SCORE-15

Using the SCORE-15 Index of Family Functioning and Change.

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The SCORE-15 is one of a group of self-report measures of family processes derived from the original SCORE-40 (Stratton et al, 2010). These measures are designed to indicate aspects of family life and relationships that are relevant to therapy and for therapeutic change.

The SCORE-15 has 15 Likert scale items, and six separate indicators, three of them qualitative, plus demographic information. It records perceptions of the family from each member over the age of 11 years. A version for younger children (8 -11 years) is now available and translated versions are being developed and tested. Alternative versions suitable for administration at consecutive sessions are in preparation.

The SCORE-15 was created through a data-driven process integrating psychometrics with clinical judgment. It is designed to enable family members to report on aspects of their interactions which have clinical significance and are likely to be relevant to therapeutic processes. Extensive consultations with therapists, service users and researchers were undertaken to obtain simple and unambiguous items that would be meaningful to families from a wide variety of cultural, ethnic and socioeconomic backgrounds.

Use within CORC (CAMHS Outcomes Research Consortium) is expected to follow standard CORC protocol. The main difference from the validation study protocol (Stratton et al, 2013) is that that study, funded through the Association for Family Therapy and a research grant from South London and Maudsley Trust (SLAM), specified the first follow-up at the fourth session whereas CORC specifies a 6 month follow-up.

SCORE will be a helpful complement to CORC measures which focus on the individual child or a parent. It will be of obvious value where there is any element of intervention with, or support of, the family system or subsystems and provides both an indication of difficulties and of change in the family. Furthermore, it can highlight differences between family members in their views of the family.

We have now completed the phase to test whether it is valid as a measure of therapeutic change. The 15 item version (SCORE-15) was administered to 584 individual family members at the start of therapy. A sample of 239 participants provided data at first and fourth therapy sessions. Consistently statistically significant change ($p<.001$) was found in the overall score using a variety of statistical analyses. Amount of change correlated with therapist judgement and independent rating

by family members of their problems (Stratton et al, 2013). SCORE-15 is now offered as a comprehensively validated measure.

We are proceeding with recruiting a non-clinical sample to establish norms, and analysing the descriptive data provided by family members on the forms. We have verbatim descriptions of close relationships and of the clients' description of the problems they want help with, which we have grouped according to the quantification of the kind of relationship difficulty. Then, the descriptive accounts are used to identify salient items in the quantitative record.

We conclude that SCORE is an effective indicator of close relationships and of change at an early stage of systemic therapy.

Relationships with other measures
SCORE does not duplicate any child focused individual measures recommended by CORC nor will it clash with them in any way. It offers the crucial addition of ratings of the family for overall scoring and differences. This fills a gap in the coverage offered by individual focused measures, when problems and/or interventions and recovery are linked to the family not just the individual child.

Administration of the SCORE-15

The SCORE is appropriate for use with individuals, couples, families and multi-family groups when the operation of relationships within the family is relevant.

The current validation study, funded by South London and Maudsley NHS Trust and the Association for Family Therapy, can provide a detailed protocol. For participation in our projects or to obtain the more extensive background information for CORC purposes, please contact Peter Stratton at p.m.stratton@ntlworld.com

The SCORE-15 should be administered to each family member individually at or just before the start of the relevant sessions. Arrangements should be made so that each person fills it in privately and their completed SCORE is not seen by other family members. It is usually presented by the therapist at the start of the session but could also be completed before the session begins, presented by another member of the therapeutic team, a researcher, or an appropriately trained administrator.

Help can be offered for people who have difficulty with the written text but the items themselves should not be elaborated. For CORC, the SCORE should be administered at the start of the first session, a session at six months and the final session (see 'information sheet on when time 1 and time 2 should be' on the CORC website).

Practicalities of administration

A more general discussion of issues in administering measures is provided in the AFT Family Therapy Outcomes Advisory Group's document, Administering Measures To Families – (http://www.aft.org.uk/SpringboardWebApp/userfiles/aft/file/SCORE%20info/Administering%20measures%20to%20families%20Oct13.pdf)

Systemic family psychotherapists recognise that different cultures and groups have different ideas of what 'family' means. We take 'family' to describe any group of people who care about each other

and define themselves as such. As well as parents and children of all ages, we may work with grandparents, siblings, uncles and aunts, cousins, friends, carers, other professionals– whoever people identify as important to their lives.

