

THE FAMILY ASSESSMENT MEASURE

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ABSTRACT

The Family Assessment Measure (FAM) is a self-report instrument that provides quantitative indices of family strengths and weaknesses. FAM is based on a process model of family functioning that integrates different approaches to family therapy and research. The basic concepts assessed by FAM include: task accomplishment, role performance, communication, affective expression, involvement, control, values and norms. FAM consists of three components: (1) a General Scale which focuses on the family as a system, (2) a Dyadic Relationships Scale which examines relationships between specific pairs, and (3) a Self-Rating Scale which taps the individual's perception of his/her functioning in the family. Each scale provides a different perspective on family functioning. FAM takes about 20-30 minutes to administer, and may be used as a clinical diagnostic tool, as a measure of therapy outcome, or as an instrument for basic research on family processes. This article reviews the theoretical model of family functioning, presents data on the reliability and discriminating power of FAM, and describes a case study as an illustration of information provided by FAM.

The assessment of family functioning presents many challenges. For instance, how much emphasis should be placed on examining the characteristics of individual members, their various interactions, or the family system as a whole (Bodin, 1968).

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Another consideration is the extent of focus on past events versus ongoing family behavior. Since each perspective may provide unique as well as corroborating information on areas of health-pathology in the family, there are obvious advantages in attempts to integrate these viewpoints. However, practical constraints and different theoretical orientations of staff often result in a more circumscribed approach being used for family assessments in a given setting (Fisher, 1982).

These challenges stimulated our work on developing the Family Assessment Measure. FAM is based on a Process Model of Family Functioning which provides a framework for integrating different ap-

proaches to family therapy and research (Steinhauer, Santa-Barbara & Skinner, 1983). Indices of family strengths and weaknesses are given by FAM from three perspectives: the family as a system, dyadic relationships, and individual family members. FAM is designed to be conveniently used in clinical and research settings as a diagnostic tool, as a measure of therapy process and outcome, and as an instrument for basic research on family processes. Still under development, this instrument should lead to gains in the assessment, treatment and understanding of problematic families. The aims of this article are (1) to review the process model of family functioning, (2) to describe the development and empirical

evaluation of FAM, and (3) to give a case study as an illustration of information provided by FAM.

Process Model of Family Functioning

The Process Model of Family Functioning provides a conceptual framework for conducting family assessments. This model is not offered as a replacement for other approaches, but as a means of organizing and integrating various concepts into a comprehensive, yet parsimonious framework. Steinhauer, Santa-Barbara and Skinner (1983) provide a detailed description of the model and supporting literature. The following discussion gives a synopsis of the key concepts depicted in Figure 1.

