Journal of Marital and Family Therapy
1988, Vol. 14, No. 1, 67–87

THE FAMILY TASK INTERVIEW: A TOOL FOR CLINICAL RESEARCH IN FAMILY INTERACTION

Warren Kinston
Brunel University
Uxbridge, England

Peter Loader
Hornsey Rise
Child Guidance Clinic
London, England

The Family Task Interview (FTI) is a multiple task interview administered by tape recorder and designed to elicit clinically relevant family interaction. The FTI has been designed to improve on previous similar instruments and a series of studies to evaluate its validity, reliability, and acceptability have been carried out. Further psychometric and practical evaluation is necessary, but results so far suggest that the FTI is a well standardized and easily administered instrument which is useful for research where assessment of family interaction using direct observation is required.

Direct observation of whole family interaction is essential in family therapy research. Individual family members, even if intensively interviewed by highly trained interviewers, cannot provide crucial data on the affective, communicative and relational behaviors which therapy focuses upon (Brown & Rutter, 1966). Although direct methods for the observation of whole families exist, many are irrelevant to clinical work with families (Cromwell, Olson, & Fournier, 1976). Naturalistic studies in the home, at a mealtime or over several days, have some appeal; but they are complicated and lack standardization. Interview approaches are of potential value for therapists, but have not been thoroughly evaluated and no single method has passed into regular use.

The principle of any method for eliciting family interaction of interest to family therapists are that it produces *clinically relevant* behavior in a reliable and valid fashion. This perspective differs from that called for in sociological, psychological or anthropological studies where validity typically refers to veridical replication or knowledge of some aspect of family life in its natural setting.

The Family Studies Group at the Hospital for Sick Children (London) has tackled this clinical research need in two ways. One approach was to construct a "Standardised Clinical Family Interview" (SCFI), which developed and refined whole family interviewing and, therefore, needed to be administered by an experienced therapist (Kinston

Assistance in developing and testing the Family Task Interview has been provided by Liza Miller, Lorian Rein, Jackie Stratford, Charlotte Burck, Arnon Bentovim, and other members of the Department of Psychological Medicine, Hospital for Sick Children, London, England. Generous financial support has been provided by the Leverhulme Trust.

Warren Kinston, BSc(Hons), MBBS, MRCPsych, is an Honorary Consultant Psychotherapist, The Hospital for Sick Children, London, England, and Senior Research Fellow, Institute of Organisation and Social Studies, Brunel University, Uxbridge, Middlesex UB8 3PH, UK.

Peter Loader, MBBS, MRCPsych, is former Research Fellow and Honorary Senior Registrar, The Hospital for Sick Children, London, England, and presently Consultant Child Psychiatrist at Hornsey Rise Child Guidance Clinic, London, England.

Address reprint requests to Dr. Kinston at the Brunel University address.

& Loader 1984, 1986). A major disadvantage of this approach was the intensive and expensive training effort. Our second approach, developed in parallel, was to devise a Family Task Interview (FTI). Our FTI draws on previous reasonably successful attempts by family therapists to elicit family behavior by asking members to perform various exercises which demand interaction.

This paper describes the rationale, development, structure and use of the FTI and gives evidence for its reliability, validity and usefulness.

PREVIOUS FAMILY INTERACTION TASKS

The use of single tasks to elicit family interaction has been popular amongst family-interaction researchers. Cromwell et al. (1976) reviewed such family tasks and divided them into three groups: (a) problem-solving, (b) decision-making, and (c) conflict-resolving. The research strategy associated with each group can be distinguished by varying degrees of relevance and standardization. This is because the three strategies each originated from different conceptual bases and were used for differing research objectives.

An alternative to the use of one lengthy, and often complex, task is the administration of a series of short and simple tasks. This has been the style favored by family therapist researchers who choose tasks highly relevant to clinical objectives and processes.

Watzlawick's (1966) Structured Family Interview was designed primarily as an interesting clinical tool and not further developed or validated. In this method, an interviewer administers five tasks: (a) what are the main problems? (to family members separately and then together); (b) plan something together; (c) how did you meet? (to the parents); (d) discuss a proverb (to the parents alone), and teach it to the children (children brought in after five minutes); and (e) an attribution of blame game. This interview is unwieldy because it requires family members to be separated and brought together repeatedly. The way the family is confronted and provoked is also questionable.

