GARF

Assessment Sourcebook

Using the DSM-IV Global Assessment of Relational Functioning

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Foreword

The history of family therapy has been packed with innovative concepts, claims about new paradigms and models, and dramatic demonstrations of charismatic wizardry. In contrast, there has been only a modest number of proposals for methods of assessing the quality of therapy and evaluating treatment outcome. In addition, the field has conspicuously lacked consensus about principles.

In this book, Lynelle Yingling and colleagues have made the first major effort to describe in detail, and to evaluate, a family assessment method that has achieved sufficient recognition, both within and beyond the field of family therapy, so that a considerable number of clinics, training programs, and research projects have agreed to incorporate this method into their work. This method, the Global Assessment of Relational Functioning (GARF) scale, is presented by the authors, not as a final or fully confirmed approach, but as a feasible means of starting to share something across the highly diverse varieties of relationships, treatment approaches, and contexts that crowd the terrain of the family therapy field.

It is interesting to consider why family assessment, including this particular method of assessment, is being actively tried out at this time. Many, if not most, leading family therapists continue to be preoccupied with teaching, supervision, and clinical practice, not with research-based methods. Indeed, there continues to be a considerable number of therapy theoreticians who challenge the very idea that research on the "art" of therapy can be meaningful or relevant. However, as Yingling and colleagues show, the GARF is rooted in some of the best-established concepts and models for family therapy and can be used in teaching these concepts. Having members of trainee groups observe, independently rate, and discuss their rating discrepancies is an excellent teaching device, helping instructors to identify trainees who misunderstand certain concepts, fail to make on-target clinical observations, or, at times, who do make observations that others have missed. Thus, the GARF ratings can have a training function, even for instructors who are phobic or disdainful of formal research.

But the time has come when documented, preferably quantitative, evidence is being demanded of all forms of healthcare services, especially those, such as family therapy, that are not well established as reimbursable components of the healthcare repertory. At present, the GARF is certainly not a complete or definitive answer to these demands. However,

it has the special merit of being practical—that is, suitable for routine and quick inclusion in clinical records—and is capable, the growing evidence indicates, of quite reliably making distinctions among various levels of relational dysfunction and changes in level of dysfunction during the course of therapy. As Yingling and colleagues sensibly discuss, this is the kind of evidence that managed care organizations are increasingly looking for. The GARF is the only family-oriented measure included in the pages of the DSM–IV—to be sure, in the Appendix for "Criteria Sets and Axes Provided for Further Study." This can only be viewed as a foot in the door controlled by the mental healthcare establishment. However, it seems to be an appropriate status for the GARF at this stage. This volume by Yingling and colleagues is a highly noteworthy effort to carry out the "further study" that is, in fact, needed.

In addition to presenting copies in full of the forms used in constructing GARF profiles, the work with the GARF reported here includes many ingredients of research programs that should be replicated and expanded. Here is a sample of such studies reported with varying degrees of confirmation in this book.

1. Comparison of the GARF as a single global rating and both separately and as a composite of ratings in the three major domains that have been identified—Problem Solving/Communication, Organization, and Emotional Climate.
2. Comparison of the GARF ratings with those from more complicated multidimensional scales such as those originated by Beavers, Epstein, and Olson, both in their observational forms and questionnaire self-report forms. Yingling and colleagues also include new scales they have devised that will help illuminate overall relational functioning beyond what can be suggested by GARF ratings.
3. Evaluation of the amount and kind of training needed to make reliable GARF ratings. (As with any clinical skill, the training needs to be gauged in relation to the experience of raters with a wide range of relational problems and mental disorders and in relation to their experience with couples and families. Earlier estimates that training could be very brief were misleading.)
4. Evaluation of change in GARF ratings from the initial session through the processes of later therapy. (The findings reported here indicate that GARF ratings do significantly improve in a substantial portion of clients, but that the poorest level of functioning quite often is not rated as evident in the initial session but, instead, two or three sessions later, perhaps as trust and self-disclosure have progressed.)

In summary, this book includes and also goes beyond the development of the GARF as a measure of relational functioning that has wide applicability for facilitating and evaluating clinical practice with families and other relational systems, for enhancing family therapy education and supervision, and for opening up new opportunities for clinical research that will be of interest both to family therapists and to many others in the current mental healthcare environment.

Lyman C. Wynne, M.D.

Preface

The compilation of this book has been a developmental journey. It began many years ago with the seed of interest in family systems being planted in each of us individually. We came together at a moment in time that supported the creation of a diversified writing team. However, we did not create this book in isolation. The entire context of our professional experiences provided the nurturing environment.