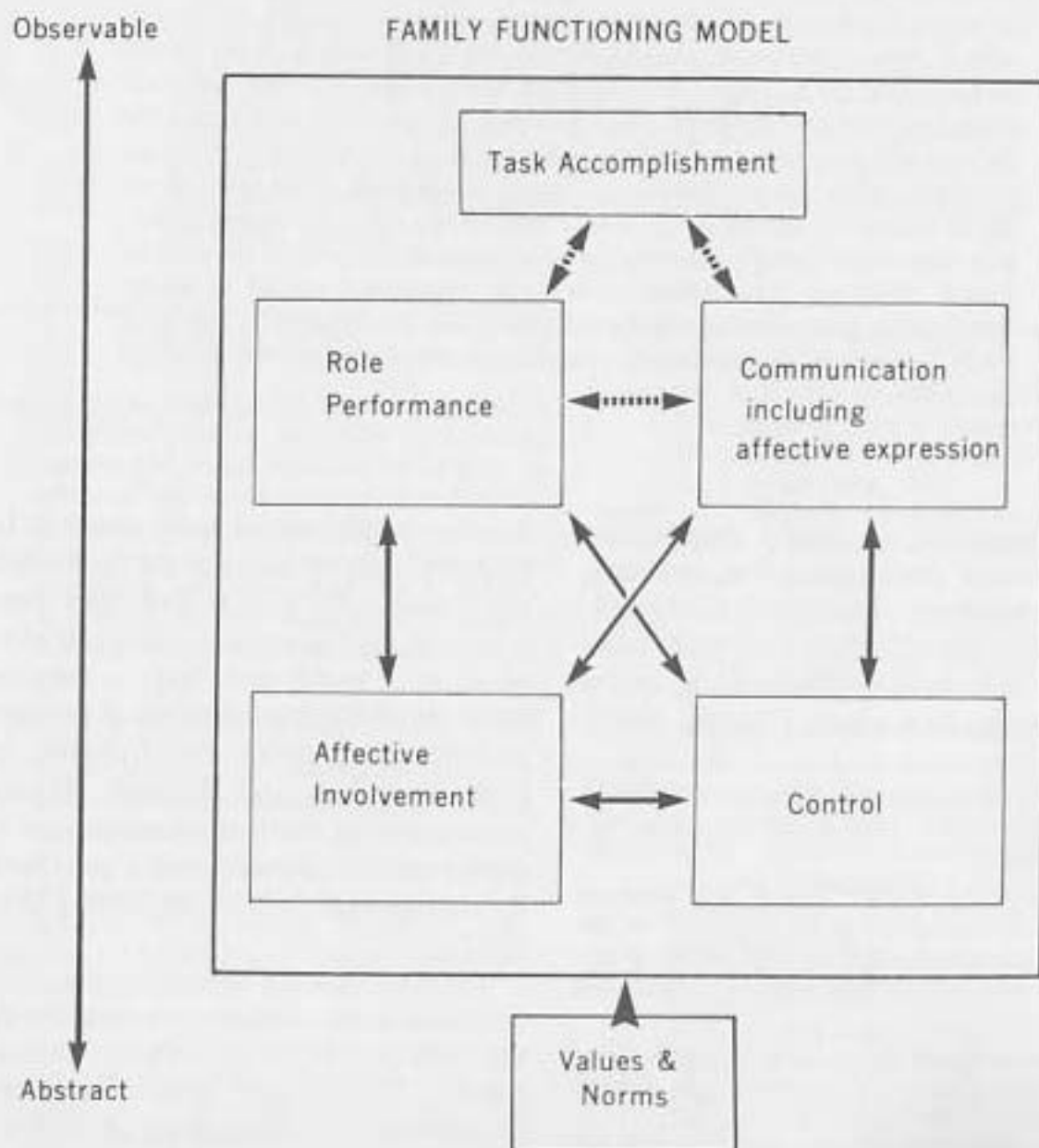


Figure 1. Schematic representation of the Process Model of Family Functioning

The overriding goal of the family is the successful achievement of a variety of basic, developmental and crisis tasks (**Task Accomplishment**). Each task places demands that the family must organize itself to meet. It is through the process of task accomplishment that the family attains, or fails to achieve, objectives central to its life as a group. These functions include allowing for the continued development of all family members, providing reasonable security, ensuring sufficient cohesion to maintain the family as a unit, and functioning effectively as part of society. The process by which tasks are accomplished includes: (1) task or problem identification, (2) exploration of alternative solutions, (3) implementation of selected approaches, and (4) evaluation of effects. Thus, task accomplishment is the most basic activity of the family.

Successful task accomplishment involves the differentiation and performance of various roles. **Role Performance** requires three distinct operations: (1) the allocation or assignment of specified activities to each family member; (2) the agreement or willingness of family members to assume the assigned roles; and (3) the actual enactment or carrying out of prescribed behaviors. Essential to the performance of these roles is the process of **Communication**, by which information essential to task accomplishment and ongoing role definition is exchanged. The goal of effective communication is the achievement of mutual understanding, so that the message received is the same as the message intended. If the message sent is clear, direct and sufficient, then mutual understanding is likely to occur. However, the process of communication may be avoided or distorted by the receiver. Thus, critical aspects of the reception phase of communication include the availability and openness of the receiver to the message. A vital element of the communication process is the expression of affect (**Affective Expression**), which can impede or facilitate various aspects of task accomplishment and successful role integration. Critical ele-

ments of affective expression include the content, intensity and timing of the feelings involved. Affective communication is most likely to become blocked or distorted in times of stress.

Similarly, the kind of involvement family members have with one another (**Affective Involvement**) can either help or hinder task accomplishment. Affective involvement refers to both the degree and quality of family members' interest in one another. These two aspects may be used to describe five types of affective involvement including: the uninvolved family, a family which expresses interest devoid of feelings, the narcissistic family, an emphatic family and the enmeshed family. Other important elements of affective involvement include the ability of the family to meet the emotional and security needs of family members, and the flexibility to provide support for family members' autonomy of thought and function.

Control is the process by which family members influence each other. The family should be capable of successfully maintaining ongoing functions, as well as adapting to shifting task demands. Critical aspects of control include whether or not the family is predictable versus inconsistent, constructive versus destructive, or responsible versus irresponsible in its management style. Certain combinations of these characteristics may give rise to four prototype styles: rigid, flexible, laissez-faire, and chaotic. Finally, how tasks are defined and how the family proceeds to accomplish them may be greatly influenced by norms and values of the culture in general, and the family background in particular. **Values and Norms** provide the background against which all basic processes must be considered. Important elements consist of whether family rules are explicit or implicit, the latitude or scope allowed for family members to determine their own attitudes and behavior, and whether family norms are consistent with the broader cultural context.

The Process Model of Family Functioning emphasizes family dynamics; it is not a

model of family therapy. This distinction recognizes that understanding families and treating families may require somewhat different skills. Since there is evidence that including a positive or health orientation in treatment is therapeutic, the Process Model emphasizes family health as well as pathology. While it is important to identify dimensions that are relevant to family health-pathology, the Process Model also attempts to define the processes by which families operate. Hence, the model emphasizes **how** basic dimensions of family functioning interrelate. A useful assessment model should incorporate notions about family functioning that have been supported by research, as

well as hypotheses and clinical notions which have been found useful in clinical practice. The Process Model attempts to summarize clinical wisdom and research findings. Finally, the model emphasizes neither the total family system nor individual intrapsychic dynamics, which may characterize other approaches to the family. Instead, basic family processes are considered with a clear acknowledgement that a variety of factors (whether intrapsychic or environmental) may influence these processes. Thus, the Process Model encourages formulation at both the intrapsychic and system levels (Steinhauer & Tisdall, 1982).

TABLE 1
TEST DEVELOPMENT STRATEGY

I. THEORETICAL COMPONENT

- Formulate the Model of Family Functioning
- Prepare a precise definition of each construct
- Generate a large pool of items

II. STRUCTURAL COMPONENT

- Choose items for the initial scales
- Administer scales to relevant samples
- Conduct statistical analyses to evaluate item properties and scale reliability
- Select "best" items for each FAM scale

III. EXTERNAL VALIDATION

- Compare FAM scales with expert clinical ratings and behavioral observations (*construct validity*)
- Evaluate prognostic value of FAM with respect to treatment outcome (*predictive validity*)
- Examine correlation of FAM with other family assessment instruments (*concurrent validity*)
- Determine the perceived relevance of FAM profiles to family therapists (*clinical validity*)

Development of FAM

The Family Assessment Measure was developed according to a construct validation paradigm (Jackson, 1971; Skinner, 1981). This strategy involved an active interplay between specification of the theoretical

model of family functioning and construction of an instrument to measure concepts of the model (Table 1). Thus, FAM was aimed at providing an operational definition of constructs in the Process Model.