The SCORE questionnaires orient respondents towards thinking of their household but then invites them to choose who they want to include. Based on our clinical experience of using SCORE-15, you may find it useful for each family member to list, in the empty space just below "For each line, would you say this describes our family", the constellation of family they are thinking of when answering the 15 questions:

"Before you start, it might be helpful if you could list down who in your family you are thinking of when answering the questions. For example, Ann (mother) you may be thinking of yourself, your partner Marie and Jack (son), while Jack you may include your mother and your biological father. It is totally fine each of you include or exclude different people as we all define family in different ways. Writing it down will help you and me remember who you were thinking of at the end of the treatment when we compare the before and after. Who knows, you may be thinking of slightly different people before and after, for example, Jack you may end up including your dog and iPad at the end of treatment when answering it again!"

Here we offer some samples of ways to introduce the SCORE to family members. They are not intended as a fixed script, but as ideas from which you can construct your own introductions, adapted to the family and your relationship with them.

1st Meeting

Therapist

In agreeing to work together to see if we/I can be helpful to you and your family it might be helpful to have a think about how you see things within your family at the moment. To help us to do this we have a short questionnaire which gives everyone an opportunity to rate how you think things are going at the moment for your family. If it is OK with you we will spend the first part of today's meeting having a look at these questions and giving you all an opportunity to individually rate your answers about how you see things. Families usually find it is best for each person in the family to complete these on their own and I will be here to help you if you have any questions about the form. So it is probably best if you don't discuss it yet, but just each give us your first thoughts on the form.

When you have all completed the form we can decide together whether or not you want to share your answers or just let me/us see them to help me/us think about how I/we might be most helpful to you. There are no right or wrong answers, however completing the form will help us think about what areas we might want to focus on together. It will also give us a chance in a few weeks' time to perhaps revisit the form and see what, if anything, has changed and to view how things are going together. Here is a pen and a form for each of you and as we/I said we/I will be here if you want to ask me anything about the questions.

SCORE 2

6TH OR LATER, AND REVIEW MEETING

Therapist

Do you remember that form we filled in when we began work together four or five meetings ago called SCORE? I/we thought it might be helpful to review where we are at now and think about what, if anything, has changed for you all as a family. To help us with this I/we thought we might fill in the form again to see what changes have occurred and to see if things are the same, better or worse. This will then help us think about how I/we might be most helpful if we decide to continue meeting together. As before, it would be helpful if you complete them individually and I/we will be here again to help you with any of the questions if anything is unclear. When everyone has filled in their form we can decide together whether we should keep them privately or if you would like to share them as a family as we plan for the future.

SCORE 3

FINAL SESSION

Therapist

In agreeing to end our work together (/ as it looks as if we may be coming towards ending our work together) I/we thought it might be helpful to complete the SCORE form one last time to see what has changed and to help you as a family think about anything you might want to continue to change in the future beyond our meetings together. Again it would be helpful if everyone could complete a form individually and we can then decide whether or not to share the answers or keep them private. It will also be very helpful for me/us to think about what has been helpful and what we might do similarly or differently in our work with families in the future.

Some suggestions for clinical use

Before introducing SCORE, make all of your decisions about whether and how the information acquired from the family will be used clinically. In some contexts you may guarantee privacy so that family members will not know each other's ratings. But this offer will severely limit the open discussion of tendencies and differences in family ratings. Usually, clinical usefulness will over-ride 'purity' of the data.

"Ann (mother), you rated 'well' for item 6 'we trust each other' and Jack (son) you rated 'not at all' for the same item. Could you help each other understand what trust means to you that could be so different? What particular event could you think of that might help us understand how differently you see this?"

"I know Chris (brother) is not here with us today. What do you, Ann (mother) and Jack (son), think he would rate item 11 'things always seem to go wrong for my family'? What do you think he observes between you that he based his rating on?"

"If you were to answer SCORE-15 in six months' time, what would be one thing that you hope to

see yourself and other family members give a better rating? How would things be like in your family then for you to be able to rate it that way?"

"It's amazing to see that all of you rated item 15 'we are good at finding new ways to deal with things that are difficult' rather highly even though you have been arguing a lot in sessions. I wonder if my presence or involvement make a difference to your interaction? What are some new ways you have found as a family outside of sessions that you could remember?"

"What words would best describe a family like yours where most family members rate item 9 on crisis to be high and item 5 finding it easy to deal with everyday problems?"

