

Family therapy process – works on the Polish version of SCORE-15 tool

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Summary

Aim. The aim of the paper is to demonstrate progress of the works on the Polish version of SCORE-15 and the results of the preliminary data analysis of changes in the process of family therapy, obtained with this tool. The works on the Polish version, ongoing since 2010, were inspired by the Research Committee European Family Therapy Association EFTA. Since the Polish version of SCORE-15 will be made public and published on EFTA website in the near future, therefore, it is important that people interested in the tool know the context of its development.

Methods. The Polish version of SCORE-15, the tool designed to examine the process of family therapy, was used.

Results. The comparison of the results obtained by family members before the first family session and before the fourth one and psychotherapists' assessments show that the perception of the weight of the problem with which the family members came to therapy is indeed significantly lower already after three sessions of family therapy. Additionally, the obtained results show great coherence of the assessment of the family therapy progress in families and their therapists.

Conclusions. The preliminary analysis of data obtained during the research project conducted in Outpatient Family Therapy Clinic, Department of Adult, Child and Adolescent Psychiatry, University Hospital in Krakow and in Laboratory of Psychology and Systemic Psychotherapy, Department of Child and Adolescent Psychiatry, Jagiellonian University Medi-

The study was not sponsored.

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cal College between 2010 and 2014 revealed that SCORE-15 is a useful tool in research on changes in the systemic family therapy process.

Key words: SCORE-15, monitoring on family therapy process, efficiency of family therapy

Introduction

In recent years greater interest in monitoring therapy process as a factor increasing efficiency of therapeutic process have been observed. Monitoring presupposes the necessity of creating tools that are easy and practical in a daily use. Such tools include the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) developed by American researchers (Miller et al. [1, 2]). ORS is used in evaluating individual, interpersonal and social functioning of a patient/client. SRS, on the other hand, evaluates the quality of therapeutic alliance focusing on 3 aspects: (1) the quality of relationship bonds, (2) the level of consensus between patient/client and therapist/doctor with regards to the objectives and goals, and (3) the level of consensus with regards to the treatment and problem-solving methods. Even though they are also used in monitoring family therapy [3], they have their limitations as they do not consider functioning of a family as a whole, nor the dyadic relations. Therefore, the researchers have been on a lookout for methods more appropriate and fitted to research on family therapy process.

SCORE-15, developed in the recent years by family therapists from the United Kingdom led by professor Peter Stratton, seems to be such a tool [4, 5]. In its assumption, the tool is supposed to measure the effects of therapy and those changes in the functioning of the family that are considered symptoms of beneficial therapeutic changes by systemic therapists and couple therapists.

Development of SCORE-15 tool was preceded by years of work realized with the support of the Association for Family Therapy and Systemic Practice AFT, the leading British association gathering family therapists and practitioners of systemic approach. In the first stage of the project, draft version of the questionnaire containing 40 items was developed. This stage also encompassed consultations with experts, persons in therapy and therapists running therapy sessions. Peter Stratton, Julia Bland, Emma Jones and Judith Lask are the authors of this version [4]. Clinics from all over the United Kingdom provided the research group with over 500 reports obtained from members of 228 families. After applying appropriate statistical analyses and researching the inner coherence of the scale, the questionnaire was modified. A shorter version of SCORE, that included 15 statements describing different aspects of family life and related processes as well as other indicators of family functioning, was developed [5]. Statistical analysis showed that the questionnaire has high coherence and reliability. Cronbach's alpha for the test is 0.89 and the split-half consistency coefficient is also 0.89 [4]. The results of SCORE-15 match the results of SCORE 40 in 97.5% [5]. The simplicity and the fact that completing the questionnaire takes only a few minutes are big advantages of the tool. Therefore, it is possible and doable to include the tool in a daily therapeutic practice with regards to different people and different therapies – family or couple therapy as well as individual therapy.

In the recent years, the tool's authors have been working on adapting the tool to suit younger children. Pilot research confirmed satisfying psychometric properties for

the age group of 8–11 years [6]. The literature also contains reports on validating the tool and standards in the Irish population [7, 8].