The first step involved an explicit defini-

tion of each construct as well as specification of functional linkages among constructs in the Process Model of Family Functioning (Steinhauer et al., 1983). Then, a large pool of items was generated for each construct. These items were rated according to clarity, content saturation and clinical relevance. The best 30 items for each scale were administered to 433 individuals that represented 182 clinical and nonclinical families. Individuals were asked to answer each item for his/her family as a whole. Statistical analyses were conducted that examined the discriminatory power of each item, scale reliability, inter-correlation among scales, and influence of response style biases. The median internal consistency reliability was substantial at .93 for the 30-item scale and .87 for the best 10 items. Also, FAM significantly differentiated between clinical and nonclinical families. Mothers provided the most critical information in that mothers of nonclinical families rated their family functioning as most healthy, whereas mothers of clinical families gave the most pathological FAM profiles (Skinner, Santa-Barbara & Steinhauer, 1981).

From these analyses a briefer 115-item instrument, designated FAM-II, was developed. This version is being used in several treatment research projects. However, feedback from users of FAM-II combined with statistical analyses of its measurement properties indicated a need to provide more differentiated information about areas of family functioning. Accordingly, the present version of the instrument (FAM-III) was devised, which assesses the family from three different perspectives:

(1) **General Scale** (50 items, 9 subscales): focuses on the level of health-pathology in the family from a systems perspective. This scale provides an overall rating of family functioning, seven measures (subscales) relating to the Process Model, plus two response style subscales (Social Desirability and Denial);

(2) **Dyadic Relationships Scale** (42 items, 7 subscales): focuses on relationships among specific pairs (dyads) in the family. For each dyad, an overall rating of functioning is provided along with an index (subscale) for each construct of the Process Model;

(3) **Self-Rating Scale** (42 items, 7 subscales): focuses on the individual's perception of his/her functioning in the family. An overall index is provided along with seven measures relating to the Process Model.

FAM-III generally takes around 30 minutes to administer and it may be completed by family members who are at least 10-12 years of age.

Preliminary analyses have been conducted on FAM-III using a heterogeneous sample of 475 families ($N = 933$ adults, $n = 502$ children) that were tested at various health and social service settings in the Toronto area. The mean age of the adults was 38.0 years ($S.D. = 8.8$); 46% were men and 54% were women. There was a broad range in education level, with 45% of men and 38% of women having some post-secondary education. The mean age of the children was 14.9 years ($S.D. = 4.3$); 45% were male and 55% were female. Half of the children were in Elementary School, 40% were in Secondary School and 10% had achieved some post-secondary education. Approximately 70% of the families owned their present residence. Spouses had been living together for an average of 13.5 years ($S.D. = 8.3$), and 93% were legally married. About 22% of the spouses had had a previous marriage. The modal family income in the past year was in the \$20,000 to \$29,999 range. With respect to usual type of employment for the father, 30% were professional or senior management, 20% were middle management, 5% were clerical-sales, 24% were skilled tradesmen, and 20% were semi or unskilled occupations. Of the mothers, 46% were homemakers, 15% were professionals, whereas the remainder were engaged in various occupations.

TABLE 2
Internal Consistency Reliability Estimates

	Adults	Children
I. GENERAL SCALE		
Overall Rating (35 items)	.93	.94
Subscales (5 items each)		
Task Accomplishment	.67	.60
Role Performance	.73	.64
Communication	.73	.70
Affective Expression	.74	.71
Involvement	.78	.75
Control	.71	.63
Values and Norms	.70	.62
Social Desirability (7 items)	.87	.87
Denial (8 items)	.65	.70
II. DYADIC RELATIONSHIPS		
Overall Rating (42 items)	.95	.94
Subscales (6 items each)		
Task Accomplishment	.74	.73
Role Performance	.82	.71
Communication	.77	.77
Affective Expression	.59	.55
Involvement	.64	.59
Control	.72	.68
Values and Norms	.72	.66
III. SELF-RATING		
Overall Rating (42 items)	.89	.86
Subscales (6 items each)		
Task Accomplishment	.51	.40
Role Performance	.53	.27
Communication	.67	.58
Affective Expression	.64	.55
Involvement	.44	.44
Control	.39	.39
Values and Norms	.60	.46

Reliability estimates are given in Table 2 for the overall rating and various subscales of FAM. Coefficient alpha (Nunnally, 1978) provides a measure of the consistency of individuals when responding to items on the same subscale. For example, if an individual agrees with the Task Accomplishment item "When problems come up, we try different ways of solving them", then how likely is it that the individual will endorse other Task Accomplishment items in the healthy direction? Coefficient alpha provides a summary index of this consistency based on the degree of inter-item correlation. With respect to classical reliability the-

ory, coefficient alpha provides a lower bound estimate of the population reliability (ratio of true score to observed score variance). The estimates in Table 2 for the overall ratings are substantial: *Adults* .93 General Scale, .95 Dyadic Relationships, .89 Self-Rating; *Children* .94 General Scale, .94 Dyadic Relationships, .86 Self-Rating. Since the reliability of a measure is influenced by the number of items, some decrease in reliability should be expected for the much briefer subscales. This trend is evident in Table 2, although the subscale reliabilities are quite respectable for the General and Dyadic Relationship Scales. Fur-

ther work is needed to boost the subscale reliabilities on the Self-Rating Scale, especially for Control and Involvement.

