The current study set out to describe family functioning scores of a contemporary community sample, using the Family Assessment Device (FAD), and to compare this to a currently help-seeking sample. The community sample consisted of 151 families who completed the FAD. The help-seeking sample consisted of 46 families who completed the FAD at their first family therapy appointment as part of their standard care at an outpatient family therapy clinic at an urban hospital. Findings suggest that FAD means from the contemporary community sample indicate satisfaction with family functioning, while FAD scores from the help-seeking sample indicate dissatisfaction with family functioning. In addition, the General Functioning scale of the FAD continues to correlate highly with all other FAD scales, except Behavior Control. The cut-off scores for the FAD indicating satisfaction or dissatisfaction by family members with their family functioning continue to be relevant and the FAD continues to be a useful tool to assess family functioning in both clinical and research contexts.

Keywords: Assessment; Family Functioning; Measures

The Family Assessment Device (FAD) (Epstein, Baldwin, & Bishop, 1983; Kabacoff, Miller, Bishop, Epstein, & Keitner, 1990; Miller, Epstein, Bishop, & Keitner, 1985) was developed 30 years ago as a self-report measure of perceived family functioning. It was designed to assess the six dimensions of the McMaster Model of family functioning (Epstein, Bishop, & Levin, 1978) as well as a family’s overall or general functioning. Since the development of the FAD, a variety of measures to assess family functioning have been developed, but the FAD continues to be one of the most widely used measures of family functioning. It has been translated into 27 languages, and has been in use for 30 years. It is easy to administer, and yields information about a family’s satisfaction with its functioning in six domains. It also provides cut-off scores that allow clinicians to categorize family members as either satisfied with functioning in a domain or dissatisfied (Miller et al., 1985).

The FAD has been used extensively in research. It has been used to discriminate between mentally ill and nonclinical samples, between physically ill and well samples (Friedmann et al., 1997; McFarlane, Bellissimo, & Norman, 1995; Miller, Kabacoff, Keitner, & Epstein, 1986), to evaluate family functioning in the context of a variety of physical and mental illnesses (Keitner et al., 1987; Leonard, Jang, Savik, & Plumbo, 1985).
2005; McFarlane et al., 1995; McKay, Maisto, Beattie, & Longabaugh, 1993; Miller et al., 1986; Sarmiento & Cardemil, 2009; Uebelacker et al., 2006; Weinstock & Miller, 2010), has been used in both adolescent and adult samples (Bihun, Wamboldt, Gavin, & Wamboldt, 2002; Byles, Byrne, Boyle, & Offord, 1988; Herzer et al., 2010; Leonard et al., 2005), and is tied to a comprehensive model of family assessment and treatment (Bishop, Epstein, & Baldwin, 1980; Epstein et al., 1983; Keitner, Heru, & Glick, 2010; Ryan, Epstein, Keitner, Miller, & Bishop, 2005; Stevenson-Hinde & Akister, 1995). The FAD continues to be used to evaluate perceived family functioning in samples both large and small (Growing Up in Canada: National Longitudinal Survey of Children and Youth, 1996; Guada, Brekke, Floyd, & Barbour, 2010; Sarmiento & Cardemil, 2009).

The FAD was designed to assess the six dimensions of the McMaster Model of Family Functioning (Epstein et al., 1978), and as such, is one of the only family assessment scales that is based on a comprehensive model of family assessment and treatment. The first six scales of the FAD assess Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, and Behavior Control, while the seventh scale assesses General Functioning. Problem solving refers to the ability to solve both instrumental and affective problems. Communication refers to the ability to communicate clearly and directly with other family members. Roles refers to the way in which families allocate responsibilities, oversee health and developmental issues, and maintain relationships with extended family. Affective Responsiveness assesses both the capacity of family members to experience the full spectrum of human emotions, and to do so in a way that is appropriate to what the situation demands. Affective Involvement refers to the way in which family members show interest and involvement in each other and in each other’s interests, while Behavior Control refers to the ability of family members to set and abide by rules and standards of behavior. General Functioning is a measure of satisfaction with general family functioning.

