Detecting therapeutic improvement early in therapy: validation of the SCORE-15 index of family functioning and change

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The SCORE index of family functioning and change is an established measure, with strong psychometric properties, of the quality of family life. We report the sensitivity to therapeutic change of the short form, the SCORE-15. Data are reported from 584 participants aged above 11 years, representing 239 families. All couples and families had been referred for systemic couples and family therapy, completing the form at start of the first session and close to the fourth. The SCORE-15 is shown to be acceptable with strong consistency and reliability. Change over only three sessions was highly statistically significant. Further validation is provided by improvements in quantified scores correlating significantly with independent measures provided by family members and by their therapists. The SCORE-15 is a proven measure of therapy and of therapeutic change in family functioning. It is therefore a routinely usable tool applicable to service evaluation, quality improvement, and to support clinical practice.

Practitioner Points

• The SCORE provides practitioners with brief descriptions of varied aspects of family interaction that have proven significance for many families who present for therapy.
• SCORE-15 can be used with confidence to monitor and report proven indicators of progress in systemic therapy.
• Because SCORE identifies clinically significant issues of family interaction it has many potential uses in therapy.
• There are many new possibilities for therapists to undertake collaborative research.

Keywords: SCORE; outcome; validity; family functioning; systemic psychotherapy.

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Introduction

Commissioning decisions are increasingly reliant on demonstrating the effectiveness of therapies and the possibility of ongoing monitoring of outcome. In the UK, both the Child and Adolescent Mental Health Services Outcomes Research Consortium (CORC) and the children and young persons component of the improving access to psychotherapy (CYP-IAPT) are committed to measuring the outcomes of therapy. The movement to payment by results presumes that results can be efficiently assessed though the whole issue of social cost-benefit analysis is coming under intensive scrutiny (Fujiwara and Campbell, 2011). In the USA a parallel development is of value-based purchasing (Jordan et al. 2012). However, the psychotherapy measures currently recommended are all primarily directed to an assumption of psychopathology in the individual. In family therapy, research has been hampered by a complete lack of consistency in measures used (Sanderson et al. 2009; Stratton et al., ‘Couples and family therapy in the previous decade – what is the state of the evidence’ submitted). Currently, two new measures are being proposed: the systemic therapy indicator of change (Pinsof et al., 2009) and the SCORE measure of family functioning and therapeutic change. The SCORE measure has been shown to have strong psychometric derivation and ‘is an effective indicator of family functioning, and aims to be sensitive to the kinds of change to which SFCT is directed’ (Stratton et al., 2010, p. 253). This article reports an investigation into its effectiveness in indicating change at an early stage of systemic couple and family therapy and reviews its overall validity.

The initial development of the SCORE index was influenced by theory, clinical experience and research. The SCORE approach starts from the systemic belief that the ways that relationships operate in the family are central to the welfare of all family members. There is a range of systemic approaches and each has a different emphasis. Some

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are more likely to highlight the ways in which dysfunctional family processes lead to psychological problems while others focus on the impact of problems on families or the role of positive and supportive family processes in supporting therapeutic change. We concluded that indicators of the quality of family functioning would reflect the most important achievements of a family therapy, going beyond possibly transient symptom improvement to changes in the ways that people relate. Within systemic therapy this has been conceptualized as a shift from first order to second order change (Watzlawick et al., 1974; Fraser and Solovey, 2007). The measure would have most value if it could be provided by as many family members as possible and the items were designed to ask about concrete indications of family functioning that were widely applicable to the great range of family social and cultural contexts, family compositions and conditions, and concerns that are encountered in family therapy clinics.

The process of constructing the available versions of SCORE has been comprehensively described by Stratton et al. (2010) and Cahill et al. (2010). From this intensive process of cycling between the psychometric validation of each item and informed clinical judgement of the cross-cultural applicability and therapeutic relevance of the items, the SCORE-15 has emerged as the most practicable version for clinical use. The SCORE-15 index of family functioning and change was derived from data generated by the forty-item version of SCORE (Stratton et al., 2010).

