], with members interacting synergistically to create the family environment[2]. Families with adolescent members must support them in completing their developmental tasks: the achievement of identity, independence and sense of responsibility[3,4,5] – thus accommodating increasing autonomy whilst maintaining appropriate values and boundaries[6,7].

There are no objective measures of family functioning as such; even observer-based ratings record particular subjective viewpoints. Moreover, members' perceptions of their family environment may be more predictive of wellbeing than observer-based measures[8,9,10]. Consequently, a number of self-report instruments have been developed, such as the McMaster Family Assessment Device (FAD)[11]. Such tools have been criticised for inconsistency in design and poor psychometric properties[12]. Moreover, these instruments do not focus on adolescence, with most existing data relating to adult responses. The adolescent viewpoint is often more negative than those of adult members[13,14], and it has been suggested that this is partly because they are the least 'invested' in providing a favourable view[15]. Thus, the perceptions of adolescents may correspond more closely to non-family members than those of carers[16].

In contrast, the Family Functioning in Adolescence Questionnaire (FFAQ)[17] does focus on the teenage family member. However, the wording of FFAQ items does not allow completion by adults, precluding the exploration of disparities in perceptions between members. Postmodernists stress the importance of listening to the plurality of voices within the family[18] and deconstructing the concept of objectivity, thus creating space for multiple 'realities'[19]. Moreover, the psychometric properties of existing instruments do not allow the resolution of particular patterns of reported family functioning in specific groups of respondents. The FPS is intended to fill this gap.

Filling a gap

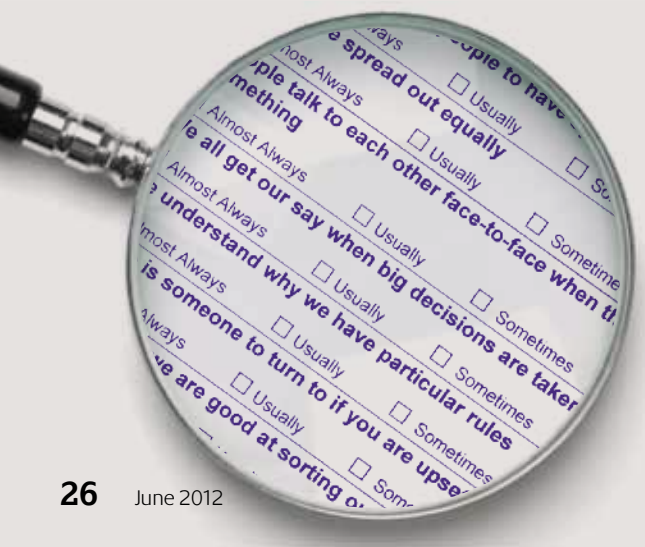
The FPS in its present form was derived from the findings of an exploratory factor analysis of a pool of 75 items relating to life in an 'adolescent family'[20]. These items, in turn, had been derived from the family/systemic literature and comments from adolescents and a panel of experts[21].

Understanding how young people and their families experience family life is an important part of assessment in mental health services. The FPS can be used to help provide some structure to this process, and the findings may guide both individual and systemic interventions. In addition, feeding back scores to a family may help facilitate discussions regarding their relative strengths and struggles. In turn, this may enhance communication and empathy – two core goals in family work or therapy.

The FPS is also a potentially valuable research tool. The unique design has led to a questionnaire that is sympathetic to the adolescent perspective but also able to be completed by adults. The tested psychometric properties of the FPS are at least as good as similar family self-report instruments. Moreover, the relatively low degree of correlation between most of the subscales means that distinctive patterns of perceived family functioning are more likely to be detected between differing clinical groups of respondents than with existing similar instruments.

The FPS is administered as a self-report questionnaire that takes around five minutes to complete and requires a reading age of approximately 10 years. Although 'post and return' completion is possible, it is best done when the administering clinician is present. The administrator is thus able to clarify points or meaning and also discourage any interference or conferring between family members.