The FAD was originally developed and normed on both clinical and nonclinical individuals and families. The original sample on which the FAD was developed consisted of 209 students in an introductory psychology course at a Canadian university, as well as 112 families. Of these families, four had children in a psychiatric day hospital program, six were participating in a stroke rehabilitation program, nine were related to students taking an advanced psychology course, and 93 had a family member who was an inpatient at an adult psychiatric hospital in Canada (Epstein et al., 1983). Later samples included families of patients on adult psychiatric units, and from outpatient medical specialty clinics, as well as nonclinical participants, both individuals and families from a university setting (Kabacoff et al., 1990).

The purpose of the present study is to describe FAD data from a community sample in southern New England, and to compare these scores to FAD data from families in the same region who are seeking therapy for stress in their family. We expected that in the community sample, means on all FAD dimensions would be similar to FAD means of a nonclinical sample collected in the 1980s when the measure was developed. Further, we expected contemporary community sample means to indicate satisfaction with family functioning. By contrast, we expected FAD means from the help-seeking sample to indicate dissatisfaction with family life, based on previous research that found that help-seeking samples tended to be less satisfied with family functioning (Friedmann et al., 1997; Kabacoff et al., 1990; Keitner et al., 1987; Miller et al., 1986; Weinstock, Keitner, Ryan, Solomon, & Miller, 2006). All families in the help-seeking sample came to the clinic because they had concerns about their family life.

We also set out to explore agreement between family members on the FAD. We expected moderate levels of agreement between family members, with the highest levels of agreement expected between spousal dyads because they are typically at the same stage in life.
and therefore more aligned in their experiences than other family dyads. Finally, we set out to explore the use of the General Functioning scale of the FAD as a general measure of family functioning that can be used as a proxy when a short measure is desirable, and when detailed information about the six dimensions of the McMaster Model is not needed.

METHOD

Description of Sample

This study compared FAD data from two groups: a community sample and a help-seeking sample.

Characteristics of the community sample

The community sample was comprised of 151 families. Families were recruited through newspaper and cable television advertisements, and via flyers posted throughout the community. Adult family members and children 12 years and older completed a set of assessment instruments focusing on perceived family functioning (the FAD) and sociodemographic information. Families were compensated for their time. Participation occurred at a major urban hospital in southern New England. The study was approved by the local Institutional Review Board.

The mean age of adults in the community sample was 46.8 years, and the mean age of children who completed questionnaires was 13.8.

Education

Of the adult community sample, 14% reported that they had less than a high school education, 25% reported that they had a high school education, 16% reported that they had “some college,” and 46% reported having a college degree.

Income

Of the community sample, 22% reported a household income of less than $20,000; 21% reported a household income between $20,000 and $39,000; 24% reported a household income between $40,000 and $70,000; and 32% reported a household income of $80,000 or higher.

Race and ethnicity

Of the community sample, 71% self-identified as White, 17% as Black or African American, 4% as Asian, and 8% as “other.” Twelve percent of the sample identified as Hispanic or Latino.

Psychiatric status

Families in which one or more members reported taking medication for a psychiatric condition were considered to have a psychiatric illness in the family. Of the community sample, 29 families (19%) reported that one or more members were currently taking medication for a psychiatric condition. This is consistent with the proportion of the general population that reports taking medication for a psychiatric condition.

Characteristics of the clinical sample

The clinical sample was comprised of 46 families who sought treatment for concerns about family functioning at an urban, hospital based, outpatient family therapy clinic in southern New England. As part of their standard care at the clinic, families completed the FAD at their first family therapy appointment. Data were extracted via post hoc chart reviews of family therapy patients from winter 2011 to summer 2013, and IRB approval was obtained for data collection. All of the families had health insurance. For each family,
one adult family member was identified as the patient of record, and the chart was kept under that person’s name. Treatment addressed issues as they related to the couple or family as a whole. The mean age of the primary patient was 48 years, and the mean number of years of education was 16. Although the clinic asks patients to report household income, race, and ethnicity, many patients refused to give answers to questions. Of the clinical sample, 75% identified as White, the remaining 25% did not identify their race.