The Wiltwyck Family Tasks instrument (Elbert, Rosman, Minuchin & Guerney, 1964) has been further developed as The Family Task (Minuchin, Rosman & Baker, 1978), and also consists of five tasks: (a) plan a menu; (b) discuss a family fight; (c) what do other family members do to make you happy or unhappy?; (d) make a story about a picture; and (e) copy a model. The family is responsible for operating the tape recorder which gives them all the instructions and they may allow themselves as much time as necessary for each task. This disturbs standardization. In addition, an experimenter does some explaining and intervenes if necessary—again, disturbing standardization. A further problem with this instrument was the relative infrequency of affective behavior or interparental activity. Psychometric data have not been reported, but the method has been used for comparing treated and control families before and after the treatment period.

The Timberlawn group (Lewis, Beavers, Gossett & Phillips, 1976) has provided the most substantial evidence to date of the value and strength of the Task Interview method. An earlier version required an interviewer and reshuffling of the family; however, the later version was administered by tape recorder with a set time of 10 minutes for each task. In the latter, they also used 5 tasks: (a) discuss family strengths; (b) end a story in which someone is dying in hospital; (c) discuss the best and worst in the marriage (to parents only); (d) discuss what closeness means in the family; (e) plan something together.

In their pilot study, Lewis et al. used 12 patient-containing families and 11 nonlabelled volunteer families as controls; and in the main study, used 70 patient-containing families and 33 similar controls. Their interview enabled discrimination between patient-containing and control families, and distinguished between styles of interaction seen in

families where the patient suffered neurotic disorder, behavior disorder and psychotic disorder. Rank ordering of the initial 12 patient-containing families in terms of health pathology, on the basis of clinical interviews, correlated significantly with independent assessments made from the Task Interview. These assessments included global evaluation, a sum of a variety of scales evaluating functions, and microanalytic dissection of interaction. The researchers also found that the patterns of interaction held constant across different tasks, and that correlations of rating on single tasks with ratings on the whole interview were positive and moderately strong. The most obvious difficulty with the Timberlawn Task Interview is that it is restricted to verbal discussion tasks. This not only impairs its use in families with young children, but also limits the possibilities of evoking patterns or problems around nonverbal activities and physical interaction. Lewis et al. also did not examine standardization, repeatability, applicability and other aspects of reliability and validity in depth, nor did they look at clinical usefulness.

The overall picture, therefore, is that a multiple task interview can be constructed to generate systemic interaction of interest to clinicians, but that problems still remain. As the field is at an early stage of development, we decided to start again from the beginning. We clarified the aims and requirements of a multiple task interview; established principles for choosing tasks and linking them; collected and invented a variety of tasks; and piloted various forms of interview. Having created an interview format we began establishing its psychometric properties through using the interview in studies. Finally, we developed modifications to increase its research and clinical usefulness.

DEVELOPMENT OF THE FAMILY TASK INTERVIEW

Aims

Our overriding purpose was to elicit family interaction that was clinically significant and potentially usable by family therapists engaged either in research or clinical work. We believed it was essential that the FTI should be simple, easy to administer and standardized. We wanted it to feel natural and relevant to the family, as well as being reliable and valid for our own purposes. It was essential that all the tasks should require involvement of all family members, and we wished the tasks, so far as possible, to be applicable irrespective of the size of the family, stage of the family life cycle, or members' social class, education or psychiatric disturbance.

Issues for Consideration

Administration: Man or machine? Our initial trials showed, perhaps surprisingly, that an interviewer is more, rather than less, disturbing to the family than prerecorded audiotape instructions. His entrances and exits seem to disrupt the family, and the family's efforts to draw him into conversation spoil attempts at standardization. A cassette tape recorder provides for a cheap, simple, unobtrusive, clear and comfortable mode of administration. Videotape presentation might possibly improve the quality of the tape recorded instruction mode still further, but provision of such facilities entails greater complexity and expense.