The reliability estimates in Table 2 consider sources of measurement error at *one point in time*. These could include attitudes, emotional reactions or habits that are particular to the testing situation. For example, family members may be less consistent or reliable if FAM is administered while the family is undergoing a crisis. Other reliability studies are planned that will examine the temporal consistency of FAM over repeated administrations.

Next, a multivariate comparison of problem and nonproblem families was conducted to provide evidence on the diagnostic power of the FAM-III General Scale. "Problem" families were defined as currently having one or more family members receiving professional help for: psychiatric/

emotional problems (14%), alcohol/drug problems (2%), school-related problems (14%) or major legal problems (7%). In total, 28% were designated as Problem families. The breakdown by family position was *Non Problem* $N = 305$ fathers, $n = 348$ mothers, $n = 359$ children; Problem Families $n = 108$ fathers, $n = 131$ mothers, $n = 151$ children. A multiple discriminant analysis (Bock, 1975) was conducted to identify linear combinations of the nine General Scale measures that significantly differentiated among the six groups. Conceptually, this procedure defines dimensions of FAM subscales that optimally display differences among family groupings. Although four discriminant functions were statistically significant ($p < .001$), the first two functions were the major discriminators accounting for 84% of the between group dispersion.

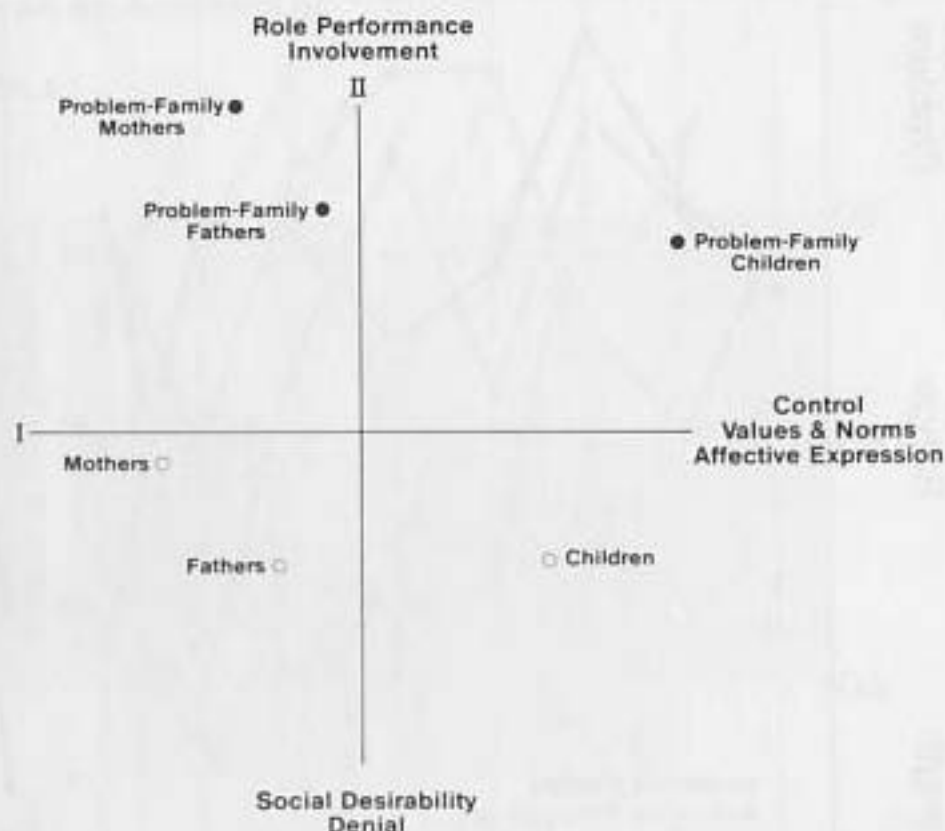


Figure 2. Group centroids for family positions plotted on the first two discriminant functions

Group centroids on the first two functions are plotted in Figure 2. The first dimension is defined by problems in the area of Control, Values and Norms and Affective Expression, and serves mainly to differentiate children from adults. That is, children are more likely to report problems on these three subscales than are adults. On the other hand, the second dimension clearly distinguishes Problem from Nonproblem families. This dimension is bipolar, with the positive pole marked by problems in the

area of Role Performance and Involvement and the negative pole characterized by elevations on the two response style scales (Social Desirability and Denial). Hence, Problem families in general are likely to report family dysfunction in roles and affective involvement (especially the mothers). The Nonproblem families have a tendency to be somewhat higher in Social Desirability and Denial, however, their location toward the midpoint of this dimension is suggestive of only minor difficulties.