First, being in a doctoral program with a strong training emphasis in marriage and family therapy unified us. When the request for volunteers for GARF DSM–IV research field sites was announced in the Brown University newsletter, the enthusiastically naïve Texas A&M University training director volunteered the staff. Our enthusiasm for in-depth GARF research was encouraged and supported by Dr. Keith McFarland, Dean of Graduate Studies and Research at Texas A&M University–Commerce (formerly East Texas State University).

Perhaps our biggest debt of gratitude is owed to Dr. Lyman Wynne. His many years of work in the field, which led to the development of the GARF, made this book possible. But more than providing scientific expertise, he provided a kind and gentle spirit of a true founding father. Working with such a man of distinction over the past five years has been a lifetime highlight experience.

Other leaders in the field contributed generous amounts of time in reviewing materials describing their work and in providing permission to include those materials in this book. We are especially grateful to Dr. David Olson and Dr. Robert Hampson.

There are other members of the team whose names do not appear as authors. Many doctoral students contributed greatly to the research and theoretical understanding of the GARF. But the most important contributors are the families with whom we work. The real reason for this book being written is the families who were, are, and will be willing to work collaboratively with family therapists for family system change. In the case studies (altered to protect client identity), families who courageously shared personal stories for the benefit of others inspired us to focus on assessing family strengths. Hopefully, this book will

provide some useful tools for improving the therapeutic relationship with clients to evoke more effective and efficient change.

As we progressed through the development of this book, each of our families offered unique involvement and nurtured this process. A special thanks to Isaac Fuller, Janet Fuller, and Susan Vaughn for artistic depiction of family functioning metaphors, and to Todd Smith for Spanish translation of the SAFE. For that, we are grateful.

CHAPTER 1

A Multi-Systems Approach: Collaborating for Health Through Systems Theory

Purpose and readers' guide
Marriage and family therapy (MFT) evolution
Futuristic partnering with systemic business principles

PURPOSE AND READERS' GUIDE

The purpose of this book is to present the Global Assessment of Relational Functioning (GARF) as a practical tool for integrating family assessment in ways that meet the needs of the client, the therapist, managed care, and contractual payers. This "why" and "how" book is designed as a sourcebook for therapists incorporating the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition; DSM–IV; American Psychiatric Association, 1994) GARF to improve the quality of their clinical work. When effectively used, the GARF may provide therapists with assessment data for guiding their clinical work and outcome data for verifying treatment success to outside evaluators. Further exploratory and confirmatory research, as well as research-based application, will provide needed refinement of this new family systems DSM–IV tool.

The basic elements of the GARF described in the DSM–IV are:

A. *Problem solving*—skills in negotiating goals, rules, and routines; adaptability to stress; communication skills; ability to resolve conflict
B. *Organization*—maintenance of interpersonal roles and subsystem boundaries; hierarchical functioning; coalitions and distribution of power, control, and responsibility
C. *Emotional climate*—tone and range of feelings; quality of caring, empathy, involvement, and attachment/commitment; sharing of values; mutual affective responsiveness, respect, and regard; quality of sexual functioning (American Psychiatric Association, 1994, p. 758).

Our author team has translated these concepts into (a) interactional processes, (b) organizational structure, and (c) emotional climate/developmental nurturing output of the client family system. We have also extended these applications to broader cybernetic therapeutic/supervision/training/societal systems.

To achieve our goals, the necessary tools of *structural* knowledge, *process* charts, and *growth-producing environmental* proposals are included. Graphic language is used throughout to facilitate efficient communication in this busy world of the reader. Each chapter includes an outline of topics covered under the chapter title. Achieving our sourcebook goals with a tentative attitude of encouraging further research is perhaps the "miracle" goal for which we strive. Different readers may take slightly different paths in proceeding through this sourcebook to meet their specific interests and needs.

Goal-Based Reader's Guide

The *clinician* will likely be most interested in finding a quick understanding of the GARF and how it can direct treatment interventions to produce effective outcomes. For the therapist who has a clear understanding of family systems theory and how assessment is foundational to the therapeutic process, we suggest that Chapter 2, Chapter 4, and the Appendixes will serve as the "getting started" manual. Focusing on Chapter 2 will give a comprehensive theoretical understanding of the GARF. Chapter 4 will then illustrate how to put those concepts into practice following ethical guidelines. The forms included in the Appendixes will supply ready-to-use resources for implementation. As the clinician begins to partner more with managed care to produce the best outcome research procedures possible, reading Chapters 5 and 6 will be useful in formulating research plans. A good review of theory in Chapters 1 and 3 may be helpful reminders.