"Jack, you found it hard to answer item 3 'each of us gets listened to in our family' as some of you do and some don't, so in the end you rated it as 'partly'. Could you help your family understand more what you have noticed so far about these differences?"

Discussing the results and using them to inform therapy - working with complexity

Time to provide therapy is often limited by the session (1/2 day) employment practices of the NHS and other agencies. We tend to split things into half days whether with staff who are paid or those who are on honorary contracts. Additionally demand for the limited resources of therapy staff and rooms leads to the (i) pre session, (ii) session and (iii) post session consideration being divided something like (i) 25 minutes, (ii) one hour and (iii) 15 minutes. Under these constraints, the therapist's time may be used for being with the family when they fill in the SCORE or she may wish to spend the time preparing for the session. But if the therapist can take the completed SCORE into the pre-session, the therapy may more easily integrate both the written and the spoken words. That is, the hypothesising before the session can be enriched by looking at the SCORE.

For example, an issue of race was written about very briefly in the ('What is the problem/ challenge' section at the top of SCORE 15 side 2) by a parent of an African/Caribbean/white mixed race 12-year-old girl. This enabled the therapist to hear conversation during the session, may be ten - fifteen minutes later, with this comment (written) in mind. So when she heard about hair care for the girl, there was an opportunity to explore the stories behind this and connect it with the problem identified in the referral. It is possible that the hair care could have been left uncommented on if the SCORE hadn't been read beforehand and the connection with race not made.

Integrating the 'Maps' for Assessment, Reviews and Clinical Use

Clinical judgment over influencing factors such as developmental and cognitive abilities of persons answering the question, therapeutic alliance, confidentiality or safeguarding issues needs to be made on whether the written answers and discussions would be best conducted separately with individuals, or with a constellation of family members and/or professionals. The clinician could cross-reference the answers from other questionnaires with SCORE-15 and Current View, such as scores of depression in RCADS by the child/young person and parents could be compared with the severity rating of depression rated by various persons in the current view.

The assessment or reviews could either take a single focus or multi focus lenses that would capture

the background context (including silent concerns), that comes along with the referred child/ young person. This might include an additional component/element of the assessment or reviews, which would make visible the associated concerns that other family members bring forth at the assessment/ review stage that the clinician has to work with. This could be done by having each family member answering the Current View questionnaire as suggested above. This also reinforces the methodological position from which a systemic family therapist gets engaged.

Below are some examples of questions that could be asked to help integrate and clarify information collected from various outcome measures:

"I notice that your mother rated family relationship difficulties as mild while you rated it as severe in this Current View questionnaire. I also noted that your mother's rating of family strength in SCORE-15 is better at 2.0 than your rating at 3.4. What strengths in your family do you think she sees that you might not at this moment?"

"I'm struck by how similar the family and I see the father's depression as more severe than the behavioural difficulties of the child. Could you help us understand how you (social worker) see it, which is the other way round?"

"Mr. James (teacher), you rated Andy (identified patient) to be severe for depression, while Andy and his father rated it mild, which is consistent with the results their RCADS rating (show the summary tables of RCADS score). All of us, however, rated school problems to be severe and home mild, could you tell us more about what you observed about his mood in school which might be different when he is at home?"

Examples of how to make use of outcome information with families: restoring multiple perspectives and constructing stories about the wider system

A family with a 13-year-old white girl who had suicidal ideation and an Asian/ white mixed race 15-year-old boy with their white in-house parents were in their first session of therapy in CAMHS. The white half-sister of the boy had a chronic and serious anxiety problem. The therapist was getting rather preoccupied with the boy and when the therapist prompted himself with what was in the SCORE, that is thinking about the effect of relationships on problems, he moved to a more multi perspective way of working with the family. This meant that the mixed race boy was not the focus of the problem talk.

The SCORE can often provide a historical context when preparing to see a family. In the preparation time for the fourth session the therapist reviewed the SCORE filled in before the first session. This helped him to pick up on a remark (mention of a first name) of someone (in this case, an outreach worker) who was helping the 15-year-old boy. This then led to opportunities of more talk about helpful and unhelpful people for other members of the family.

Scoring and data recording

The SCORE-15 can be interpreted very quickly during the session or when writing up the session notes. The instructions that follow enable computation of the overall total and if wanted, the sub-totals for the SCORE's three dimensions.