FAM GENERAL SCALE

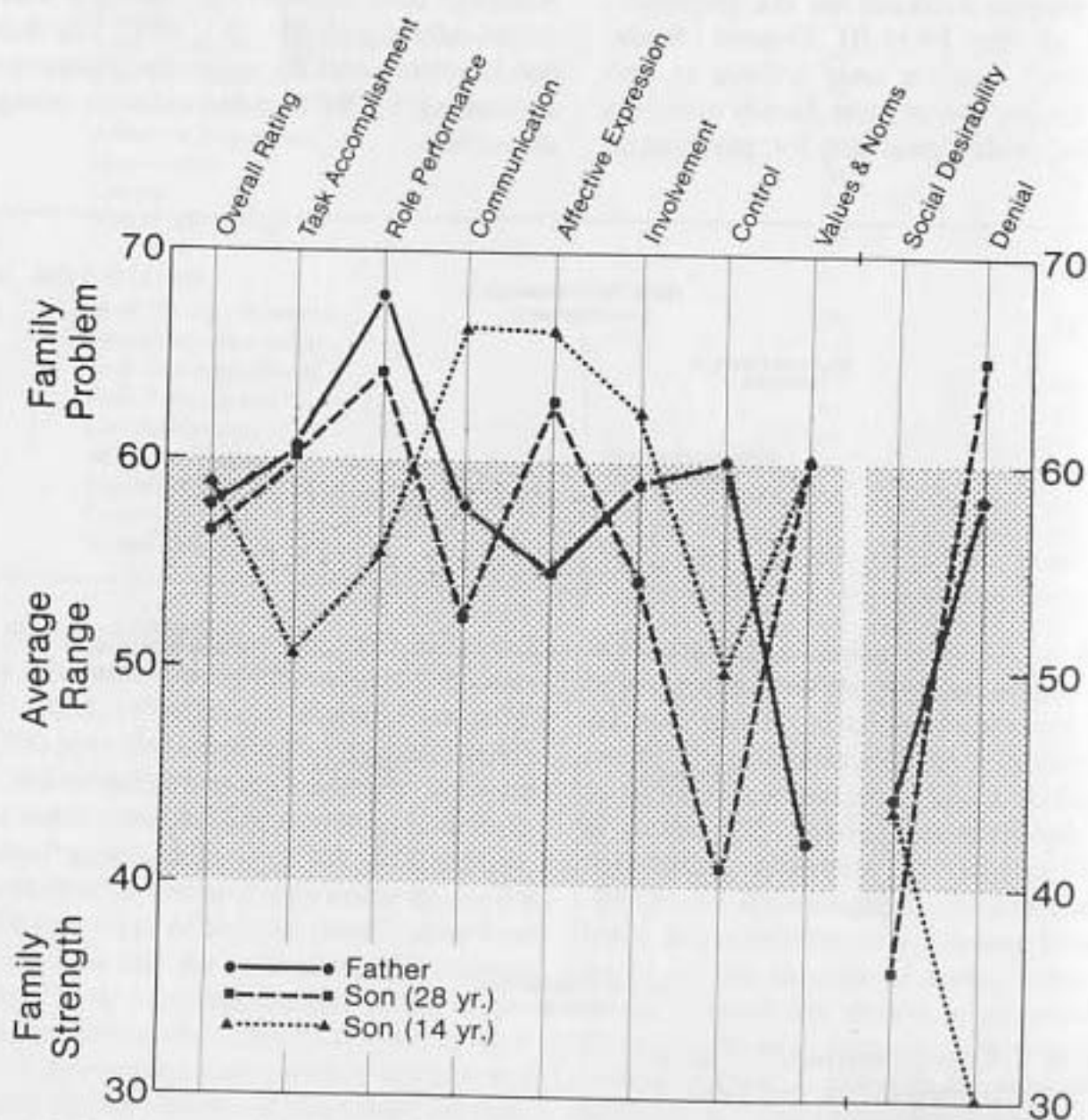


Figure 3. FAM General Scale profiles for the father and two sons

Case Study

One problem faced by family therapists is that of knowing what data to collect, how to gather it, and how best to organize it to provide a systematic picture of the family's structure and functioning. The following case illustrates how FAM may be used to reveal congruences and discrepancies among family members in their perception of family strengths and weaknesses.

The older son, aged 28, had requested help for his 14 year-old brother who was in danger of failing Grade VIII for the second time. Their mother had died four years ago, so that only the two sons and father participated in the assessment and treatment. This family was working class. The younger son was chubby and untidily dressed. The elder son had both a marked stutter and a major physical disability, such that his legs were much less developed than his chest and arms and he walked with difficulty on crutches. The father seemed chronically depressed and was willing to leave the leadership of

the family to the older son. The father talked a great deal, mainly in an attempt to avoid criticism and to defensively ally himself with the therapist against the younger son.

According to the other family members, the younger son had problems related to school, he had no friends and complained of being teased, he was constantly lying to a point that they never knew when he was telling the truth, and he failed to take responsibility for himself either at school or in the home. The younger son repeatedly launched father and older brother into massive attacks on his credibility and self-esteem. They stated that his behavior had deteriorated since mother had died. She was no longer available to maintain discipline and supervise his work. Father and elder brother greatly missed the mother since both had been extremely dependent on her. The father stated that he found it too much after a hard day's work to come home and supervise the younger son. Hence, the elder brother took over various parenting roles by default.