Interview applicability. Family size and children's ages inevitably affect the type of tasks that can be chosen. To suit our interests, we decided to aim for an interview which is usable with either one or two parents, and with from one to four children. At least one child would have to be over 4-years old. We devised the interview to suit children from 4–12-years, but aimed for most of the tasks to be suitable regardless of age. Families in which all children were in their teens, would therefore require a change in one or two of the tasks. Similarly, we assumed that for special groups of families or for special research purposes, modification of one or two tasks might be appropriate.

Interview length. Young children have difficulty in participating in a procedure that stretches much beyond an hour. We therefore settled on about 50 minutes of task time, plus 5 minutes or so for explanations.

Task complexity. Tasks which require complicated preparations or instructions, demand the presence of a trained experimenter and increase the likelihood of his intervention. This spoils standardization, undesirably lengthens the interview, results in inadequate or handicapped families either refusing or being unable to participate, and affects general use by family therapists. We, therefore, chose straightforward tasks and kept trying them out and modifying or rewording them until the instructions were as simple and unambiguous as possible. The instructions, therefore, are always complete in one or two short sentences, and ancillary materials are kept to the minimum.

Task variety and number. Given a fixed time limit, the number of tasks will depend on the length allowed for each. We were concerned that the tasks should span a number of interactional areas, not overemphasize verbal participation, and allow different subsystems of the family to come into prominence. We initially settled on 6 tasks—5 tasks of 9 minutes and 1 task of 4 minutes; but later moved to 7 tasks—4 tasks of 9 minutes, 2 tasks of 4 minutes and 1 task of 5 minutes.

Interview atmosphere. Families differ in their perception of an experimental situation and may automatically view the environment as hostile and confusing (Reiss, 1971). However, some tasks in earlier methods implied or provoked psychopathology or family pathology, for example, by labelling members. Others depended on deception or trickery to stress the family and provoke a reaction. Given the absence of an interviewer or any followup in a research setting, such treatment of families, especially nonlabelled families, is ethically dubious. We aimed to produce a safe and supportive interview atmosphere which reduced the likelihood of the family experiencing failure or feeling attacked. Tasks were, therefore, chosen and worded so as not to stress the family unduly or unfairly. During the procedure, the family is reassured that the way they handle the tasks is their own way, and therefore, just right for us.

Type of task: Innocuous or relevant. The main idea behind this type of task interview is that interaction is generated as a spontaneous by-product of the task. Tasks which ask questions like, "What are your problems?" appear more relevant than seemingly innocuous tasks like, "Plan something together." However, the former focus an observer on the content of the response and distract him from interaction *around* the response. Most "relevant" questions have a seriously adverse effect on atmosphere.

Further varieties of FTI. For practical purposes, more than one FTI is required. For example, use of the method in certain experimental designs might call for two FTIs with different contents, to avoid staleness or a practice effect. We tackled the need for a second version (FTI-B) only after the principal version (FTI-A) was well developed and tested; it will be described later. Development of an FTI for use by clinicians (FTI-C) and for special application (FTI-S) are our most recent innovations.

STRUCTURE OF THE INTERVIEW

The FTI on audiotape consists of an introduction, a series of task instructions, and a brief conclusion. During the introduction, the family is welcomed and the rules and procedure are explained in a simple straightforward way. Each task instruction is repeated twice, and in case the family do not hear, or are still unclear as to the instruction, there is the option of reading instructions printed in large letters on cards inside envelopes next to the cassette recorder. The family are told approximately how long they have for each task. At the end, the family is thanked and informed that someone will come to them.

The principal FTI (FTI-A) in its finally evolved form consists of 7 tasks and these are described briefly below, together with the rationale and specific issues which characterize each. As mentioned above, a second FTI (FTI-B) has been produced, modelled closely on the FTI-A but with only 6 tasks, and deliberately shorter by 25%. Its structure in comparison with FTI-A is shown in Table 1.

Task 1: Plan Something Together. The family is requested to plan something to do together which must take at least an hour. This task, or some variation of it, is so popular that for comparability alone its inclusion seemed essential (Jacob & Davis, 1973; Lewis et al., 1976; Minuchin et al., 1978; Riskin & Faunce, 1970; Waltzlawick, 1966). It is simple, neutral and realistic, so we placed it first and allowed 9 minutes. However, we found that the notions of "planning" and "doing something together" could be alien to some families. We therefore reduced the task to 4 minutes, and now see it as launching the family into the event.