In 2009, the second stage of the project commenced with the objective to research and confirm the reliability and accuracy of the new modified 15-item SCORE questionnaire. Pilot research was conducted on two populations: clinical and non-clinical, and at the same time the project was spread over to other European countries. The latter was possible thanks to establishing, within the European Family Therapy Association EFTA, a research group – Research Committee, led by professor Stratton. The objective of the research committee was the initiation and promotion of research on family therapy and systemic practice. Its leading project was to verify the accuracy of SCORE-15 in other European countries and to develop the tool so that it could be adapted to conditions of any given country, but would still be a common European tool. It was expected that each country would examine 200 clinical and 100 non-clinical families. It was assumed that research could be conducted by a few or a dozen or so groups in a given country where systemic family and couple therapy is present and practiced.

The completion of this objective required that all participants follow detailed procedures regarding the scheme of the research, the manner of inviting a family to the project, informing about the aim of the research and rules of obtaining the consent, as well as the way of answering most frequently asked questions. It was assumed that each country would have a principal investigator responsible for observing ethical rules and correctness of the progress and course of the research process as well as for coordination of research actions undertaken in different sites and run by persons conducting research in their own centres (research associate).

In mid-2009, at the annual meeting of EFTA-NFTO¹, which the Scientific Section of Family Therapy of the Polish Psychiatric Association is a member of, the idea of the joint European research was presented and the representatives of national family therapy organizations with membership in EFTA-NFTO were invited to participate in the study. Majority of the organizations that belong to EFTA-NFTO accepted the invitation and recently first publications on the results were publicized [8] and conference presentations were delivered [9].

Development of the Polish version of SCORE-15 tool

The Board of the Scientific Section of Family Therapy of the Polish Psychiatric Association considered the works on SCORE-15 questionnaire important for Polish family therapists and decided that the Section should join in the process of piloting the research process and gave the role of the coordinator and principle investigator to Barbara Józefik, who at that time represented the Section in EFTA-NFTO.

¹ It should be explained that the European Family Therapy Association EFTA, established in 1991, is the most important European association gathering family therapists and systemic practitioners. It consists of 3 chambers: the Chamber of Individual Members, EFTA-CIM, the Training Institute Chamber EFTA-TIC, and the Chamber of National Family Therapy Organization EFTA-NFTO).

The decision prompted many actions that needed to be taken and decided upon. Firstly, works on translating all documentation prepared by the EFTA Research Committee were initiated. The documents included the general and detailed research protocol, information for families and the consent form, detailed definition of systemic therapy, the list of most frequently asked questions and the answers to these questions, the chart of the list documenting families coming into therapy, an Excel program for inputting the data, and most importantly, two versions of SCORE-15 questionnaire: for the clinical and non-clinical population. Translation procedure was described in detail and encompassed the following aspects: 1) including in the translation process people of different age, education and origin, 2) accounting for cultural differences, 3) conducting a back translation procedure in the final stage.

At the same time, all members of the Scientific Section of Family Therapy of the Polish Psychiatric Association, received the information on the research project and the invitation to participate. 19 sites expressed their interest in participating in the project. Among those were: 7 academic centres including: two family therapy groups – Family Therapy Outpatient Unit of the Department of Adult, Children and Adolescent Psychiatry, University Hospital in Krakow and Department of Family Therapy of the Psychiatry Department, Jagiellonian University Medical College, Department of Child and Adolescent Psychiatry of the Institute of Psychiatry and Neurology in Warsaw, Department of Developmental Age of the Medical University of Warsaw, Clinic of Developmental Psychiatry, Psychotic and Geriatric Disorders of the Medical University of Gdańsk, Medical University of Białystok, 5 private therapeutic and training centres, 1 association, 1 foundation, 2 out-patient clinics, and 3 private practices.

After completing the preparation stage mainly involving translation of all materials, including SCORE-15 tool in both clinical and non-clinical versions, on the 14th of September 2010 in Warsaw in the Institute of Psychiatry and Neurology, the meeting for all interested parties – the coordinators, that presented details of the project and established which centres would eventually take part in the project, took place.

Participation in the project meant that a given site would examine families coming to therapy before their first consultation session, then before the fourth one and after the last one, completing the therapy. Original copies of the obtained empirical material were supposed to be delivered to professor Stratton by the principle investigator and, of course, were to be used by the groups conducting the research.

The research was to be conducted based on a detailed procedure as per the scheme presented below.

Due to adherence to such a detailed procedure, it was possible to conduct research at many sites while maintaining uniformity of conditions in which it was conducted what enabled the incorporation into one common database.