Aspects of validity of the SCORE-15

Historically, different forms of validity have been distinguished and each has value. However, Messick (1995) has successfully argued that they should all be seen as aspects of an overarching assessment of the validity of a test or measure. Consistent with Messick’s approach this article presents an assessment of the overall validity of the SCORE but offers new research relevant to its functionality as an indicator of therapeutic change. The report of the original SCORE-40 and the derivation of the SCORE-15 (Stratton et al., 2010) amounted to the empirical base for claiming their construct validity. The processes of formulating and testing the self-report questionnaires provided a strong basis for claiming that they in fact measure what they claim to measure: the quality of family functioning. One of the criteria for selecting the fifteen items was whether they had been given a higher average score in the clinical sample
than in a non-clinical sample. The items were also judged by a panel of clinicians to describe less good interactions when scored more highly. A higher score is therefore taken as indicative of more problematic family functioning.

Convergent validity of SCORE items was demonstrated by Cahill et al. (2010) when a twenty-eight-item version derived from the original SCORE-40 was found to correlate with established measures of family functioning. More recently, Fay et al. (2013) reported a telephone survey in Ireland using a twenty-nine-item version that includes all the items from the SCORE-15. The SCORE-15 totals extracted from the twenty-nine items correlated significantly ($P < 0.01$) with all of the family and parenting measures applied concurrently: the McMaster family assessment device, the Kansas marital satisfaction scale, the Kansas parenting satisfaction scale, the five-item mental health inventory, the strengths and difficulties questionnaire and the satisfaction with life scale. In all comparisons a lower total on SCORE-15 correlated positively with more favourable scores on the other measures.

The next phase of research, reported here, has been to apply the clinically practicable fifteen-item version in a range of therapeutic contexts to determine whether it shows significant change over the early stages of systemic family therapy and relates meaningfully to other indicators of therapeutic progress. So our concern in the research reported here has been to determine its validity as an indicator of therapeutic change. A definitive indicator of criterion validity is not available to us. The SCORE has been deliberately designed to correspond to systemic therapy practice in which a great variety of families with an equally varied set of concerns present for therapy. We need an outcome measure that can be applied to the full variety of therapeutic objectives that unfold in the process of working systematically with each unique family, couple or individual. Therefore, an evaluation of SCORE by how well it correlates with a definitive measure of a ‘cure’ for a diagnosed condition is not available. In this research we have approached criterion validity in three ways: (i) whether SCORE totals correlate with independent judgements by the family of their level of difficulty and degree of change during therapy; (ii) whether changes in SCORE over sessions early in therapy correlate with therapists’ judgements about therapeutic progress; (iii) perhaps rather presumptuously, whether SCORE indicates an improvement in families early in therapy. The justification for this last test relies on a belief that standard systemic family and couples
therapy generally achieves positive change in families early in therapy. Fortunately, the evidence supports this claim (Stratton, 2011).

**Method**

In the first stage of the development of the SCORE-15 it was shown that it could be used as a coherent indicator of family functioning. For this next part of the study service users of family and couple therapy aged 12 years or over were asked to complete the SCORE-15 at the first session and again at the fourth session (or, at the discretion of the therapist at session five or six). These paired measures were then analysed to assess the sensitivity of the measure to change in a clinical setting. Family members who agreed to participate were asked to complete the fifteen items together with questions asking their view of the main challenges to the family, how well they were dealing with these and their view of the usefulness of family therapy. They were also asked open questions inviting them to describe their family qualitatively.

Taking the follow-up measure at the start of the fourth session meant that families had received only three sessions of therapy. We recognized that this placed a tough requirement on systemic therapy to produce measurable change in such a short time but made the decision for the following reasons:

1. It provides a long enough gap to avoid carry over from its administration at the first session.
2. It captures data from a range of therapies when we know that some complete in four to six sessions.
3. It reduces the risk that therapists would forget to administer the questionnaire at the follow-up session.
4. It allows the change indication to come at a time within the range that Lambert and Vermeersch (2008) and others have shown to be predictive of the outcome of therapy.
5. It complies with the ethical consideration of finding out as soon as possible whether it is justified to ask therapists and clients to spend clinic time on completing the SCORE.