Task 2: Build a Tower with Blocks. The family is asked to get the box of blocks provided and build a tower. The nonverbal task allows the children to be given the initiative and offers the family the opportunity of experiencing the event as playful and creative. Because the family must move about the room and work around the central low table, there is the possibility of repositioning of members and physical contact between them. The task allows observation of the family's capacity for coordination, flexibility and role shifts. (4 minutes is allowed.)

Task 3: Discuss Likes and Dislikes. The family is asked to discuss the likes and dislikes of each member, and although the task is verbal, even very young children understand and participate with enthusiasm. The task allows expression of family problems, conflicts and wishes for change, and can reveal capacities and problems of individuation and differentiation. (9 minutes is allowed.)

Task 4: Pattern Recognition via Card Sorting. This problem-solving task uses blocks of color in patterns on cards, and the family is asked to take the deck of cards provided and sort them into groups in some appropriate fashion. The patterning is based on that originally devised by Reiss (1967) using alphabetic characters. There are several ways to sort the cards, but some solutions are more or less crude and use only part of the information available, while one solution is complete, complex and elegant. Once again,

Table 1
Comparison of FTI-A and FTI-B

FTI-A (60 minutes)		FTI-B (45 minutes)	
Introduction	2 min.	*Introduction*	2 min.
Plan something together	4 min.	What are family members like?	7 min.
Build a tower	4 min.	Build something together	5 min.
Likes and dislikes	9 min.	Affect-fantasy: School	9 min.
Pattern recognition: card sorting	9 min.	Pattern formation: arranging shapes	7 min.
Affect-fantasy: Hospital	9 min.	Children's names	7 min.
Proverb	9 min.	How did you find the interview?	5 min.
How did you find the interview?	5 min.		
Conclusion	1 min.	*Conclusion*	1 min.

Note. Both interviews use the same introduction and conclusion.

the family needs to regroup itself around the central table to work on the sorting. This task can elicit parent-child interaction of an interesting sort as children respond to the cards and see patterns in ways different to adults. How this task should be tackled must be negotiated within the family and decisions must be reached. (9 minutes is allowed.)

Task 5: Affect-Fantasy Task. We wished to use a task which demanded an affective and value-laden response and required sustained imaginative play together with the tolerance of painful feelings. It proved most difficult to devise one in a way that was not overwhelming, excessively threatening or too sophisticated. We considered asking the family to imagine emotive scenes, to look at emotive pictures, to draw on emotive events from the media, to refer to emotive events in their own life. We finally chose a story completion approach. The family is asked to make up a story using the following scenario: A family is at home—one member is missing and late returning—the phone rings and the family is asked to come to the hospital urgently. (9 minutes is allowed.)

Task 6: Explain a Proverb. The parents are asked to choose a proverb or a well known saying (because some do not know what a proverb is) and decide on what it means; then they must explain it to the children. This task gives an opportunity for the parents to interact together apart from the children, but with the children in the room, and then to perform a specific parenting activity. (9 minutes is allowed.)

Task 7: Reflection on the Interview. The family is asked to discuss their experience of the interview. This relatively late addition to the format gives an opportunity for the observer to compare his view of the family's experience of an event with their own view. It also allows for a variety of affective and instrumental responses by the family. Finally, it permits some self-debriefing. (5 minutes is allowed.)

CONDUCT OF THE FAMILY TASK INTERVIEW

Preparation

Families who are being recruited for an FTI require careful and sensitive preparation. The circumstances of recruitment should allow sufficient time for explanation of the procedure. This explanation should be simple, clear and honest. The family should be informed of the length of time involved and it must be emphasised that all family members are required to attend. They should be told that the interview will not inquire into their problem (if any), but that they will be asked to talk about some things and to do some things together. They should not be told any of the specific tasks. If the interview is to be videotaped, which is usually necessary, the family should be informed and reassured that permission to keep the videotape will be sought after the end of the FTI. In our experience, telephone recruitment and preparation are unsatisfactory.