Despite great initial interest, eventually 7 groups took part in the study and delivered obtained materials. Each group had its own coordinator responsible for proper conduct of the research in accordance with the procedure. Table 1 below contains detailed list of site names, coordinator details, and the number of families examined by the end of 2014 by each centre.

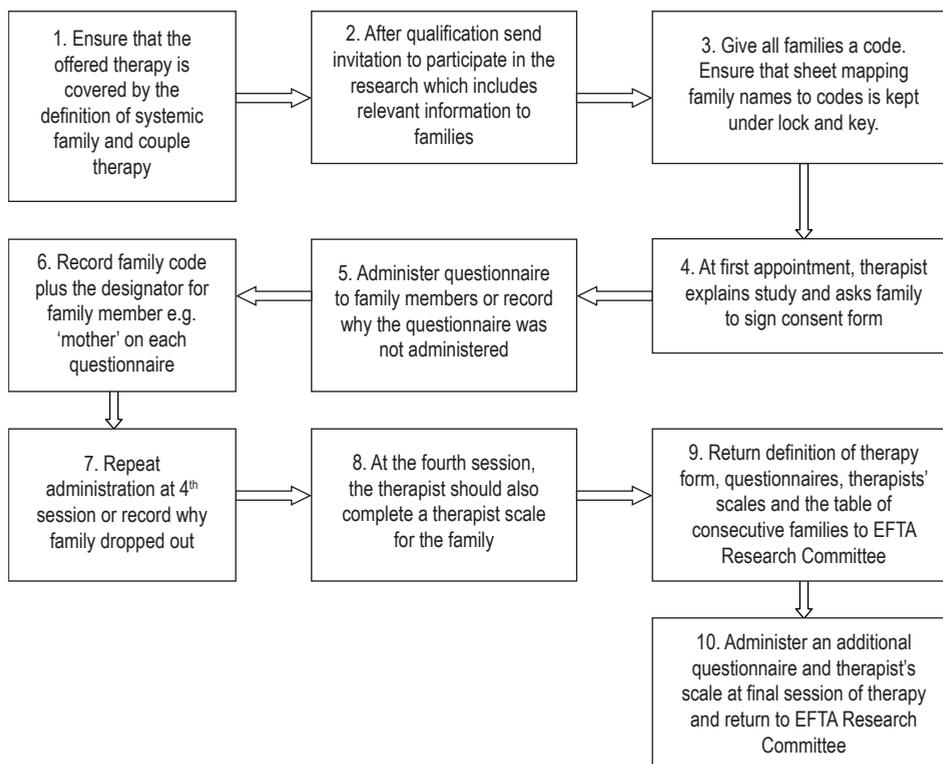


Figure 1. Research procedure scheme [10]

Table 1. Detailed list of site names, coordinator detail, and the number of families examined by the end of 2014 by each centre

Item	Site name	Coordinator	Clinical population			Non-clinical population
			Number of families examined before 1 st consultation	Number of families examined after 4 th consultation	Number of families examined at the end of therapy process	One time examination
1.	Family Therapy Outpatient Unit in Krakow	Małgorzata Wolska	108	71	29	0
2.	Clinic of Developmental Psychiatry, Psychotic and Geriatric Disorders of the Medical University of Gdańsk	Izabela Łucka	67	2	0	0

table continued on the next page

3.	Medical University of Białystok	Aleksandra Malus	45	27	6	20
4.	Therapy and Development Laboratory in Warsaw	Marta Ramm, Martyna Figurska	15	3	1	0
5.	Therapy Centre in Krakow	Bogusława Piasecka	12	11	4	6
6.	"Dom Nadziei" Foundation	Bogdan Peć	8	5	5	0
7.	Department of Family Therapy in Krakow	Katarzyna Gdowska	4	3	3	0
	Total		259	122	48	26

Data analysis show that in Poland total of 259 families searching for family consultation due to family or couple relationships problems or problems and/or symptoms of one family member were examined. Significantly lower number of families, total of 122, was examined before the fourth session and even fewer families were examined at the end of therapy – 48. In one of the sites, families were examined just once because the site only provides family consultation sessions. In other sites, small number of examinations after the fourth and the last session was caused by other reasons, i.e. resigning from therapy, referral to stationary treatment, revoking the consent to participate in the project at the later stages of therapy or site's organizational problems. Small number of families examined at the end of therapy process sometimes resulted from the fact that the therapy lasted for a short period of time, e.g. 5–6 sessions, and therapists did not offer completing of the questionnaire again due to the short time elapsing since previous examination. Sometimes the cause was just the opposite – families stayed in therapy for a very long time, e.g. 2–3 years and when therapy finished, therapist did not remember that this particular family was in for the research procedure.