For each family seen in the clinic, there is one identified patient of record under whom a chart is opened. Clinicians are required to assign a diagnosis for that patient, and we have data as follows for the patients of record in the help-seeking sample of families: 16 were diagnosed with some type of mood disorder, 9 with an anxiety disorder other than PTSD, 2 were diagnosed with PTSD, 2 were diagnosed with alcohol or substance abuse, and 7 were diagnosed with adjustment disorder. Treatment addressed the needs of the couple or family as a whole, and did not center on the diagnosis of the patient of record.

**Measures used to collect data from the community sample**

*Psychiatric history*

Psychiatric history was assessed using a questionnaire that asks whether any members of the family are taking medication for a psychiatric condition. Families in whom one or more members were either taking psychiatric medication or being treated for a psychiatric condition were counted as having a psychiatric illness. It is important to note that none of the families in the study were recruited from psychiatric clinics. Thus, even though some families included one or more members who took psychiatric medication, all were recruited from the community at large, and all were organized enough to respond to a study recruitment advertisement, make an appointment with the study coordinator, and follow through on participation in the study.

*Family functioning*

Family functioning was assessed using the FAD. As noted previously, the FAD is a 60-item self-report measure of satisfaction with family functioning that provides cut-off scores that indicate either satisfaction with family functioning, or dissatisfaction (Miller et al., 1985). All family members, 12 years of age and older, who participated in the study completed the FAD. A mean family score was created, as has been done in previous studies (Epstein et al., 1983; Keitner et al., 1987; Miller et al., 1985, 1986). Each participant who completed the FAD therefore had seven dimension scores associated with responses to FAD items. Within each family, individuals’ scores on each dimension scale were averaged to create a family mean score for each dimension for each family. As was noted in other publications about the Family Assessment Device (Ryan et al., 2005), there are various ways to analyze data from the FAD, including use of individual scores, use of family means, and use of discrepancy scores between an individual and his or her family. The method that makes most sense depends on the question being posed. In the present study, we were concerned with learning about average levels of satisfaction with family functioning in two samples: a community sample and a help-seeking sample. Because we were concerned with average functioning in these two samples, averaging scores across each family made the most sense for this study.

**RESULTS**

We set out to test several hypotheses. First, we expected that in the community sample, mean scores on all FAD dimensions would indicate satisfaction with family functioning, while FAD mean scores on all dimensions in the help-seeking sample would be indicative...
of dissatisfaction with family life, as measured by cut-off scores developed in 1985 (Miller et al., 1985). We expected this because all members of the help-seeking sample were seeking help for concerns with family life, whereas in the community sample, although some participants were receiving psychiatric treatment, the majority of participants were not. In addition, as noted previously, we expected the community sample to be fairly high functioning because they had to respond to a recruitment advertisement and organize themselves to come to participate in our study. We are aware that not all nonhelp-seeking families have satisfactory family functioning and that not all families seeking help are necessarily dysfunctional. Previous studies have shown, however, that when comparing groups of families, nonclinical families perceive their functioning as satisfactory, while families with an ill member or with concerns about their functioning report unsatisfactory family functioning (Keitner et al., 1987; Miller et al., 1986; Weinstock et al., 2006). Second, we set out to explore levels of agreement between husbands and wives, parents and adolescent children, and parents and adult children. We expected the highest rates of agreement to occur between husband and wife dyads, because they are most likely to be aligned in their experiences and goals. We expected slightly lower levels of agreement between parents and adult children, and we expected the lowest level of agreement between parents and adolescent children. We based these expectations on the premise that parents and adolescent children are least likely to be aligned in their experiences as they are at different life stages (Sawyer, Sarris, Baghurst, Cross, & Kalucy, 1988). Of note, we did not expect high levels of agreement between any of the dyads because we expect family members to experience things slightly differently. Finally, we expected the General Functioning scale of the FAD to correlate highly with other scales, and with a composite of the items on the FAD that do not include the General Functioning scale items.