Procedure

A researcher should, if possible, use an anteroom to explain the procedure just prior to administration. The length should be mentioned again and use of the toilet suggested for young children. He then explains that the interview will consist of a tape recording requesting them to do things together as a family, and that there is no need for them to touch the cassette player which will run continuously throughout the session. The family is reminded that there are videocameras and microphones and that, at the end, the videotape will be erased if they so wish. Any queries should be taken up and answered simply. The purpose of the interview may be restated as a wish to understand families. The attitude of the researcher is important during this introduction. Whilst he should be personable and warm, the explanation of the interview procedure should be assured and neutral. It is important that he does not pass on any expectations to the family, for example, that they will or won't enjoy it, or that it is going to be difficult or easy. The researcher then takes the family immediately to the interview room, points out the

equipment, announces the commencement of the interview, turns on the cassette recorder and leaves the room promptly.

A member of the research staff should promptly join the family at the end of the FTI and not leave them waiting. The researcher must obtain consent for preserving the videotape, and then administer further research procedures or organize departure of the family. Comments made by the family after the FTI is over to the person who joins them in the interview room should be listened to in an interested, but neutral, manner. The family should not be told that they have done well or poorly, and the researcher should not be apologetic, defensive or enthusiastic about the procedure.

Setting

The interview room should accommodate up to a six-member family comfortably and be carpeted and simply decorated. Its contents are solely as required for the research: a low table with an ashtray, and around it a semicircle of identical chairs. Extra-small chairs are provided for toddlers and young children. A shelf or table next to a wall is required for the cassette recorder, the box of blocks and set of cards and the envelopes containing the task instructions. Video/CCTV facilities are extremely useful, but (depending on the purpose of the research) not necessarily vital. In our set-up we use two high-quality microphones hung from the ceiling, and two video cameras mounted on adjacent walls out of the reach of children. One camera has a fixed, wide-angle lens, taking in the whole room and the other is fixed with a motorized platform and fitted with a motorized zoom lens and can be directed via remote control.

EVALUATING THE FAMILY TASK INTERVIEW

Our concerns were to develop extensive experience with the FTI by administering it to a range of families, and to study its validity, specificity, reliability, acceptability and applicability. The end result was to be a research tool that could be used with some degree of confidence in studies of family interaction.

Sample of Families

The FTI has now been used with about 300 families, and 30 families have received it on two occasions. Many families have been recruited in the course of pilot and research studies, and these can be grouped as follows:

1. Families of children with physical or psychosomatic illness attending various clinics in a large children's hospital: coeliac clinic (n = 36); obesity clinic (n = 13).
2. Families of children referred with emotional or behavioral problems to various centers: to a child psychiatry department in a children's hospital (n = 12); to an adolescent psychiatry clinic for school nonattendance (n = 26); to a community family therapy service (n = 12); to a child sexual abuse team (n = 12).
3. Families of children who are obese: on a general practitioner's list (n = 11); attending a local school (n = 13).
4. Families of nonlabelled children attending a local school (n = 15); and families in a Norwegian study of the effect on the family of a second child (n = 60).

Sampling methods varied according to the need of the particular study for which the family was recruited. From hospital clinics, consecutive attendances were taken. A similar approach was used for school attendance problems and family therapy service families. From the school, a random sample of nonlabelled children was obtained, and all children judged to be obese by their teachers. Other groups consisted of families available at the time. Basic data on many of these families are provided in Table 2. The data set is incomplete, but it is clear that we have tapped a wide variety of families.

Table 2
Basic Demographic Data on 120 Families given the FTI

Source of Families	
Hospital Clinics	43
Psychiatric Services	38
General Practice	11
School	28
Family Type	
Two Parent	94
Single Parent	26
Other (extended, additional adult, etc.)	0
No. of Children (Age range)	
One	25
Two	59
Three	28
Four	8
Age of Index Child	
0–5 years	13
6–10 years	55
11–16 years	52
over 16 years	0
Sex of Index Child	
Male	63
Female	57
Social Class	
I	9
II	25
III	62
IV	16
V	8
Cultural Origin	
Both parents British	91
One parent British	15
Both parents non-British	14

Note. The FTI has been used on about 300 families, but complete data on some families and from some projects is not available.

Psychometric Evaluation

The FTI is a *context* for research, not a measurement instrument. The extensive literature on psychometric evaluation of scales and questionnaires is, therefore, not immediately applicable. The discipline of psychology, where psychometry developed, traditionally ignored the context of their researchers and laboratories as irrelevant (Friedman, 1967; Rosenthal, 1966). In the absence of clear guidance from the literature on context evaluation, we have had to develop an approach from first principles. Our first decision was to base evaluation of the FTI on the purpose for which the FTI was to be used rather than on the data which was to be obtained. This purpose was clinically relevant description and evaluation of families.