The above situation illustrates the difficulties of conducting research prolonged in time. For therapists and staff working at a given site, it was easier to remember and motive themselves to administer the examination when a family came for the first time because completing the questionnaire was a part of filling in other documents related to the registration to the centre than in the later stages despite the monitoring role of a coordinator.

It should be noted that despite of those difficulties, studies conducted in Poland with SCORE-15 were sufficient to constitute the basis for an article [11] and conference presentations [12–14] and are still used for further studies and analyses.

SCORE-15 questionnaire description

SCORE-15 questionnaire has a clinical and non-clinical versions and is intended for person aged 12 years and over.

Both versions of SCORE-15 are divided into four parts.

First part of the questionnaire consists of 15 items divided into 3 scales describing functioning of a family in the following dimensions:

1. Strengths and adaptability;
2. Overwhelmed by difficulties;
3. Disrupted communication.

Second part consists of 3 open-ended questions:

1. Which words describe your family best?
2. What problem/reason made you come to therapy?
3. Main problem is: ...

Third part consists of three additional scales that allow for the quantitative assessment on the 0–10 continuum:

1. How serious is the problem (there is no problem – it is very bad);
2. How do you cope as a family (very well – very bad);
3. Do you think therapy will be/has been helpful? (very helpful – useless).

The last, fourth part contains demographic data, such as age, sex, origin, education, profession, information about people living together.

The first part of the non-clinical version of the questionnaire mirrors the clinical version. There are however differences in the second and the third part. The second part of the questionnaire consists of 3 questions:

1. Which words describe your family best?
2. How would you describe the main problem/challenge that your family faces?
3. The main problem is: ...

In the third part, the difference concerns the last question formulated in the conditional form: Do you think that family therapy or couple therapy would be helpful for your family?

SCORE-15 questionnaire is supplemented by another questionnaire filled by a therapist after the fourth and the last session. This tool consists of 2 scales:

1. Helpfulness Scale: “Do you think that therapy has been helpful for this family?” (0–10 continuum: visibly helpful – not helpful at all);
2. Change Scale: “Compared with the first session, you would describe the family as? (“having more problems (1) no change (2) stronger (3) significantly stronger (4)”).

Both versions of the questionnaire were translated in accordance with the project procedure. The following persons were involved in preparation of the Polish version: Katarzyna Gdowska, Barbara Józefik, Bogdan de Barbaro, Barbara Nowak, Jakub de Barbaro, Barbara Folga, Grzegorz Iniewicz.

Our study

Research and examination of families conducted at the Family Therapy Outpatient Unit between 2010 and 2014 have provided substantial amount of data that is

currently being coded for further detailed analysis. It should be noted that part of the obtained data is qualitative and requires accounting for grounded theory methodology and thematic analysis.

As shown in Table 1, the Family Therapy Outpatient Unit examined total of 108 families before the first consultation, 71 before the fourth one, and 29 after the last session. In this study, it was decided to compare the results obtained during these particular sessions. This decision was based on the fact that some families remained in therapy until the end of 2014. This paper will present the results from the analysis of data obtained from 49 families: 130 individuals who completed the questionnaire before the first and the fourth meeting. The research team decided to conduct pilot analyses mostly out of curiosity. The whole Family Therapy Outpatient Unit² team was involved in the research project at our site. The research procedure required constant cooperation and engagement from the therapists and therefore, the need for at least preliminary rough verification of the value of the tested tool seemed to be justified.

The research team was looking for the answers to the following questions:

1. Do the results of the examination with SCORE-15 tool reveal differences in functioning of the family between the first and the fourth family therapy sessions?
2. Is there a correlation between the changes in functioning of the family within the time span of first 3 sessions and how do therapists working with those families assess the changes in functioning of those families as well as the usefulness of family therapy?

Regardless of the results presented herein, the study is being continued and analyses are conducted in order to fully describe the psychometric properties of the Polish version of SCORE-15. At the current stage, research on families which do not take part in therapy, is still ongoing.