Family Functioning

We began by running means and standard deviations on all measures. These means are listed in Table 1, along with FAD satisfaction cut-off scores, which were developed in 1985 (Miller et al., 1985). As discussed in the Method section, a mean of all FAD scale scores was created for each family, and all family members, 12 years old and older, completed the FAD. As expected, all FAD means from the total community sample were in the

<table>
<thead>
<tr>
<th>Measure</th>
<th>Current community sample Mean and SD, N = 155 families</th>
<th>Current clinical sample Mean and SD, N = 46 sample</th>
<th>t test comparing community to help-seeking sample (t score and p value)</th>
<th>Current community sample coefficient alpha</th>
<th>1985 FAD cut-off</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Solving</td>
<td>2.00, .36</td>
<td>2.45, .49</td>
<td>−6.95, p &lt; .01</td>
<td>.75</td>
<td>2.20</td>
</tr>
<tr>
<td>Communication</td>
<td>2.05, .38</td>
<td>2.38, .43</td>
<td>−5.38, p &lt; .01</td>
<td>.80</td>
<td>2.20</td>
</tr>
<tr>
<td>Roles</td>
<td>2.22, .34</td>
<td>2.30, .39</td>
<td>−1.60, NS</td>
<td>.70</td>
<td>2.30</td>
</tr>
<tr>
<td>Affective Responsiveness</td>
<td>1.97, .47</td>
<td>2.30, .58</td>
<td>−4.25, p &lt; .01</td>
<td>.75</td>
<td>2.20</td>
</tr>
<tr>
<td>Affective Involvement</td>
<td>2.02, .42</td>
<td>2.21, .44</td>
<td>−3.24, p &lt; .01</td>
<td>.74</td>
<td>2.10</td>
</tr>
<tr>
<td>Behavior Control</td>
<td>1.65, .30</td>
<td>1.93, .40</td>
<td>−5.06, p &lt; .01</td>
<td>.68</td>
<td>1.90</td>
</tr>
<tr>
<td>General Functioning</td>
<td>1.79, .42</td>
<td>2.31, .49</td>
<td>−7.26, p &lt; .01</td>
<td>.89</td>
<td>2.00</td>
</tr>
</tbody>
</table>

Note. Mean scores are based on family mean scores. Coefficient alpha is based on individual FAD scores. Bolded scores are in the dissatisfied range, as computed by rounding to one decimal place.
satisfied range. Scores from the help-seeking sample are also presented in Table 2. All FAD scores from the help-seeking sample were in the dissatisfied range. We also ran t tests to compare FAD dimension scores from the community and the help-seeking samples and found that the samples were significantly different on all dimensions except for Roles. These t-test results are presented in Table 3.

Next, we analyzed two subgroups of the community sample: single-parent families and families in which one or more members were being treated for a psychiatric diagnosis. In the community sample, single-parent families indicated dissatisfaction with Roles. In the community sample, families in which one or more members were being treated for a psychiatric condition endorsed dissatisfaction with Affective Involvement. All other dimensions in these subsamples were in the satisfied range. In the help-seeking sample, there were no single-parent families, and by definition, families were receiving psychiatric care in their receipt of family therapy, so similar subgroups could not be created for comparison.

Intraclass correlation coefficients (ICCs) were calculated to assess level of agreement between husbands and wives, parents and adolescent children, and parents and adult children. Because some families had both parents complete questionnaires, and some families had only one parent complete questionnaires, a mean parent score was created.
for each family. Similarly, if there was more than one adolescent child in a family, a mean adolescent score was created, and if there was more than one adult child in a family, a mean adult child score was created. Interpretation of ICCs for this study was based on the assumption that in healthy families, agreement between family members should not be perfect. We expect healthy families to be able to agree to disagree, and to perceive things slightly differently from each other. Thus, we expected ICCs to range from .40 to .69, indicating overlap in perception of family functioning, but not perfect agreement. Children younger than 12 years of age do not complete the FAD, so they were not assessed. Samples for other family constellations (e.g., agreement between adolescent siblings, agreement between adult siblings) were too small to be meaningful.