Unfortunately, here the family research field is weak. From the beginning, conventional researchers have largely avoided clinical issues (Framo, 1972; Winter & Ferreira, 1969). Even now, a recent, thorough review concluded that the most basic requirements of meaningful family interaction research have been bypassed (Turk & Kerns, 1985). The authors claimed that key issues such as "the characteristics of family health and 'unhealth' " are obscure, and asked in desperation, "What tools are available to assess

and diagnose families as functional or dysfunctional?". Kerns & Curley (1985) went on to note that the literature on the effect of illness on the family relied on evidence from self-report and rarely used direct observational methods, despite the known limitations of the former and the value of the latter. Family therapy research has not been of much assistance. It has focused excessively on dysfunction and has paid more attention to theories of its "master" clinicians rather than to the development of a fundamental descriptive (phenomenological) base. Too often, it has adhered to methodological prescriptions based on the tradition of empirical psychology rather than developing its own tools and techniques.

Our own research has attempted to tread such a basic scientific path. On the one hand, basic epistemological inquiry has been pursued and argued in the social science and systems literature (Kinston, 1983; 1985; in press); and our approach to the family has firmly adhered to a systems approach. On the other hand, in this early phase of systematic family research, our concern has been to see the research-oriented clinician, rather than the clinically oriented researcher, as the primary observer and to leave him relatively unconstrained in his observation of the family. All our published research tools have been developed with these clinical and epistemological considerations in mind (cf. Bentovim & Kinston, in press). The Family Task Interview is a research tool which is integral to this general effort.

Table 3 lists the various approaches to assessing the reliability and validity of a Task Interview and compares our work with that of Lewis et al. (1976), the only previous researcher to have paid substantial attention to such issues. A fundamental principle

Table 3
Psychometric Properties and their Method of Study

Psychometric Property	FTI: This Paper	Lewis et al. (1976)
Validity and Specificity		
Against interaction elicited as part of clinical work	Done using FHS and qualitative descriptions	Not done
Against research clinical interview	Done using SCFI	Done, using own clinical interview and various health scales and micro-analytic studies
Against known differences between family groups	Not done (Some evidence available)	Done
Against individual psychopathology	Done, using well established questionnaires	Done, using MMPI and own "Adolescent Psychopathology Scale"
Against family self-report	Done, using FFI	Done, using own "Family Characteristics Inventory"
Reliability		
Test-retest reliability	Done, using FTI-A and FTI-B	Not done
Comparison of individual tasks with the whole FTI	Not done	Done, using global health rankings
Acceptability		
Family reactions	Done, using "Consumer Assessment" Reports after every FTI administration	Not done

in validating a method is the comparison of the method with an independently derived method. In the case of the FTI, the independent methods used have been the Standardised Clinical Family Interview (SCFI) (Kinston & Loader, 1986), derived from concepts of diagnostic clinical interviewing; the Family Experience Interview (FEI) (Kinston et al., in press) derived from the SCFI but with a focus on self-report; and routine clinical work derived from the impetus of therapeutic efforts with a family. As, from our perspective, validity relates to clinical relevance, no studies use family interaction in the home setting as a standard for comparison. It is also necessary to show that the Task Interview can discriminate between different groups of families, and that it cannot be replaced by self-report measures or measures of member psychopathology either taken individually or grouped. The main issue in reliability is whether the Task Interview shows up the same form of family interaction on different occasions or whether, what it reveals on a particular occasion, is excessively idiosyncratic and variable. We used our two similar instruments FTI-A and FTI-B to check this.

It will be clear from what follows, that there is still a long way to go in establishing the psychometric properties and limitations of the FTI, and methodological problems will be raised both in the body of the paper and in the Discussion section. However, over the past decade, we have become convinced that the FTI is a unique and indispensable tool for direct observation, and epitomizes the family therapy approach. The aim here has, therefore, been to stake out the ground covered so far and to provide a base from which further research may grow.