Description of the research group

The basic criterion for inclusion in the project was a conscious consent from the family. Research procedure was consistent with the requirements of the research program described earlier in the present paper. Families with an identified adolescent patient diagnosed in accordance with ICD-10 referred to therapy by the Outpatient Adolescent Psychiatry Unit or Adolescent Unit of the Psychiatry Clinic took part in the research project.

Data obtained during 1.5 years of research was processed and analyzed. For that time being 171 persons gave their consent to participate in the project; these were members of 51 families (Table 2 contains detailed data).

² The following people, apart from the text's authors, took part in the research project: Magdalena Zdenkowska-Pilecka and Grzegorz Iniewicz

Table 2. Data of subjects included in the research project

Research subject	Number	Mean age	Min. age	Max. age
IP	47 (F 35; M 12)	15.75	11	18
IP's mother	49	43.35	33	54
IP's farther	42	44.07	35	60
IP's step farther	3	47.00	41	51
IP's sister	14	17.14	12	25
IP's brother	15	17.87	12	30
IP's grandmother	1	58.00	58	58

IP – identified adolescent patient

Planned analyses required that the research persons complete the questionnaire before the first and the fourth meeting. This requirement was met only in 76% (130 people out of the group of 171). Data of people whose results were subjected to further analysis are shown in Table 3.

Table 3. Data of subjects included in further analyses

Research subject	Number	Mean age	Min. age	Max. age
IP	44 (F 33; M 11)	15.89	12	18
IP's mother	44	42.80	33	54
IP's farther	26	45.31	35	57
IP's step farther	1	51.00	51	51
IP's sister	7	15.00	12	18
IP's brother	7	19.71	12	30

IP – identified adolescent patient

As clearly evident in the comparison of the two groups (Table 2 and Table 3) incomplete data concern mostly IP's fathers (40% missing) and IP's siblings (50% missing). Although in the case of siblings, it is possible to have them excluded temporarily or permanently from the therapy process, "drop out" of fathers is, however, puzzling and worrying.

44 identified patients were diagnosed with: anorexia nervosa (12 people), behavioural disorders (9), bulimia nervosa (5), adjustment disorders (5), psychotic disorders (4), depressive behavioural disorders (4), anxiety disorders (3), and anxiety-depressive disorders (2).

The structure of 49 families was diverse: majority of the families were nuclear (29), 8 families were multigenerational, 7 patients lived with only one parent, in 5 cases family was reconstructed.

Method

In order to answer the first research question concerning changes in functioning of the family between the first and the fourth family therapy session, the researchers decided to conduct, within the group of all researched subject (without specifying families), a significance analysis of differences between medians between Examination 1 (before the first session) and Examination 2 (before the fourth session) in 3 sub-scales of SCORE (“Strengths and adaptability”, “Overwhelmed by difficulties”, “Disrupted communication”), main SCORE scale and 3 additional scales (“How serious is the problem?”, “How do you cope as a family?”, “Do you think therapy will be/has been helpful?”). All results were based on Wilcoxon signed-rank test.

The second research question concerned the correlation between changes in functioning of the family as assessed by the family members themselves and how the therapist evaluates potential changes and the usefulness of the therapy for a given family. The attempt to examine such a correlation presented difficulties of methodological nature. Questionnaire’s question to a therapist concern their perception of changes in the therapy process and their evaluation of its usefulness. Thus, the assessment of changes in the process seems to constitute the basis for the answer. Taking the above into consideration, it seemed legitimate to create a “change of results” coefficient computed as the result of Examination 2 with SCORE-15 tool minus the result of Examination 1. Additionally, results of particular family members were averaged out within the family. This was a necessary adjustment as therapists in their scale referred to observed changes in a given family, not changes in functioning of particular family members. Next, Spearman’s rank correlation coefficient was calculated. Assumed level of significance $\alpha = 0.05$

Results

Table 4. Correlations between the individual subscales of the SCORE 15 questionnaire and the psychotherapist’s scale

A change in scale assessment made by family members		The usefulness of therapy for the families – therapist’s assessment	A change in family functioning – therapist’s assessment
Overwhelmed by difficulties	Correlation coefficient	0.347	
	Significance (two-tailed test)	0.016	
	N	48	
Disrupted communication	Correlation coefficient	0.487	
	Significance (two-tailed test)	0.000	
	N	48	

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Overall questionnaire score (Spearman's rho)	Correlation coefficient	0.425	-0.291
	Significance (two-tailed test)	0.003	0.045
	N	48	48

1. The change in SCORE results after three sessions: one significant score on additional scale – PROBLEM $p = 0.041$.

The research revealed statistically significant difference in the evaluation of the weight of the problem with which family members came to therapy between Examination 1 (before the first family therapy session) and Examination 2 (before the fourth session).