A template excel document for scoring data from individual family members is available, along with a guide to its use (see http://www.aft.org.uk/view/score.html)

Scoring by hand

Calculating the total score

The SCORE-15 for each person who completes it can be calculated very simply by hand by working through the following instructions line by line. For the 15 Likert scale items (this method does not require reversing of scores for negative items):

Total all negative items – Qs 2+4+5+7+8+9+11+12+13+14 (with 'very well' as 1 and 'not at all' as 5)
Subtract this total from 60
Add the remainder to the total of positive items Qs 1+3+6+10+15
This gives a total score for each person. Divide by 15 for the average.

Scoring Dimensions
The SCORE generates three dimensions which can be calculated for more specific information. In each case the total is divided by 5 to give the average, and the lower the score, the higher the functioning

For Dimension 1, *Strengths and adaptability* As all of the questions are positive, simply add the scores (Qs 1+3+6+10+15).

For Dimension 2, *Overwhelmed by difficulties* add all the scores (Qs 5+7+9+11+14) and then subtract from 30, the remainder is the dimension score.

For Dimension 3, *Disrupted communication* add all the scores (Qs 2+4+8+12+13) and then subtract from 30, the remainder is the dimension score.

The qualitative items can be listed as text as Q16description and Q17problem
The three analogue scales are Severity of problem Q17rate_a
Managing as a family Q17rate_b
Helpfulness of therapy Q17rate_c

Recording Group data

Data from a series of cases should be recorded with unique identifiers of the clinic (the site code), and a code that uniquely identifies the family, followed by digits or labels for successive family members. So 'MAU008male partner' records the eighth Maudsley family data provided by the male partner.

To record data from a number of clients and to have the totals calculated automatically, please follow these instructions using the Excel spreadsheet. They are very detailed, so they can be used successfully by someone who has never used an Excel data sheet before. If you are familiar with

Excel you will be able to use the data entry sheet without having to work through these instructions in detail.

When submitting data it is important to provide any parallel measures that have been taken at the same time.

Excel data entry

The Excel file: SCORE-15 Data Entry has been set up to enter data at up to three points in therapy and calculate totals and averages within the spreadsheet.

Each line from top to bottom is numbered as a row. First row contains the titles of the columns. Many are abbreviated to fit but if you click on one the full title will appear in the slot above the sheet.

The second line is an example so that you can see the required format. Once you are entering your own data, please remember to delete this row.

Entering the data

Use one row for each respondent. In the first 4 columns enter their:
identifier age Gender Other

Identifier should be as filled in on their SCORE data sheet. 'other' is for one other item of information if needed but can be left blank.

You should enter the raw scores as they are ticked on the SCORE-15 form (some items are negatively phrased but that will be dealt with within the Excel calculations).

From the first page. Enter the fifteen ratings of 1 to 5 into 1talk1, 2-truth1 etc. The first number in the column heading is the number of the item; – (minus) indicates a negative item and the final 1 indicates that it is the first administration. So '2-truth 1' is the second item, which is negative (so scoring it as 'describes us very well' is not a good thing), this is the item 'people often do not tell each other the truth in my family', so is summarised as 'truth' and at this point under the column that Excel labels as 'F', is the first time of administering the SCORE to this person.

When entering the data, if someone fails to tick one of the items leave the space in the relevant column blank.

Once you have entered the fifteen ratings, enter as text what they have said as a description of their family, and what they say is their main problem. Next, enter the ratings 0-10 where they have put their X along the line. We would not usually bother with decimal points so put the nearest whole number. If it is halfway between 5 and 6 (say) then record it as a 6 (i.e. rounding up). There are three ratings: of severity of the problem, how they are managing as a family, and whether they think family therapy will be (/ has been at the second and later administration) helpful.
Then enter the demographic data.

Excel will now calculate the totals for each dimension, the total SCORE and the average SCORE. The three dimensions are: 1. Strengths and adaptability; 2. Overwhelmed by difficulties; and 3. Disrupted communication and each dimension is based on 5 of the items.

A rough idea of what the total and average scores mean

The total score could in theory be 15 if they rated every question absolutely positively and 75 if every question absolutely negatively. So the higher the total, the worse the person is rating their

family. On our first samples we found that families at the start of therapy averaged 39, and non-clinical families averaged 26. Looking at the average score for someone lets you relate their score to a position on the scale of 1 to 5 that they were using. If all questions were phrased positively, full agreement is positive and would score 1, while full negative ('not at all') would score 5. Excel converts them in this direction for you. An average of 2.67 (equivalent to a total of 40) would be just more than halfway from 'describes us well' to 'describes us partly'.