The Family Health Scales: A Clinically Relevant Measure

The various measures used in different studies will be detailed below, but at this point it is necessary to introduce and describe briefly the Family Health Scales (FHS) and the measure it generates, as this has been the most important measure used. Our research has been concerned with overall family functioning and the degree of health or dysfunction. To assess this, we have devised and developed, over the past decade, the FHS, to allow reliable and valid clinical rating (Kinston, Loader & Miller, 1987a). The FHS is based on a model of the family as a system for the emotional support of all members, and the nurturance and socialization of the children. The FHS has moved through several revisions and the second and third editions have been used in the studies to follow. The rater using these scales needs to be trained. The family is rated on a variety of main scales, and the rater is sensitized by rating subscales within each main scale, and weighting those intuitively. The main scales of the third edition are *Affective Status, Communication, Boundaries, Alliances, Adaptability and Stability,* and *Family Competence.* The final FHS score is an average of main-scale ratings. There is no compulsion to complete any particular subscale or main scale.

The final score, which is calculated to one decimal place, is between 1 (poorest functioning) and 7 (optimal functioning). A score of 5 reflects adequate functioning. It must be emphasized that this is a rating based on clinical values and does not imply a population norm. Families drawn from different nonlabelled populations have been found to contain varying amounts of dysfunction, apparently related to the social and economic circumstances of the population.

Data Handling and Analysis

Data were coded and punched onto computer cards and analyses performed using SPSS (Statistical Package for the Social Sciences) on the University of London Computer. Nonparametric methods of analysis such as Spearman's rank correlation coefficient and Wilcoxon Matched Pair Signed Ranks Test were generally used because these tests are suitable for ordinal data and require minimal assumptions as to population distribution (Siegel, 1956).

Issue No. 1: Comparison of FTI with Clinical Elicitation

If the FTI is valid, it should generate interaction similar to that found during routine family therapy clinical work. The FTI should also manifest its own qualitative specificity, that is to say, it should reveal features of family interaction not apparent in routine clinical work. A moderately positive correlation between FHS ratings in the two situations would, therefore, be expected as validity becomes tempered by specificity.

Procedures. A study to check these qualitative and quantitative predictions was carried out and has been described in detail with qualitative findings in Stratford, Burck & Kinston (1982). Briefly, the study involved 12 consecutive families, each attending one of two therapists for treatment of psychiatric disturbance in a child. The families' interaction during clinical work was described by the therapist involved using the FHS dimensions as a framework, and the family was also rated using the FHS. Within 1–2 weeks the FTI was administered and the family was described and rated, this time by both therapists—the therapist who did not know the family acting as independent observer. A Comparison Questionnaire was given to each family's therapist enquiring about similarities and differences between interaction seen at the FTI and her clinical knowledge. The procedure of description, rating and comparison was repeated 6 months later, and each family was then discussed in detail.

Results: The qualitative findings may be summarized as follows. In 9 of the 12 families, the main clinical features were revealed in the FTI. In the remaining 3, conflict felt by the therapist to be crucial was absent. However, detailed examination of these cases revealed causes for this outside the FTI. Conflicts within the remaining families had been adequately revealed. The FTI, therefore, showed clinical validity. The qualitative specificity of the FTI was also marked. In 11 of the 12 families, new clinically significant information was obtained, most notably in the area of alliances. This seemed to be principally explained by the way the therapist intrudes into the family system, thereby distorting alliance patterns. The clinical validity of FTI-generated interaction was confirmed in several cases by the ease with which the new knowledge was incorporated into revised therapeutic strategies for treating the family.

The quantitative findings are reported here for the first time. The measure used was the FHS. Reliability on the FHS was adequate: Nonparametric correlation of FHS ratings by the two raters on the FTI was 0.88. No systematic bias was found, nor was there any difference according to which therapist acted as observer, nor were there differences between immediate FHS ratings and those made at 6 months. Using mean FHS ratings when available, Spearman's nonparametric correlation, r_s, between the FHS rated on the basis of clinical knowledge compared with the FHS rated on the FTI was 0.64 ($p<.02$) with no systematic bias evident (Wilcoxon Test). These findings suggest FTI validity.