Agreement Between Husbands and Wives

As expected, we found moderate ICCs between husbands and wives (n = 98 pairs). We expected partners to disagree on some issues. Agreement was in the range we predicted (.40–.69) on all scales except Behavior Control.

Agreement Between Parents and Adolescent Children

Of the 46 families with adolescents, 35 had only one adolescent who completed the FAD, and 11 had two or more adolescents complete the FAD. Within each family, a mean adolescent FAD score was created. With regard to parental participation, of the 46 families, 24 were dual-parent families and 22 were single-parent families. A mean parent score was created. Thus, for each family, a mean adolescent score and a mean parent score was created. These scores were then compared for agreement. Agreement ranged from .43 to .63 on all scales except Problem Solving and Behavior Control, suggesting that parents and adolescents overlap in their views of family functioning, but have different perspectives. Agreement on Problem Solving was surprisingly low, .19, and agreement on Behavior Control was also low, .29.

Agreement Between Parents and Adult Children

Of the 13 families with adult children, 12 had only one adult child who completed the FAD, and 1 had two or more adult children complete the FAD. Within each family, a mean adult child FAD score was created. Of the 13 families, 8 were single-parent families and 5 were dual-parent families. A mean parent score was created. Thus, for each family, a mean adult child score and a mean parent score was created. We found low levels of agreement on four scales: Problem Solving, Affective Responsiveness, Affective Involvement, and General Functioning. Agreement was in the moderate range on Communication, Roles, and Behavior Control.

Correlation Between the General Functioning Scale and All Other FAD Scales

As expected, due to the design of the FAD and the GF scale (Miller et al., 1985), the General Functioning scale of the FAD correlated highly with all other FAD dimensions except Behavior Control, with which it demonstrated a moderate correlation. Affective Responsiveness, Communication, and Problem Solving all demonstrated correlations at or above .78 with General Functioning. The correlation between the General Functioning Scale and the Affective Involvement Scale was also high, \( r = .68 \). Correlations between all FAD subscales for all participants in both samples are presented in Table 4. The correlation between the General Functioning Scale and the mean of all FAD items except those that comprise the GF scale was .87, \( p < .0001 \).
TABLE 4
Correlations between Family Assessment Device Scales from the Community and Help-Seeking Samples N = 425 Individuals

<table>
<thead>
<tr>
<th></th>
<th>Problem solving</th>
<th>Communication</th>
<th>Roles</th>
<th>Affective responsiveness</th>
<th>Affective involvement</th>
<th>Behavior control</th>
<th>General functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem solving</td>
<td>1</td>
<td>.73**</td>
<td>.55**</td>
<td>.63**</td>
<td>.55**</td>
<td>.46**</td>
<td>.81**</td>
</tr>
<tr>
<td>Communication</td>
<td>1</td>
<td>.49**</td>
<td>.75**</td>
<td>.60**</td>
<td>.49**</td>
<td>.78**</td>
<td>.78**</td>
</tr>
<tr>
<td>Roles</td>
<td>1</td>
<td>.52**</td>
<td>1</td>
<td>.55**</td>
<td>.45**</td>
<td>.60**</td>
<td>.78**</td>
</tr>
<tr>
<td>Affective</td>
<td>1</td>
<td>.54**</td>
<td>1</td>
<td>.64**</td>
<td>.45**</td>
<td>.78**</td>
<td></td>
</tr>
<tr>
<td>Responsiveness</td>
<td></td>
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<tr>
<td>Affective Involvement</td>
<td></td>
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<tr>
<td>Behavior Control</td>
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<tr>
<td>General Functioning</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Note. *p < .05.
**p < .01.
DISCUSSION