As a supplemental or required assessment textbook for family therapy training, the *academic* will likely want to cover the entire book in sequential order. Chapter 1 and Chapter 3 will provide basic theory review for students. Chapter 5 compares major family assessment tools and summarizes key information on instruments helpful in expanding our perspective that comprehensive training in family assessment is essential. Chapter 2 will provide the practical understanding of the GARF, as well as its historical development and limited verifying research. Chapter 6 will be future-directed for students, orienting them toward practice in the real world.

Parts of the book are especially useful to *managed care* quality assurance staff focusing on improvements in using outcome data for planning and implementing quantifiable measures of performance. Chapter 1 will provide the theoretical explanation of how systemic assessment is so compatible with quality assurance management. The research section in Chapter 2 describes verifying studies available at this time that empirically support the use of the GARF. Chapter 6 will provide a blueprint to implementing family system assessment outcome studies using the GARF.

Summarizing the reader's guide, a plan might look something like the following:

- Clinicians: Chapter 2, Chapter 4, Appendixes; followed by Chapter 5 and Chapter 6; supplemented by review of Chapter 1 and Chapter 3.
- Academics: Chapters 1–6 sequentially; emphasizing the family systems theory in Chapters 1, 3, and 5; emphasizing the research in Chapter 2; emphasizing the application in Chapters 4 and 6.
- Managed care planners: Chapters 1, 2, and 6.

To prepare the reader for this venture, an overview of systemic thinking, both in the family therapy field and in the business field, is our first stop.

MARRIAGE AND FAMILY THERAPY (MFT) EVOLUTION

The field of family therapy has matured since its beginnings in the 1950s. At that early time, the Batesonian double bind hypothesis highlighted the impact interactional processes within the basic social unit have on the psychological health of individual members within that unit (Bateson, Jackson, Haley, & Weakland, 1956). Becvar and Becvar (1996) trace the development of the field by identifying simultaneous happenings that formulated the connection (called *systems theory* or *cybernetics*) between the scientific world and the family relations world. This unique way of understanding human problems was built by "human relations engineers" who took scientific theory and applied it to therapeutic intervention to solve human problems.

Using a life cycle development metaphor, the field of family therapy could be considered to be in a leaving-home or young adult stage. Licensure for the independent practice of marriage and family therapy (MFT) designates the legal age of majority and has been achieved in the majority of states. However, some discipline-of-origin parents have been reluctant to allow MFT a separate independent identity, resulting in the typical enmeshed system struggles common at this stage of development. Perhaps another decade of maturity will bring a recognition of this new identity. But can the older generation step aside and allow the younger ideas to be recognized as generative? And can the younger generation appreciate and learn from the older generation's struggles? James Framo's article (1996) provides a stimulating review of the development of the MFT field.

Whatever the result of the extended family struggles, the new family of MFT is crystallizing a set of family rules distinct from the disciplines of origin. Continuing the metaphor of family development, perhaps the two adult partners forming this new family unit could be identified as traditional structural assumptions and postmodern interpretations of family systems. With the new generation of children about to emerge, whose belief systems will they be taught? Will they gain from the strengths of both parents so that the apparent conflicting rules can be reconciled into a balanced whole? Or will this new marriage suffer such difficulties in forming a union that they turn over the parenting functions to grandparents? What appears to be happening is the beginnings of conflict resolution between the two young marrieds, giving hope for the next generation of healthy children who experience clear communication and confident parental hierarchy, resulting in a balanced growth-promoting nurturing system.

What are the belief systems of this new family unit? A variety of models explaining how to intervene therapeutically in family functioning have been developed. These models will be explored briefly in Chapter 3. Generally speaking, systemic therapeutic intervention includes (a) assessing family system functioning data, (b) conceptualizing that data into a treatment plan, and (c) using MFT intervention techniques to implement the treatment plan. Some form of assessment seems to be foundational. Models identify specific methods and seem to adopt at least one of three focus areas for the intervention process:

- Organizational structure of the family system, paying particular attention to hierarchy and boundaries;

- Interactional processes of the family system, paying particular attention to dyadic interactions of the marital/parental subsystem as marital partners attempt to solve problems; and
- Differentiation from family-of-origin rules and processes that developmentally interfere with clear-thinking problem solving in the nuclear family, thereby promoting a nurturing environment for member growth.