The study received UK ethical approval both nationally and locally. Families were included from a range of adult and child and adolescent mental health services by recruiting a lead clinician for each participating service who applied for local ethics approval and ran the project locally, ensuring that it followed the protocol for this stage of
the study. Families who were about to engage in systemic family therapy were recruited. A number of services had been involved in the previous stage of the SCORE project and others were recruited through notices in Context (the Association for Family Therapy publication) and as a result of conference presentations. Efforts were made to recruit from different parts of the UK and across different services. Clinicians were asked to approach all families coming to their service to ensure that the sample was representative of a usual clinical population and that cases were consecutive rather than selected by the therapist. The families were given written information on the project and, if they agreed to take part in the study, asked to complete a consent form. They were asked to complete the measure before their first session and again before the fourth or next practicable session. Paired SCORE-15 measures were coded and sent in an anonymous form to the SCORE administrator. The lead clinician locally kept the record of codes and names. These paired measures constituted the data. At this point a younger child version of SCORE had not been developed so only family members over the age of 11 years were asked to complete measures. In the case of young people between the age of 12 and 16 years the permission of the parent was also sought. The measures were completed individually and privately.

At the follow-up session the therapists rated their own perception of change in the family on a four-point scale and made a judgment about the helpfulness of the therapy. The therapists did not see the family’s responses on the SCORE questionnaire before completing these items. The aim was to recruit a minimum of 200 families and for the analysis there were data from 239 families (584 individual participants).

**Analytic procedures**

The data were entered into R version 2.15.1 (http://www.r-project.org/) and SPSS 20 and checked for out of range or miscoded items. Missing data are reported and analyses of internal reliability use only fully complete questionnaires. For total scores, up to one missing SCORE-15 item per questionnaire was pro-rated, that is, the mean score across the remaining fourteen items was used. Change is reported as initial score minus second score, so positive values for change indicate improvement.

All analyses were planned in advance (pre hoc) but our aim was mainly exploratory and descriptive: analysing effects and their
strength and the precision with which the data estimate them, rather than focusing on binary inferential tests. Wherever possible 95% confidence intervals of estimates are reported. Family therapy data are challenging statistically for two reasons. Firstly, the distributions of scores are not strictly Gaussian; more crucially, they do not have ‘independence of observations’ but contain many scores that are nested within families as multiple members of the same family rate that family. In statistical jargon these are multilevel data in which the family is a random effect.

To test whether the findings were robust to these challenges, multiple analyses were conducted. The simplest analyses were familiar parametric analyses (paired t-tests of change) that ignore nesting and assume Gaussian distributions. These are reported alongside non-parametric tests that do not assume Gaussian distributions but ignore nesting; likewise bootstrap analyses for the 95% confidence interval of estimates. As well as simple analyses of all participants’ data, results are also reported for mean scores in each family and across 2000 simulated datasets in which one participant’s data only are selected per family. Both these methods remove nesting but lose information. The analyses of the family mean scores are a summary of the family’s collective view but ignoring differences within the family. The simulated selections within the families provide some indication of how much variance that disagreement holds. Finally, parametric multilevel analyses are reported that take into account nesting and retain all information but do assume Gaussian distributions. In only one analysis, the effect of gender on baseline scores (see below) did different methods give different findings.

As well as these group summary statistical analyses, Jacobson et al.’s reliable change paradigm (Jacobson and Truax, 1991) is used to explore which individuals and which families, showed reliable change over the four sessions. This approach, widely used in psychotherapy outcome research (Evans et al., 1998) depends on the reliable change index (RCI). The RCI is a value such that if change were just down to the unreliability of the measurement only 5% of the change would exceed this level (in line with the conventional $P = 0.05$ test of statistical significance). Change between two occasions more than the RCI is deemed reliable change, that is, it is unlikely to have happened due to chance. Reliable change can be reliable deterioration or reliable improvement. The RCI for a dataset is a function of the internal reliability and variance across the initial scores. All change in a dataset can be summarized with the percentages showing reliable change.
deterioration, no reliable change or reliable improvement and by showing all change for all the participants in a Jacobson plot (see Figure 1).