2. The correlation between the evaluation of changes as seen by the family members after 3 sessions and therapist's evaluation (correlation analysis):

- Change on "Overwhelmed by difficulties" scale x evaluation of "Usefulness of therapy" ($R = 0.347$; $p = 0.016$);
- Change on "Disrupted communication" scale x evaluation of "Usefulness of therapy" ($R = 0.487$; $p = 0.000$);
- Change in the overall SCORE-15 score x evaluation of "Usefulness of therapy" ($R = 0.425$, $p = 0.003$);

The study revealed statistically significant correlation between the change (between Examination 1 and Examination 2) averaged out for a family on the following scales: Overwhelmed by difficulties, Disrupted communication, and also between the total SCORE-15 score and how the therapist evaluates the usefulness of the therapy for a given family.

- Change in the overall SCORE-15 score x evaluation of "Change in functioning of a family" ($R = -0.291$, $p = 0.045$).

The results revealed statistically significant correlation between the change (between Examination 1 and Examination 2) in the overall SCORE-15 score averaged out for a family and how the therapist evaluates the change in functioning of a given family.

Discussion

The first obtained result implies that the perception of the problem with which a family comes to therapy undergoes significant change already in the first stage of therapy (after 3 family sessions). The problem is experienced as less severe and occupies less space in the experience of family members. This process seems to be related to getting support and creating frames and structure for the process of treatment. It should be remembered that the Family Therapy Outpatient Unit is a part of the Department of Adult, Child and Adolescent Psychiatry and provides therapy to families of adolescent patients diagnosed psychiatrically who often present acute symptoms. Therefore, in the first stage of therapy, it is important to examine the context of symptoms and how they are understood by family members as well as to establish meanings that are attributed to psychopathologies, examine the changes that symptoms introduced into the

life of the patients and their family and the ways they all cope with current difficulties. It seems that obtained results can be interpreted in relation to the efficiency of those therapeutic interventions whose objective is to decrease the sense of helplessness of the family, unburden it, decrease anxiety of particular family members, and give hope that difficulties can be overcome through treatment process. Sharing the sense of responsibility for solving problems with a therapist is an important aspect of this process. Families expect definite and ready-to-use tips how to behave and what to do and therapists struggle to find balance between trying to meet those expectations and activating the family's resources. It should be noted that similar results were obtained by Stratton's team [5] that based their conclusions on data from 584 people representing 239 families. Stratton's research showed statistically significant improvement in the perception of functioning of the family between the first and the fourth session.

Remaining results point to a strong coherence between the judgment formulated by a therapist that concerns the efficiency of therapy and changes occurring in a given family, and how a given family experiences the problem with which they came to therapy. Positive evaluation of the therapy process is accompanied by a diminishing feeling of being overwhelmed by difficulties for all family members and improvement of intra-family communication and overall functioning of the family. Considering the character of the analysis – correlation – the observed relation is two-way. The results may cautiously imply that therapy process is a process of negotiating meanings. The key question, thus, seems to be whether within the time span of 3 therapeutic meetings, families arrive at changes in communication and their functioning (changes in relationships, coping with difficulties and overall functioning of the family) or rather whether families reconstruct given meanings together with the therapist. The lack of significant changes in the results on the main scales of the questionnaire ("Strengths and adaptability", "Overwhelmed by difficulties", "Disrupted communication") suggests that at this stage of therapy the latter is the most probable process. These results highlight, albeit indirectly, the significance of the therapeutic alliance, of which the process of agreeing objectives and meanings as well as efficiency in supporting the family are the important elements.

Summary

The results obtained with SCORE-15 are very promising:

1. They indicate that this tool allows for capturing changes occurring in the first phase of the systemic family therapy and couple therapy;
2. They show that already first three sessions of family therapy introduce a positive change that diminishes the sense of difficulties and being overwhelmed by problems and symptoms that a given family comes to therapy with;
3. They reveal consistency between how the psychotherapist perceives therapy process and how it is perceived by the family.

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