The purpose of the current study was to describe family functioning scores in a contemporary urban community sample, and to compare these scores to a current help-seeking sample. The community sample used for the present study better represents community families than did the sample on which the FAD was originally normed. In the original community sample, most of the sample was drawn from undergraduate psychology classes. For these undergraduate students, there were only individual FAD responses, as none of their family members participated in the study. Family members of some students in advanced psychology courses also participated, but the majority of families in the original sample had a family member who had been admitted to an inpatient psychiatric hospital. As in the present samples, in the original sample, for each family in which more than one member completed the FAD, a mean FAD family score was created. The original sample combined university students, their family members, families in which one member was experiencing an inpatient psychiatric hospitalization, families in which one member was receiving inpatient treatment for a stroke, and families in which one member was receiving day hospital treatment for psychiatric problems. In the present study, all families in the community sample responded to a study recruitment advertisement. Despite these important differences between the present sample and the original sample, in both community samples, mean family scores indicated satisfaction with family functioning on all dimensions.

The present study represents the first instance that we know of in which FAD data from a family therapy seeking sample have been collected and studied. As such it provides important information about family functioning among families seeking help for dissatisfaction with family functioning.

Findings suggest that the means used to norm the FAD are still relevant today. In the present study, the FAD was able to discriminate between families seeking help for distress in their families and a community sample which was not engaged in family therapy. Help-seeking family FAD scores were all in the dissatisfied range, whereas community sample FAD scores were all in the satisfied range. This is consistent with findings from a community sample published in 1990, which were also uniformly in the satisfied range (Kabacoff et al., 1990). These findings do not suggest that all help-seeking families are unhealthy, or that all community families are healthy. Rather, these data suggest that although there is within-group variability, overall, the groups are distinctly different.

Regardless of family structure, family means from the current community sample were in the satisfied range on all dimensions except Roles, which was in the dissatisfied range in single-parent families. This suggests that single-parent families become overwhelmed, and experience dissatisfaction with how responsibilities are allocated. On all other dimensions, however, single-parent family means were in the satisfied range, raising questions about the notion that single-parent families are less happy or less well-adjusted than are two-parent families. Family functioning was in the satisfied range on all other dimensions except Affective Involvement among families in which one or more members were taking medication for a psychiatric condition. The elevated mean on Affective Involvement suggests that when one or more family members are being treated for a psychiatric condition, it can be challenging for family members to find comfortable ways to be involved with each other. Of note, another study based on a subset of the current sample found that such families living at or below 133% of the federal poverty line scored in the dissatisfied range on five FAD scales, including General Functioning (Mansfield, Dealy, & Keitner, 2013). This suggests that when low-income status is combined with a psychiatric condition, it may create a double jeopardy for families.

We expected to find moderate levels of agreement between family members, with the highest levels of agreement occurring between spouses. Husbands and wives evidenced...
the highest rates of agreement on all scales except Behavior Control, while parents and their adult children evidenced the lowest. Low agreement on Behavior Control is not surprising considering that partners, as well as parents and children, often disagree with regard to setting and adhering to standards of behavior. We expected to find higher levels of agreement between parents and adult children than between parents and adolescent children, however, the data demonstrated the reverse. One reason for this may be that adult children and their parents are least likely to be aligned in their goals and expectations of each other. Adolescent children and their parents, for all of their disagreements, are likely to agree about their roles in each other’s lives. When an adult child resides with his or her parents, it may be more likely that there is disagreement regarding the role each plays in the other’s life, and therefore discrepant perceptions of family functioning.

The General Functioning Scale of the FAD demonstrated correlations above .70 with all other FAD scales except Behavior Control. These findings suggest that the General Functioning Scale is a good proxy for the full FAD in contexts where brevity matters and detail regarding satisfaction with all six dimensions of family functioning is less important than an overall assessment of satisfaction with family functioning.