FAM SELF-RATING SCALE

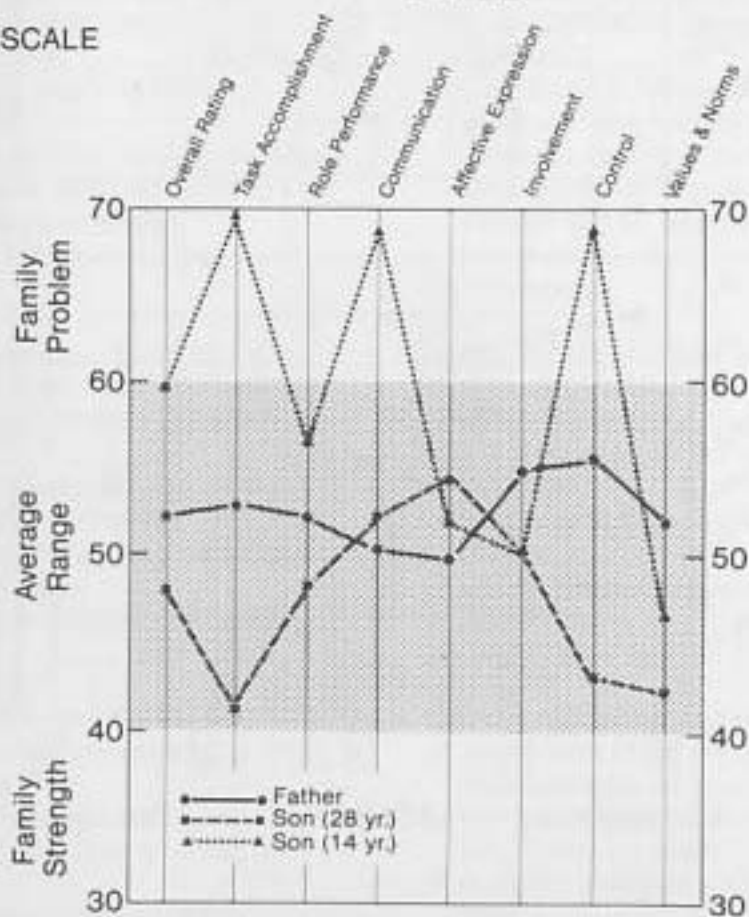


Figure 4. FAM Self-Rating Scale profiles for the father and two sons

FAM DYADIC RELATIONSHIPS SCALE

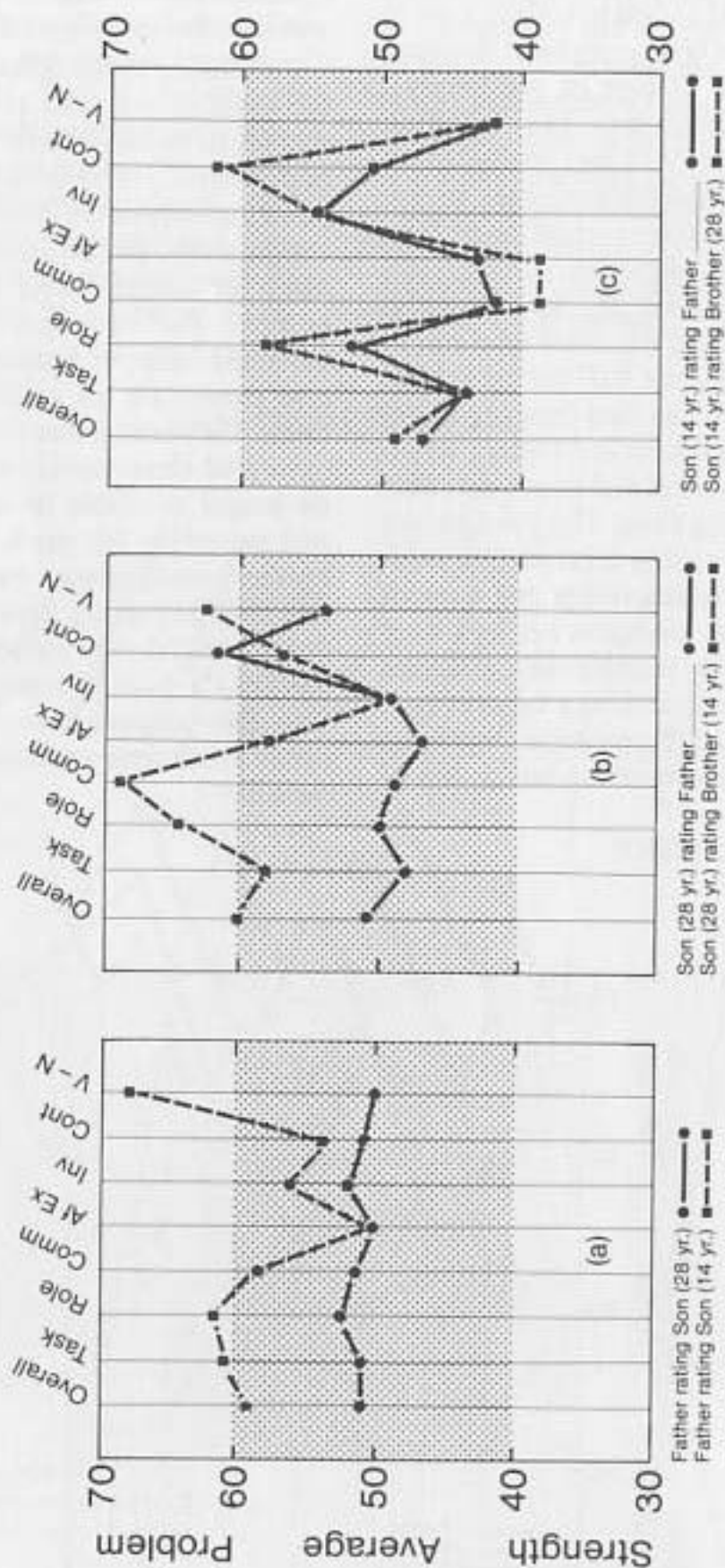


Figure 5. FAM Dyadic Relationships profiles for the father and two sons

TABLE 3

FAM Interpretation Guide

1. TASK ACCOMPLISHMENT

LOW SCORES (40 and below) STRENGTH

- basic tasks consistently met
- flexibility and adaptability to change in developmental tasks
- functional patterns of task accomplishment are maintained even under stress
- task identification shared by family members, alternative solutions are explored and attempted