Validating such a subjective measure is challenging, but a significant amount of data from an adolescent population has been accumulated, enabling age-referenced norms to be generated. The FPS has been tested in a sample of almost 700 adolescents aged 12 to 18 years, who were representative of the Teesside region of North East England in terms of sociodemographic characteristics. In addition, data has also been obtained on a community sample of almost 100 adults. Moreover, 60 participants took part in a separate evaluation of concurrent validity and test-retest reliability. The FPS is relatively insensitive to gender and socioeconomic status. In the pilot sample, there was a trend of borderline significance (p=0.04) for females to rate their families as more nurturing when compared to males. The magnitude of this effect was not considered large enough to warrant separate cut-off and normative values for girls and boys. Likewise, there was no significant effect of socioeconomic background, as estimated by the Index of Multiple Deprivation (IMD) score for the respondents' home postcodes, on any of the subscale scores. There was a modest effect of age on some of the FPS scores and for this reason normative values and cut-offs are given for both younger adolescents (under 14 years) and older teenagers (14 and above). In the normative sample, FPS scores were predictive of self-reported psychological wellbeing, as evaluated by the self-report version of the Strengths and Difficulties Questionnaire (SDQ).



Scoring the FPS

Full details about scoring are available in the FPS manual, which is downloadable from the author's website[22]. But briefly, all item responses are scored as follows:

Almost always	4
Usually	3
Sometimes	2
Rarely	1

Item scores are summed for the subscales of nurture, problem solving, expressed emotion, behavioural boundaries and responsibilities. A communication index score is also obtained by adding or transforming certain of the other scores. An Excel© spreadsheet that is designed to automatically calculate subscale scores and produce graphs is also available free of charge from the author's website[22]. A look-up table to convert raw summed subscale totals to Rasch-based scores is available too. Rasch scores are based on item response modelling and have the advantage of producing an interval metric (eg a score of 2.0 logits is one unit more than 1.0 logits) and may be particularly useful for research applications.

Interpreting the FPS scores

Perhaps the most useful way of utilising the FPS is to ask family members to complete the questionnaire, and graph out the responses using software such as the Excel© spreadsheet mentioned. Family members can then visualise their evaluations of family life, and differences in these perceptions or 'extreme' scores can be explored with the clinician. When compiling a tentative report and interpretation based on the FPS scores, it is suggested that the following points may be useful to comment on:

> "Feeding back scores to a family may help facilitate discussions regarding their relative strengths and struggles. In turn, this may enhance communication and empathy – two core goals in family work or therapy"

1. Which members of the family completed the questionnaire and under what circumstances (eg postal or with clinician present).
2. Whether any of the adolescent member's scores exceeded any of the suggested cut-off thresholds.
3. Whether scores were generally higher or lower than the mean/median scores generated from the normative population sample of adolescents (see the downloadable pdf manual[22]).
4. The degree of disparity between different family members' scores.
5. Whether any particular scoring patterns are present (eg relatively high *expressed emotion* scores accompanied by relatively low *nurture* scores across all respondents).

The case of Jenny

It is hoped that the FPS will prove a useful additional tool for all counsellors and therapists working with families and adolescents in either a clinical or research setting. The following fictional case study illustrates its use.

Jenny is a 15-year-old girl with a history of eating problems and self-harming behaviours. Previously, Jenny severely restricted her food intake and was diagnosed with anorexia nervosa. Over the last six months, she has gained weight and is now in the normal range for her age and height but still binge-eats at times and regularly harms herself by making superficial cuts to her upper arms. Jenny lives at home with her mother, Jane, and her stepfather, Robert, her parents' marriage having ended in divorce when she was three years old. Both Jane and Robert work full time in professional well-paid jobs. Jenny also has a stepbrother, John, who has recently left home to study at university.

> "The adolescent viewpoint is often more negative than those of adult members, and it has been suggested that this is partly because they are the least 'invested' in providing a favourable view"

At initial assessment, Jenny scores her family less positively (compared to age-related peers) on all subscales except for *problem solving* and *behavioural boundaries*. In contrast, Jenny's mother provides above average scores on all the subscales, including *expressed emotion* (ie perceived relatively high levels of this dimension). Robert provides scores intermediate to these, reflecting somewhat negative views on *nurture* and *expressed emotion* levels. According to the manual, the disparity between Jenny and her mother's (but not stepfather's) scores are greater than expected.

The scores are fed back to the family in a follow-up appointment in graphical form, accompanied by a written report. This feedback stimulates discussion focused on exploring the reasons behind the disparate views. Jenny feels that her mother is somewhat cold and critical of her much of the time. Jane defends herself, pointing out how she has always materially provided for Jenny as evidence of her love. Jenny is able to articulate, with support from the therapist, that it is quality time and physical affection she wants from her mother, not clothes and holidays. This surprises Jane, who subsequently agrees to offer at least 30 minutes of quality time to Jenny five times a week so she can listen to Jenny's worries, feelings and experiences. Possible barriers to this happening as planned are explored, with contingencies agreed. The high level of negative expressed emotion reported by all members is addressed by coaching on the topic of effective communication strategies (eg using fewer 'you' statements and more 'I' statements). Once these issues have been addressed, the sessions shift focus to eating behaviours and food-related issues in the home.