Results

Data came from 584 participants from 239 families. A total of 20 clinics distributed throughout the UK contributed data, mostly from child and adolescent mental health services but including some adult mental health and some private or training institutes with a mix of referrals. Gender was given by all with 348 (60%) being female. Age was missing for six participants and ranged from 11 to 84 years, with a mean of 38 years and a standard deviation of 15.92. The SCORE invites participants to specify their ethnicity. In the group of greatest interest, the 247 who completed the SCORE at both the first and follow-up sessions, 81% of participants chose British or white British (with one Anglo-Saxon); 9% chose white non-British; 4% chose African or Afro-Caribbean; 3% chose Asian and 3% chose mixed. We are not able to report the family origins of the thirty-five participants who reported themselves as British. Education ranged from none or not much (seven cases) to PhD but thirty-six chose not to specify their educational level. The number of participants per family ranged from one to six. The participants were asked to describe their household size, which revealed some disagreements, to be expected where members may be living apart or in conflict; sizes ranged from one to seven with mean 3.6 and median of four.

Our first question was whether the SCORE-15 would prove acceptable in routine practice: how many participants would omit items and how many would have usable questionnaires? On the first occasion 579

Figure 1. Jacobson reliable change index plot of 247 repeat administrations of SCORE-15 between second and initial scores (all).
family members undertook the SCORE, of whom 517 (89%) completed all items and forty-one omitted only one, so 556 (95%) gave usable questionnaires. Data from the second occasion were available for 267 (46% of the total). Of these, 237 (89%) omitted no items and twenty-five omitted only one, so 262 (99%) gave usable questionnaires.

The next question was whether the SCORE-15 would show the same very respectable internal reliability in the stand-alone format as its items had in the SCORE-40 (Cronbach alpha .89). Across the 515 with complete baseline item data the Cronbach alpha was again .89 (95% confidence intervals from .87 to .90) and was the same to the 2\textsuperscript{nd} decimal place when the mean scores for each of the 239 families were used, and across the 2000 replications in which one participant was randomly selected from each family the mean alpha was .88 (observed 95% coverage from .86 to .89). Principal components analysis attributed 38.18\% of variance to the first factor and 10.12\% to the second, with only two factors having an eigenvalue >1. All questions loaded onto the first factor, the weakest (‘People often don’t tell each other the truth in my family’) loading .477 and the strongest (‘It feels miserable in our family’) .723. We conclude that it is legitimate to report total and average scores weighting all items equally.

Those findings suggest that the items of the SCORE-15 behave as well psychometrically as they did in the SCORE-40. The next and crucial question was whether the SCORE-15 was sensitive to change. A total of 247 people had usable data on both occasions and the initial scores ranged from 1.7 to 4.6 with a mean of 2.626 and a median of 2.67. On the second occasion the range was from 1.8 to 4.2 with a mean of 2.504 and a median of 2.53.

The scores did deviate from Gaussian distribution (Shapiro-Wilk test \(P < 0.0005\) for both initial and second scores and 0.01 for the change scores). As noted above, this combination of non-Gaussian distributions and non-independence of observations invites multiple analyses and we should only accept that the measure is sensitive if all analyses concur that change is unlikely to have been due to chance. A Wilcoxon test is non-parametric so is not affected by the non-Gaussian distributions but it does assume independence of observations and gave \(V = 16488, P = 0.0024\). A simple paired \(t\)-test gave \(t(246) = 3.485, P = 0.0008\). The simple mean shift was 0.12, with bootstrap 95\% confidence interval was 0.06 to 0.19. A multilevel, mixed effects analysis of variance is vulnerable to non-Gaussian distributions but handles nesting within families robustly. This showed a mean change of .304 with a standard error of .04 and 95\% confidence intervals
for change from 0.05 to 0.22, giving $t(126)= 3.33$, $P = 0.001$. In summary, all analyses show that the SCORE-15 recorded a highly statistically significant reduction, indicating improvement between the two occasions.