HIGH SCORES (60 and above) WEAKNESS

- failure of some basic tasks
- inability to respond appropriately to changes in the family life cycle
- problems in task identification, generation of potential solutions, and implementation of change
- minor stresses may precipitate a crisis

2. ROLE PERFORMANCE

LOW SCORES (40 and below) STRENGTH

- roles are well integrated: family members understand what is expected, agree to do their share and get things done
- members adapt to new roles required in the development of the family
- no idiosyncratic roles

HIGH SCORES (60 and above) WEAKNESS

- insufficient role integration, lack of agreement regarding role definitions
- inability to adapt to new roles required in evolution of the family life cycle
- idiosyncratic roles

3. COMMUNICATION

LOW SCORES (40 and below) STRENGTH

- communications are characterized by sufficiency of information
- messages are direct and clear
- receiver is available and open to messages sent
- mutual understanding exists among family members

HIGH SCORES (60 and above) WEAKNESS

- communications are insufficient, displaced or masked
- lack of mutual understanding among family members
- inability to seek clarification in case of confusion

4. AFFECTIVE EXPRESSION

LOW SCORES (40 and below) STRENGTH

- affective communication characterized by expression of a full range of affect, when appropriate and with correct intensity

HIGH SCORES (60 and above) WEAKNESS

- inadequate affective communication involving insufficient expression, inhibition of (or overly intense) emotions appropriate to a situation

5. AFFECTIVE INVOLVEMENT

LOW SCORES (40 and below) STRENGTH

- emphatic involvement
- family members' concern for each other leads to fulfillment of emotional needs (security) and promotes autonomous functioning
- quality of involvement is nurturant and supportive

HIGH SCORES (60 and above) WEAKNESS

- absence of involvement among family members, or merely interest devoid of feelings
- involvement may be narcissistic, or to an extreme degree, symbiotic
- family members may exhibit insecurity and lack of autonomy

6. CONTROL

LOW SCORES (40 and below) STRENGTH

- patterns of influence permit family life to proceed in a consistent and generally acceptable manner
- able to shift habitual patterns of functioning in order to adapt to changing demands
- control style is predictable yet flexible enough to allow for some spontaneity
- control attempts are constructive, educational and nurturant

HIGH SCORES (60 and above) WEAKNESS

- patterns of influence do not allow family to master the routines of ongoing family life
- failure to perceive and adjust to changing life demands
- may be extremely predictable (no spontaneity) or chaotic
- control attempts are destructive or shaming
- style of control may be too rigid or laissez-faire
- characterized by overt or covert power struggles

7. VALUES AND NORMS

LOW SCORES (40 and below) STRENGTH

- consonance between various components of the family's value system
- family's values are consistent with their subgroup and the larger culture to which the family belongs
- explicit and implicit rules are consistent
- family members function comfortably within the existing latitude

HIGH SCORES (60 and above) WEAKNESS

- components of the family's value system are dissonant resulting in confusion and tension
- conflict between the family's values and those of the culture as a whole
- explicitly stated rules are subverted by implicit rules
- degree of latitude is inappropriate

FAM profiles for this family are given in Figures 3, 4, and 5. Scores in the FAM profile are normalized such that each subscale has a mean of 50 and a standard deviation of 10. Because FAM was standardized with respect to a heterogeneous sample of clinical and nonclinical families, the majority of scores for nonclinical families should fall between 40 and 60. Scores outside this range are likely to indicate either very healthy functioning (40 or below) or considerable disturbance (60 or above). A detailed guide for interpreting each FAM subscale is presented in Table 3.

Figure 3 reveals some interesting discrepancies among father and the two sons in their perception of family functioning as a whole. In general, all three members rate overall family functioning as problematic. Father and older son see problems with task accomplishment and especially role performance. In contrast, the younger son highlights communication and affective expression as major problem areas in the family. Another disagreement concerns control versus values and norms. Whereas father sees problems in the area of control, the two sons underscore values and norms as an area of family dysfunctioning. These discrepancies indicate that the three family members do not share a common perception of their family. Although the father and two sons acknowledge major difficulties in family functioning, the nature of these problems is perceived differently by each member. One of the first tasks of therapy would be to explore these differing perceptions with the family.

The FAM General Scale also reveals that both father and older son are quite defensive in acknowledging areas of family dysfunction; however, the younger son readily admits to family problems. This finding from FAM corroborates the therapist's notes from the initial interview described above. Thus, another important focus of therapy would be on helping the father and older son gain better insight into *interactional* prob-

lems of the family, not just problems of the younger son.

Defensiveness is also evident on the Self-Rating Scale in Figure 4. Both father and older son generally rate their individual functioning within the family at a healthy level. In contrast, the younger son describes his functioning to be well within the problematic range. In particular, the younger son acknowledges difficulties with his functioning in the areas of task accomplishment, communication and control. Father rates some problems in the area of control and involvement, which reinforces his statements to the therapist of detachment and leaving the leadership of the family to the older son. Although the older son sees his strengths particularly in aspects of task accomplishment, control and values and norms, he does acknowledge difficulties in the area of affective expression. Taken altogether, Figure 4 underscores the lack of consensus among the three family members in describing areas of family health and pathology.

FAM profiles of the various dyadic relationships are depicted in Figure 5. Father describes a fairly healthy relationship with the older son but there are problems in a number of areas with the younger son, especially with respect to values and norms. This latter finding reinforces a statement made during the initial interview that the younger son was constantly lying to the point that father never knew when he was telling the truth. Similarly, the older son rated relationships with his brother to be problematic in the area of values and norms, as well as in aspects of communication and role performance. Interestingly, the older son acknowledges difficulties with father in the area of control, which reflects the father's unwillingness to assume a leadership role in the family. The elder son has had to assume a parenting role in the family by default. Conflicts over this role are clearly indicated by the younger son in his relationship with the brother in the area of role performance and control.