The dimensions range from 5 to 30. At the second administration, start entering the data at the column AH, labelled 1talk2 (the 1 as it is the first item, the 2 because it is the second administration) and continue as above.

Norms for an Irish non-clinical sample are available in Fay et al, (2013).

Data for second administration

After the calculations for time 2, it will then calculate the change from first to later session, with a positive score being the preferred change in each case, as it means the SCORE average has dropped. There is space to record the two therapist ratings (see "therapists scale"). The changes in the Page 2, 10 point ratings are then calculated.
The sheet is set up to record 30 cases. Each calculation can be extended for further cases by clicking on the final cell, hold the cursor on the + at bottom right of the cell and drag down for as many rows as you need.
When you have all your data, delete any unwanted rows and calculate averages for each column. It is difficult to include the necessary calculations within a blank spreadsheet (unless someone tells me how), so here is the procedure. It looks laborious but just follow it one instruction at a time and it will work like magic.

Calculating column averages

Done here for TOTAL SCORE, then you can follow the same procedure for other columns. I am demonstrating for 30 rows but you can do it for the number you have just by choosing the cell at the bottom of the column of data.
Click on the cell below your last data point and in column AF TOTAL SCORE. In our example that is row 33. (I've left an empty row to make it easy to see but it works whether you do or not)
On the top row of Excel instructions go from Home to Formulas (4th heading along)
On the next row click on the tiny arrowhead bottom of AutoSum (2nd item)That will open a dropdown list. Click on the second item 'Average'.Excel will now put =AVERAGE(AF2:AF32) above the spreadsheet to tell you what it is doing, and calculate this average into the cell you have chosen – column AF, row 33 in this example.

Statistical calculations such as the significance of any change, correlations between different measures can be carried out in Excel or the data can be read in by PASW (SPSS) for analysing there. An SPSS file and syntax are available on request.

Good luck, and please feedback suggestions for improving this process to Peter Stratton p.m.stratton@ntlworld.com

For further detail see References below.

Current updates, templates and resources are available via the SCORE pages of the AFT website: http://www.aft.org.uk/view/score.html

References

Stratton, P., Lask, J., Bland, J., Nowotny, E., Evans, C., Singh, R., Janes, E., & Peppiatt, A. (in press) Validation of the SCORE-15 Index of Family Functioning and Change in detecting therapeutic improvement early in therapy. *Journal of Family Therapy.* doi: 10.1111/1467-6427.12022 (available in early view 22-08-2013)

Jewell, T., Carr, A., Stratton, P., Lask, J., & Eisler, I. (2013, In Press) Development of a Children's Version of the SCORE Index of Family Function and Change. *Family Process. doi: 10.1111/famp.12044* (available in early view 26-08-13)

Stratton, P, Bland, J., Janes, E & Lask, J. (2010) Developing a practicable outcome measure for systemic family therapy: The SCORE. *Journal of Family Therapy.* 32, 232-258

Cahill, P., O'Reilly, K., Carr, A., Dooley, B., and Stratton, P. (2010) Validation of a 28-item version of the Systemic Clinical Outcome and Routine Evaluation in an Irish context: The SCORE-28. *Journal of Family Therapy*, *32*, 210-231

Fay, D., Carr, A., O'Reilly, K., Cahill, P., Dooley, B., Guerin, S. & Stratton, P. (2013) Irish norms for the SCORE-15 and 28 from a national telephone survey. *Journal of Family Therapy*. 35, 24-42.

Stratton, P., Bland, J., Janes, E., und Lask, J. (2012) Entwicklung eines Indikators zur Einschatzung des familiaren Funktionsniveaus und eines praktikablen Messinstruments zur Wirksamkeit systemischer Familien- und Paartherapie: Der SCORE . pp 355-377 in Matthias Ochs, Jochen Schweitzer (Eds.) *Handbuch Forschung für Systemiker*. Vandenhoeck & Ruprecht GmbH & Co. KG, Göttingen

Stratton, P. (2008). PRN in Action: Constructing an outcome measure for therapy with relational systems. *The Psychotherapist. 38,* 15-16.

Stratton, P., McGovern, M., Wetherell, A. and Farrington, C. (2006) Family therapy practitioners researching the reactions of practitioners to an outcome measure. *Australian and New Zealand Journal of Family Therapy*. 27 pp. 199–207