After six sessions, Jenny stops self-harming and is binging/purging much less often. The FPS is administered again and all members report improvements in perceived family functioning, especially in the area of expressed emotion. ●

Paul Tiffin is a clinical senior lecturer at Durham University, and an honorary consultant in the psychiatry of adolescence with Tees, Esk and Wear Valleys NHS Foundation Trust. In 2008, he was awarded a Medical Doctorate (MD) for his work developing and validating the Family Perceptions Scale (FPS). Paul's academic post is currently supported by an HEFCE fellowship. His research interests include severe mental illness, family assessment, risk evaluation in adolescence and the application of statistical and psychometric modelling approaches in the behavioural sciences. Paul's current clinical work is with the Forensic Adolescent Mental Health Team for Teesside. In the past, Paul has also helped develop and evaluate Early Intervention in Psychosis Services for young people.

References

1 Cox MJ, Paley B. Families as systems. Annual Review of Psychology. 1997; 48:243-267.
2 Lewis JM. The adolescent and the healthy family. Adolescent Psychiatry. 1978; 6:156-170.
3 Erikson EH. Childhood and society. New York: Norton; 1950.
4 Havighurst R, Taba H. Adolescent character and personality. New York: Wiley; 1949.
5 Marcia JE. Identity in adolescence. In: Lerner RM, Steinberg L. (eds) Handbook of adolescent psychology. New York: Wiley; 1980.
6 Barnhill L. Healthy family systems. Family Coordinator. 1979; 28:94-100.
7 McGoldrick M, Carter EA. The family life cycle. In: Walsh F. (ed) Normal family processes. New York: Guilford; 1982.
8 Hooley JM, Teasdale JD. Predictors of relapse in unipolar depressives: expressed emotion, marital distress, and perceived criticism. Journal of Abnormal Psychology. 1989; 98(3):229-235.
9 Tompson MC, Goldstein MJ, Lebell MB et al. Schizophrenic patients' perceptions of their relatives' attitudes. Psychiatry Research. 1995; 57(2):155-167.
10 Waller G, Slade P, Calam R. Who knows best? Family interaction and eating disorders. British Journal of Psychiatry. 1990; 156:546-550.
11 Epstein NB, Baldwin LM, Bishop DS. The McMaster Family Assessment Device. Journal of Marital and Family Therapy. 1983; 9:171-180.
12 Halvorsen JG. Self-report family assessment instruments: an evaluative review. Family Practice Research Journal. 1991; 11(1):21-55.
13 Niedermeier CL, Searight HR, Handal PJ et al. Perceived family functioning among adolescent psychiatric inpatients: validity of the family-of-origin scale. Child Psychiatry & Human Development. 1995; 25(4):253-265.
14 Sawyer MG, Sarris A. Family Assessment Device: reports from mothers, fathers and adolescents in community and clinic families. Journal of Marital and Family Therapy. 1988; 14(3):287-296.
15 Noller P, Fitzpatrick MA. Marital communication in the eighties. Journal of Marriage and the Family. 1990; 52:832-843.
16 Gowers S, North C. Difficulties in family functioning and adolescent anorexia nervosa. British Journal of Psychiatry. 1999; 174: 63-66.
17 Roelofse R, Middleton MR. The Family Functioning in Adolescence Questionnaire: a measure of psychosocial family health during adolescence. Journal of Adolescence. 1985; 8:33-45.
18 Gergen K, McNamee S. Therapy as a social construction. London: Sage; 1992.
19 Fruggeri L. Therapeutic process as the social construction of change. In: Gergen K, McNamee S. Therapy as a social construction. London: Sage; 1992.
20 Tiffin PA, Kaplan C, Place M. Development of the Family Perceptions Scale: a novel instrument for evaluating subjective functioning in the families of adolescents. Journal of Adolescence. 2011; 34(3):593-597.
21 Tiffin PA. Development and validation of the Family Perceptions Scale. Unpublished doctoral thesis. University of Newcastle-upon-Tyne, UK. 2007.
22 www.dur.ac.uk/p.a.tiffin/fps