Though models vary in the assumptions they adopt, most models accept the following systemic functioning assumptions as valid and useful:

1 Problems are *contextually based,* meaning they are the result of ineffective interactional and organizational rules in the primary social environment versus the result of individual psychopathology.
2 Assessment focuses on *circular versus linear causality.* Linear causality looks at an isolated segment of the problem: for example, "An angry wife tries to get revenge by prolonging the divorce settlement with a contested divorce trial." A circular causality assessment broadens the focus on the problem to sound like this: "The wife grew up in a family where money was very hard to come by and the children often went without necessary food and clothing because the father irresponsibly spent family income on alcohol. The wife's relationship with her husband has been one in which she tried to play the child role so that she could make her husband play the role of the responsible father she wished she had as a child. The husband resented being coerced into this 'fathering' role and began separating from his wife by retreating to the bars. The wife became increasingly frustrated with the lack of connectedness with her husband and demonstrated more dependency in an attempt to gain his support. The husband reacted to this attempt at connectedness by withdrawing even more. Both parents, fearful of losing all aspects of 'family,' have turned to the children as sources of affirmation. A prolonged divorce trial seems to be the only way either spouse knows to protect him/herself from horrifying isolation."
3 Troubled families are *stuck in a phase of the family development life cycle* because of lack of resources needed for adjusting to the transition or inability to access the resources available. These resources include the appropriate amount of glue [cohesion] and bounce [adaptability] to respond effectively to stress. The rules for communicating with each other determine the glue and bounce levels.
4 *Symptoms are metaphorical* of the system functioning problems. Therefore, presenting problems are clues that lead to the underlying difficulties in the family's communication rules that create organizational boundaries.
5 Because *symptoms are system maintained and system maintaining,* they are difficult to give up. In other words, the presenting problems are a result of family rules that are an ineffective way of dealing with stress, but are the only way the family knows at this time. The ineffectiveness of the approach increases the stress level for the family; therefore, the family members try even harder to use the only way they know, and thus increase the stress more, resulting in their increased anxious efforts to use what they know, and so on.
6 Change in the family's interactional patterns (that are a result of communication rules that constitute organizational boundaries) results in a *second-order change* and is necessary to achieve lasting symptom relief.
7 Structural organizations that generally promote healthy system functioning and improved relationship nurturance for growth are on three levels: (a) the adults in the nuclear family need an *egalitarian relationship* to diminish power struggles, (b) a child

needs a *parental hierarchy* to provide safety for the child's developmental process, and (c) parents need to be on a *peer-type adult relationship* with their "former parents" in order to achieve intimacy and empowering support versus intrusion. Regardless of whether the family structure is married or divorced, children need the security of parent/s being in charge of the family functioning. Parenting is a demanding responsibility and generally requires the resources of more than one adult; ideally, both biological parents can work together to maintain a balanced parental hierarchy, though substitute resources for either parent can be used.

Mills and Sprenkle (1995) describe the first- versus second-order cybernetics debate with illustrations of intervention techniques. Is it necessary to give up family system functioning assumptions in order to treat families respectfully and own one's own part in shaping the therapeutic system? The postmodern contribution seems to be adding a more future-oriented, optimistic process focus to the more static traditional content focus. A focus on process has resulted in a more egalitarian multi-systems level perspective in viewing the intervention system as well as the client system.

The challenging postmodern perspective seems to create a balanced MFT theory. The traditional structural systemic identification of the field, blended with the lowered hierarchy collaborative postmodern focus on process, results in a healthy nurturing theoretical system. Preparing competent family therapists today includes combining theory and skill development from both traditional and postmodern perspectives into a smooth integrative approach that is flexible enough to meet the needs of the clients (M. Nichols & Schwartz, 1995; Ratliff & Yingling, 1996). Perhaps it is time to move from adolescent squabbling to take on adult responsibility for what we do.

Regardless of model biases, the foundation to the practice of MFT is legalistically defined as systemic thinking (Licensed Marriage and Family Therapist Act, 1991; American Association for Marriage and Family Therapy [AAMFT], 1993). Perhaps we can reflect on our roots of understanding systems from the field of physics and see our philosophical compatibility with the current societal understanding of human systems in all types of organizations.

Part of being accountable/adult is being scientific enough to defend what we do. With increased competition in the field and tightening budgets everywhere, the payers of our services demand justification for their expenditure. Without assessment, scientific accountability is an impossible challenge. With too rigid a scientific approach, growth is stifled. Can we integrate assessment of the family system in a practical way clinically and still respond to the accountability demands of those who keep our doors open for business?