So there is a statistical group change, but what about the clinically important question: how many individuals (and families) show reliable change? The RCI was .68, based on the Cronbach alpha and the initial standard deviation of scores. For the 247 participants with usable SCORE-15 questionnaires from the initial and the second occasion fourteen (5.7%) showed reliable deterioration, 201 (81.4%) showed no reliable change and thirty-two (13.0%) showed reliable improvement. The latter percentage (13%) is markedly more than the expected 2.5%, showing the SCORE-15 does detect clinically interesting reliable change.

Points within the grey tramlines in Figure 1 on either side of the no-change line are participants whose scores changed less than the RCI of .68, that is, who do not show reliable change over this fairly short interval. Those above the grey tramlines showed reliable deterioration and those below showed reliable improvement.

It is important to test validity but, as discussed in the introduction, there are no gold standard measures against which to compare it. The data provided by these family members and their therapists do, however, allow several indicators of validity. In addition to its fifteen conventional nomothetic items, SCORE-15 asks each person to describe the main family problem and then asks ‘how severe is it?’ with answers given by marking a 10-cm visual analogue scale (VAS) anchored between no problem at all and really bad. It also asks ‘how are you managing as a family?’ with a similar VAS anchored between very well and very badly and finally ‘Do you think the therapy here has been helpful?’ with VAS anchored between very helpful and unhelpful. One would expect answers on these questions to show a convergent correlation with the SCORE-15 scores. The initial question ‘How severe?’ correlates .26 with the initial SCORE-15 scores and ‘How are you managing?’, which is reverse scored, correlates .44 with those scores, both significant at $P < 0.0005$ (Spearman rho, ignoring the multilevel nature of the data). On the second occasion these correlations are .32 and .56, respectively, and the correlation of ‘Do you think the therapy here has been helpful?’ with change is -.2 (negative sign as expected), $P = 0.002$. The mixed effects regressions were also all statistically significant, respectively, $P < 0.0005$, $P < 0.0005$ and $P = 0.004$. So all these show convergent validity for the SCORE-15.
In addition, therapists were asked ‘Do you think the therapy here has been helpful for the family?’ rated on a VAS between very helpful and unhelpful. This rating correlated with SCORE-15 at the second session (rho = .33, \( P < 0.001 \)) but non-significantly with the corresponding rating from the participants of the helpfulness of therapy (rho = .16, \( P = 0.062 \)) and not with the change of the participants’ SCORE-15 (rho = -.12, \( P = 0.15 \)). They were also asked ‘Compared to the first session would you describe the family as: 1 = having more difficulties, 2 = much the same, 3 = improved, 4 = greatly improved’. This therapists’ rating correlated significantly, if weakly, with the participants’ rating of the helpfulness of therapy (rho = .17, \( P = 0.048 \)), while correlating significantly with SCORE-15 change (rho = .25, \( P = 0.003 \)).

Finally, we checked simple divergent validity. We would not expect scores to be much influenced by age, index patient status or gender. Age showed no statistically significant relationship with initial or second scores or change and the same was true for index patient status, even in the multilevel analysis taking into account nesting within families. Gender showed no simple effects but the multilevel analysis showed a marginally significant effect (\( P = 0.0458 \)) with men scoring the families .13 lower than the women (95% confidence interval from .003 to .26).

**Discussion and implications**

The results, based on a sample of 239 families and 584 participants, provide robust and compelling evidence to support the use of SCORE-15 as a reliable, valid instrument that is sensitive to change over brief therapeutic interventions. SCORE-15 showed a highly statistically significant improvement between the first and the follow-up session, which was usually at the start of the fourth session, that is, after the family had experienced three sessions.