TABLE 4
Dyadic Relationships Grid
For Values and Norms

Target Relationship

	Father	Son (28 yr.)	Son (14 yr.)
RATER			
Father	(53)	50	68
Son (28 yr.)	54	(42)	64
Son (14 yr.)	43	43	(46)
	49	47	66

RECEPTION SCORES

Another way of interpreting data from FAM is to construct a dyadic relationships grid. Table 4 presents this grid for Values and Norms. Entries in off-diagonal sections may be readily compared to highlight discrepancies and congruences. For instance, the younger son rates relationships with his father (43) and brother (43) to be healthy. In contrast, both the father (68) and older son (64) point out problems in the area of values and norms in relationships with the younger son. Diagonal entries of the grid (in brackets) contain self-ratings of the individuals functioning, which may be compared with dyadic relationships. Reception scores (column average excluding self-rating) provide an overall index of which family members are particularly healthy or problematic in family dyadic relationships. Here, the younger son (66) scores well above the brother (47) and father (49). Thus, the grid provides a compact yet powerful way of displaying results from FAM.

In review, FAM has corroborated and elaborated upon impressions by the therapist from the first interview. Father and the two sons differ in the extent to which they acknowledge problems in family functioning. Moreover, the nature of these problems is perceived differently by each. Many of

the family's problems are complications of their failure to complete mourning for the wife/mother who died four years ago. The main issues that need to be addressed are interactional: how to clarify and reach agreement on roles, how to help members take responsibility for their own behaviour and hold others responsible for theirs, how to increase understanding of each other's feelings and foster trust, and how to reassert the intergenerational boundary.

Discussion

The Family Assessment Measure gives an overview of family functioning with respect to constructs in the Process Model. FAM profiles cannot in and of themselves identify which *critical aspects* of each construct are a strength or weakness. Further assessment would be required, for example, to determine if an elevated Communication score is due to an insufficiency of communication rather than a lack of clarity or direction. Thus, the Family Assessment Measure is not a substitute for a good clinical assessment of a family. Rather, FAM provides an important complement to a clinical assessment by giving a comprehensive overview of family functioning, by providing an objective and independent verification of the

clinical assessment, by identifying areas of potential difficulty that warrant further assessment, and by providing quantitative indices of family health/pathology that may be used as a baseline for evaluating the course of therapy.

Work to date on FAM has concentrated upon the theoretical and structural components of Table 1. Presently, normative data are being collected on various clinical and nonclinical populations. These normative data will enhance the interpretation of FAM profiles by allowing the user to select the most appropriate comparison group for his/her assessment context. Also, a number of validation studies are in progress. A principal consideration is to evaluate the *construct* validity of FAM by means of the multitrait-multimethod approach (Campbell & Fiske, 1959). That is, to what extent do self-report data (FAM) on family functioning converge with clinical ratings and behavioural observations of the same construct. Another study will compare relationships among FAM, the Family Environment Scale (Moos, & Moos, 1981), and FACES (Olson, Portner & Bell, 1982; Olson, Sprenkle & Russell, 1979). These data bear upon the *concurrent* validity of FAM with respect to other popular self-report instruments for

family assessments. Perhaps of most concern to clinicians is the *predictive* validity of FAM with respect to differential treatment outcome. The Dyadic Relationships Scale is expected to be particularly sensitive to change in family dynamics over the course of therapy. Finally, the perceived relevance and meaningfulness (*clinical* validity) of FAM profiles to clinicians engaged in family therapy will be evaluated. This research is vital for fostering the clinical acceptance and use of FAM (Skinner & Blashfield, 1982).

In conclusion, the Family Assessment Measure has the advantage of being grounded in a comprehensive model of family functioning. FAM offers considerable potential for providing the busy clinician with a brief assessment of major strengths and weaknesses in a family, and for providing the researcher with a carefully developed instrument for basic studies on family processes. Empirical analyses to date have shown that the FAM scales are quite reliable, and they significantly differentiate between problem and nonproblem families. Thus, a continued refinement of FAM and the underlying Process Model should lead to a better understanding of family dynamics.

RESUME

Le Family Assessment Measure (FAM) est un instrument autoadministrable qui fournit des indices quantitatifs des forces et des faiblesses d'une famille. Le FAM se fonde sur un modèle qui décrit le processus du fonctionnement familial et qui intègre les différentes approches de thérapie et de recherche familiales. Les concepts de base que le FAM entend évaluer sont: l'accomplissement des tâches, l'exercice des rôles, la communication, l'expression de l'affectivité, l'implication, le contrôle, les valeurs et les normes. Les trois composantes du FAM sont: 1) une échelle générale centrée sur la dimension systémique de la famille 2) une échelle de relations dyadiques qui examine les interactions entre paires spécifiques et 3) une échelle d'auto-évaluation qui saisit la perception de l'individu de son fonctionnement dans la famille. Chaque échelle fournit une perspective différente du fonctionnement familial. De 20 à 30 minutes sont requises pour administrer le FAM qui peut être utilisé comme instrument de diagnostic clinique, comme instrument d'évaluation des résultats d'une thérapie et comme outil de recherche fondamentale sur les processus familiaux. Le présent article présente le modèle théorique du fonctionnement familial, offre des données sur la fidélité et le pouvoir discriminatif du FAM et fait une étude de cas illustrant le type d'information recueillie par le FAM.

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