Clinical Utility

The FAD offers clinical utility in identifying levels of satisfaction in multiple domains of family life. Use of the FAD in clinical applications has been discussed elsewhere (Archambault, Mansfield, Evans, & Keitner, 2014). In addition to offering clinicians an overall view of family members’ satisfaction with family life, which can be useful by itself, the FAD offers specific information about areas of satisfaction and dissatisfaction, which may differ between families and between members of the same family. For example, one family from the help-seeking sample (a husband/wife dyad) illustrates how examining FAD scores can be useful in treatment. The husband’s scores were uniformly satisfied, but the wife’s scores indicated dissatisfaction with problem solving, communication, affective responsiveness, and general functioning. Although her General Functioning scale score would have indicated dissatisfaction, the dimension scores helped to illuminate specific areas of distress and dissatisfaction, which in turn informed how treatment proceeded. Although a competent therapist may eventually arrive at this information, the family’s FAD responses enabled this information to be uncovered and shared with the family at the start of treatment, setting a focus from the beginning. Treatment centered on issues related to emotion regulation and expression in the family. Problems in these areas prevented the wife from speaking directly with her husband about her distress, making it difficult for them to discuss their concerns and arrive at a mutually satisfactory solution. Treatment therefore addressed ways of handling overwhelming emotions, effective communication, and problem solving in the context of strong emotions.

Limitations

The present study has some limitations in its threats to internal and external validity. First, both samples lack objective data on family functioning, which would have to be obtained through a clinical interview rated by the McMaster Clinical Rating Scale. We did not have the resources to carry out such interviews for the families that participated in this study. Second, the sample was limited to an urban area in New England and was not necessarily representative of families in the area. Third, we do not have any data on how many families had divorced and recoupled in the community sample. The way that two-parent families were defined in both samples was that if two adults were living together in an intimate relationship, the family was counted as a two-parent family. In the community sample, we did not ask families if parents had divorced in the past or if parents had
recoupled, so we have no data about this. We do not know how many families in the community sample were divorced and recoupled, and we cannot compare family functioning in recoupled families to family functioning in “first” families. Retrospective chart review revealed that, in the help-seeking sample, seven families were divorced and recoupled, but consistent with the way data were collected in the community sample, they were considered two-parent families. Fourth, our limited demographic information about the help-seeking sample limits what we know about whether it is a comparable group to the community sample. Future studies should collect information about income, education, ethnicity, race, and religion from all samples. Fifth, we made the choice to use family mean scores, and a byproduct of this choice is that some differences between family members may be obscured. We made this choice because the central research question pertained to gleaning a better understanding of average family functioning in a community versus a help-seeking sample. Sixth, the community sample does not represent a random sample from the community. To some degree, families self-selected, and it is likely that only families that were high enough functioning to respond to an advertisement and organize themselves to participate in the study participated. In a related vein, the help-seeking sample consisted of families with health insurance. Future studies should explore family functioning in uninsured or under insured help-seeking samples. Seventh, we relied on self-reported income and education as proxies of socioeconomic status in the community sample, and lack comprehensive data on these points in the help-seeking sample. Eighth, one problem with looking at agreement between family members is that only moderate agreement should be expected in the first place. This is because family members experience feelings, events, and situations differently, even though their experiences may overlap. Thus, it is difficult to explore agreement between family members when perfect agreement is not expected in the first place.

Despite these limitations, the current study used a sample that is much more representative of the U.S. families than did prior studies from the 1980s that explored the psychometric properties of the FAD. Findings indicate that contemporary family scores on the FAD from a community sample are quite similar to nonclinical samples collected over three decades ago. These findings should be replicated in other similar samples. Nonetheless, it seems that the FAD, both in its 60-item form and in its 12-item General Functioning Scale, continues to offer both clinicians and researchers a way to assess family functioning that is informed by a comprehensive model.

REFERENCES


www.FamilyProcess.org