The main implication of the findings is that SCORE-15 (which takes only 10 minutes to complete) can easily and justifiably be used in diverse clinical settings. SCORE-15 is proven to be a valuable, acceptable to clients and therapists and easy to use tool to create evidence across a range of agency settings for the early effectiveness of systemic family and couples interventions. SCORE-15 correlated with the various measures that participants provided independently of the SCORE items. The fact that the weakest relationship was with their judgement about the usefulness of the therapy is consistent with a
common claim by therapists that clients often do not attribute improvements to the therapy. It could also be seen as consistent with the claims that external factors are more influential than therapy (Wampold, 2001). However, therapists may feel that change that is achieved in three sessions is unlikely to be largely due to unconnected external events.

A total of 19% of the sample showed reliable change, as indicated by the RCI, with more than twice as many participants improving as deteriorating. It is, however, important that a measure should be sensitive to possible deterioration early in therapy and the 6% whose SCORE changed for the worse indicates that the SCORE may be effective in this direction as well. An interesting finding that emerged was that although there was a significant association between the change in the SCORE and the therapists’ judgment that the family had improved and was having fewer difficulties, this was not the case for whether clinicians thought that the therapy had been helpful. This could have been for a number of different reasons. Consistent with previous research (see for example Helmeke and Sprenkle, 2000), clinicians’ and clients’ ideas about significant change may be radically different. The word helpful is used quite loosely and could mean different things to different systemic psychotherapists, making it difficult to rate. The reader is invited to hypothesize about other reasons for this discrepancy.

With regard to intra-family differences in perception, it emerged that gender was found to have a marginally significant effect, with men scoring their families lower (better) than women. We wondered whether this was a finding that fitted well with clinical observation and that could influence our understanding of the way in which men and women may view family functioning and therapeutic change differently.

**Limitations of the study**

This study set out to discover whether SCORE-15 would show significant change over the early stages of family therapy. Although the data amply showed statistically significant improvement between the two occasions, only 13% of the sample showed reliable improvement between the two sessions. While this figure is high enough to indicate that clinical change occurred, it does raise the question of why more of the families did not demonstrate improvement. Perhaps this has to do with the fact that SCORE was administered at the beginning of
the first session and the fourth session. It will be necessary to see whether change is more substantial after 6 months and at the end of therapy.

Another potential limitation is the way in which the sample was built up through services and psychotherapists opting to take part in the study. The sample was across the life cycle and diverse in terms of age, ethnicity, education and occupation. It is likely to be representative of clinical populations in the National Health Service but we did not request referral information or diagnosis by the therapist. It is also possible that the psychotherapists taking part in the project represented those who were more positive about outcome measures and perhaps more experienced. In this part of the study we did not collect data from other measures (for example measures of symptom improvement) and this would be a helpful next stage to the research. Service users were involved in the initial development of SCORE (Stratton et al., 2010) and should now be included in planning future research and clinical applications of SCORE-15.

**Further directions**

This initial study has yielded rich data and points to a number of areas for further exploration and research, some of which are already under way. Firstly, as this phase of the study was carried out on a clinical population, the next phase will examine a non-clinical population to see whether SCORE-15 can distinguish between clinical and non-clinical groups. Secondly, how do these findings transfer across culture and class? As SCORE has already been translated into a number of different languages, we have started researching whether its translations are equally sensitive to registering clinical change. Thirdly, as suggested earlier, SCORE-15 could be used to measure whether there would be greater change when it is used in the sixth and final sessions of family therapy and at subsequent follow up. Fourthly, we have started analysing families’ descriptions of themselves and seeing how these change over the course of therapy. Finally, it will be useful to extend the age range downwards, and a version for children aged 8 to 11 years has been created and tested (Jewell et al., ‘Development of a children’s version of the SCORE index of family function and change’, submitted). Clinicians may want to explore therapists’ scales and clients’ ratings and look closely at how their own perceptions of change fit with service users’ ideas of whether and in what ways their families have changed.
SCORE-15 has been adopted by the UK advisory body, the CORC. Guidance on the practicalities of administering the SCORE-15 and on using outcome measures for service evaluation and to support the clinical process have been provided by SCORE users for the CORC website (http://www.corc.uk.net/resources/). Regular updates on SCORE developments including podcasts on SCORE-15 are posted on the Association for Family Therapy and Systemic Practice website (www.aft.org.uk/view/score.html). SCORE-15 is included as Appendix 1 and is free to use so that clinicians and researchers will join us in its further development.