FUTURISTIC PARTNERING WITH SYSTEMIC BUSINESS PRINCIPLES

Partnering with managed care in some form of relationship seems to be the future picture for mental health providers. Managed care companies for outpatient behavioral health are competing under the criteria of the National Committee for Quality Assurance (NCQA), which are to be implemented for accreditation reviews in 1997 ("NCQA Develops Standards," 1996). The NCQA is a private, not-for-profit organization using accreditation and performance measurement to assess and report on the quality of managed care plans. Although it has no regulatory authority, the NCQA is seen as the industry standard by many business payers. Its annual Public Call for Measures invites professional provider

feedback on the HEDIS (Health Employer and Information Set) performance measurement set. This invitation is an opportunity for MFTs to be heard (Jennings & Towers, 1996). The NCQA can be contacted either by calling (202) 628-5788 or (800) 274-2237, or by visiting its website at http://www.ncqa.org. The first standard for NCQA is quality management and improvement ("NCQA releases," 1996).

Incorporating the terms *quality* and *system* in company titles and slogans seems to be a trend. Total Quality Management (TQM) has been identified as the way for American business to survive. But do we truly understand how the quality assurance concepts from TQM are parallel to the concepts in systemic family therapy and how they can be applied in the successful practice of family therapy?

Paralleling the development of family therapy, Dr. W. Edwards Deming, a statistician with a degree in mathematical physics, began revolutionizing the field of manufacturing and service organization management with his 1950 work in Japan (Deming, 1993). These principles laid the foundation for what later became known as TQM, which has been defined as "a systemic organizational philosophy that concentrates on meeting and exceeding the customer needs by constant improvement of the system, involvement of all people in the organization, and using statistics [objective data] as a tool for enlightenment" (Yingling, 1994, p. 5). TQM seems to be the systemic approach to management much as MFT is the systemic approach to therapy.

In this management approach, a *system* is defined as "a network of interdependent components that work together to try to accomplish the aim of the system" (Deming, 1993, p. 50). People are viewed as the foundation of any business system, even manufacturing. Transformation (second-order change) is seen as essential for our economy to survive. The leadership for this transformation has to be based on profound knowledge about system functioning, variation within the system, perpetual testing of predictive hypotheses for system improvement, and human relationships.

Deming's (1986) famous 14 points for management include a strong focus on a collaborative, supportive interactional process within a relatively flattened hierarchical structure in order to create a smooth functioning system that produces quality outputs, whose consistency can be measured with objective statistical tools. Another important concept is to first assess the system functioning before making a symptomatic relief change. This allows for special causes of excessive system variation to be identified and corrected before focusing on improving quality through reducing the in-control variation. Special causes are definable stressors separate from the normal system variation. Changing a symptom without understanding the impact on the system, a first-order change, can lead to throwing the system out of balance, a second-order change, in a way that creates worse symptoms. Assessing the system functioning first and making any necessary adjustments to system functioning will generally relieve symptoms in a permanent way. With much recent criticism of TQM not delivering what it promised, Brown, Hitchcock, and Willard (1994) have described the short-sighted focus on linear output versus the humanistic focus on systemic functioning predicting failure. They emphasize that our society needs valid implementation of TQM systemic beliefs and principles now more than ever. Perhaps the focus on linear output is a part of the quandary the mental health profession is currently encountering.

Family therapists are already trained to conceptualize in systemic functioning terms. We understand the importance of assessing and possibly intervening in the organizational structure and the interactional processes of the family-therapeutic system in order to produce quality outputs—symptom-free members of the system who develop in a healthy way, drawing from the nurturance provided by the healthy system.

Applying systemic principles to the business practice of MFT challenges our objective analytical skills. As the practice of MFT matures and is recognized as an "adult" in the

business world, we will be expected to compete under quality-assurance standards. The GARF is one systemic family functioning assessment tool that can be useful in this competitive marketplace.

In what way will NCQA standards influence managed care's selection of providers and demands on providers for outcome data? A draft copy of accreditation standards for managed behavioral health care organizations was developed in April 1996 (NCQA, 1996). These standards incorporate many external criteria according to which managed care companies will be judged in order to achieve NCQA accreditation. However, the first principles documented are the quality-improvement standards. These standards state that "Quality management is an integrative process that links knowledge, structure, and processes together throughout the MBHO [Managed Behavioral Healthcare Organization] to assess and improve quality" (NCQA, 1996, p. 2). These words seem to be very compatible with Deming's writings describing systems, as well as with the GARF's description of a relational system as emotional climate (nurturing output similar to Deming's knowledge), organizational structure, and problem-solving skills (interactional processes). Perhaps these three variables are the essence of life that permeate the sciences and the humanities.