Conclusion

The SCORE-15 has been shown to be sensitive to change early in systemic family and couples therapy. It meets all the criteria for a coherent measure and indicators of all aspects of validity have been shown to be positive. In accordance with Messick’s (1995) framework of overall validity deriving from a combination of all measurable aspects, we therefore claim that the SCORE-15 is a valid indicator of family functioning and change. The possibilities for the future use and exploration of the measure are exciting. We are interested to know how it operates on populations not yet studied (for example, families who have been impacted on by outside events such as illness, the loss of employment or migration). The way in which change on the SCORE measure relates to information gathered by other measures is also of great interest. We are in the process of developing clinical cut-off points and further exploring the way it performs with different cultural groups. Our hope is that clinicians will use the measure in their own work and research in order to increase the available datasets.

References


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**Appendix 1: The SCORE-15**

When administering SCORE-15 the definitive version available at www.aft.org.uk should be used.

**Site Code □□□ Family Number □□□ Family Position ....................**

*Describing your family (Date).................................*)
We would like you to tell us about how you see your family at the moment. So we are asking for YOUR view of your family.

When people say ‘your family’ they often mean the people who live in your house. But we want you to choose who you want to count as the family you are going to describe.

For each item, make your choice by putting ✓ in just one of the boxes numbered 1 to 5. If a statement was ‘We are always fighting each other’ and you felt this was not especially true of your family, you would put a tick in box 4 for ‘Describes us: not well’.

Do not think for too long about any question, but do try to tick one of the boxes for each question.

<table>
<thead>
<tr>
<th>For each line, would you say this describes our family:</th>
<th>Describes us:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In my family we talk to each other about things which matter to us</td>
<td>1. Very well</td>
</tr>
<tr>
<td>2. People often don’t tell each other the truth in my family</td>
<td></td>
</tr>
<tr>
<td>3. Each of us gets listened to in our family</td>
<td></td>
</tr>
<tr>
<td>4. It feels risky to disagree in our family</td>
<td></td>
</tr>
<tr>
<td>5. We find it hard to deal with everyday problems</td>
<td></td>
</tr>
<tr>
<td>6. We trust each other</td>
<td></td>
</tr>
<tr>
<td>7. It feels miserable in our family</td>
<td></td>
</tr>
<tr>
<td>8. When people in my family get angry they ignore each other on purpose</td>
<td></td>
</tr>
<tr>
<td>9. We seem to go from one crisis to another in my family</td>
<td></td>
</tr>
<tr>
<td>10. When one of us is upset they get looked after within the family</td>
<td></td>
</tr>
<tr>
<td>11. Things always seem to go wrong for my family</td>
<td></td>
</tr>
<tr>
<td>12. People in the family are nasty to each other</td>
<td></td>
</tr>
<tr>
<td>13. People in my family interfere too much in each other’s lives</td>
<td></td>
</tr>
<tr>
<td>14. In my family we blame each other when things go wrong</td>
<td></td>
</tr>
<tr>
<td>15. We are good at finding new ways to deal with things that are difficult</td>
<td></td>
</tr>
</tbody>
</table>

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Now please turn over and tell us a bit more about your family. What words would best describe your family?

What is the problem/challenge that brought you to therapy? The main problem is...

How severe is it? Please mark your answer on the line below:

<table>
<thead>
<tr>
<th>no problem at all</th>
<th>really bad</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>

How are you managing as a family?

<table>
<thead>
<tr>
<th>Very well</th>
<th>very badly</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>

Do you think the therapy here will be / has been helpful?

<table>
<thead>
<tr>
<th>Very helpful</th>
<th>unhelpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>

Some basic information about you:

Age
Gender
Ethnicity
Education achieved
Main occupation
People living in your household (type, such as ‘daughter age 12’, no names please).

THANK YOU FOR YOUR TIME