Issue No. 2: Comparison of FTI with a Research-Style Family Interview

The validity revealed under Issue No. 1 cannot be automatically extended to nonlabelled or "normal" families. Families in therapy have particular expectations and have learned ways of being with the therapist, and these factors may account for the validity. For nonlabelled families, clinically relevant interaction needs to be generated by a specially designed research interview. As indicated earlier, we designed such an interview, called the "Standardised Clinical Family Interview" (SCFI). Details have been provided in full in Kinston and Loader (1984, 1986). The semistructured format requires the interviewer to carry the family through discussion of a variety of relevant issues. These include what sort of family they are, who does what with whom, who is like whom, roles and responsibilities, conflicts, and so on. The interviewer must follow a number of rules and guidelines in conducting the interview, and is expected to take a nontherapeutic stance in relation to any problems or pathology which may emerge.

The SCFI has been demonstrated to be reliable and has its own specificity. Clinical validity, however, appeared to be interfered with by the demands of the interview protocol. Although this problem may be less relevant for nonclinical families, it suggests that the FTI may be less similar to the SCFI than to interaction elicited clinically. We, nevertheless, predicted a broad similarity, both qualitatively and quantitatively, between interaction revealed by the FTI and SCFI. This was tested in two projects.

Project 1: Procedures. Consecutive families attending the coeliac clinic were screened and requested to attend for two whole family interviews until 17 had consented. Six families refused to attend, and 2 were excluded because English was not the language spoken at home. All families had both parents and from 1–4 children, ranging in age from 6 months to 16 years. All social classes were represented. Half the families received the SCFI initially and half received the FTI initially. At the second interview, 2–5 weeks later, each family received the other research interview. For practical reasons, the FHS ratings of the two interviews were performed at different times. The SCFI ratings were performed at the time of the interview by the interviewer and an observer watching on closed circuit television. The FTI ratings were made by two observers watching the 12 available videotapes 3 years later. The FHS ratings in the latter case were based on 3 of the 6 tasks, and we justified this, using the Timberlawn demonstration that family assessment based on viewing part of a task interview is highly correlated with assessment based on viewing the whole interview (Lewis et al., 1976).

Project 1: Results. FHS ratings were again reliable. For the SCFI, $r_s = 0.73 (n = 17)$, and for the FTI, $r_s = 0.73$ ($n = 12$). Correlation between mean FHS scores on the SCFI and on the FTI was moderately high, $r_s = 0.49$ ($p < 0.05$), but lower than that found in comparison with clinical elicitation, as expected. There was no tendency for either of the interviews to reveal the families systematically as more or less well functioning (Wilcoxon Test). Analysis to check whether the order in which the interviews were administered to the family affected these conclusions also revealed no effect.

An attempt to make detailed qualitative comparisons between the SCFI videotapes and the FTI videotapes failed because of the difficulty in obtaining agreement between clinicians as to the family interaction observed at the SCFI. Our clinical assessors found themselves unable to disentangle the role and contribution of the interviewer.

Project 2: Procedures & results. In the obesity study (Kinston, Loader & Miller 1987b), 33 families with an obese child were given both an FTI and the Family Experience Interview (FEI), an interview derived from the SCFI (Kinston & Loader, 1984, 1986). The FEI was administered in the home setting. The FHS ratings were made using the FTI, and inter-rater reliability was satisfactory at .87. The FEI was used to make a global rating of overall family functioning (HIFR) on a 1–7 scale homologous with the FHS. Reliability on the HIFR was also satisfactory at .79. Correlation (using mean scores) between the FHS rating using the FTI and the HIFR using the FEI was .52 ($p < 0.001$). The FEI, like the SCFI from which it derived, was subject to a significant interviewer effect. When the FEI was administered by one interviewer, families were judged at a similar level of family health to the FTI, but when administered by the other interviewer, they were regularly judged to be more healthy.

Issue No. 3: Discrimination of Distinct Groups of Families

This standard component of test construction has not been deliberately addressed, as yet. Conventionally, the FTI would be expected to discriminate clearly between samples of families independently assessed as varying on family health or other clinically significant interactional characteristics. It would, of course, be expected that the FTI should reveal similarities and differences among groups of families; and circumstantial evidence does exist from numerous studies. On examining our use of the FTI, we have noted that psychiatrically labelled families frequently scored in the range 2–4 on the FHS, e.g., the psychiatric clinic group used to study Issue No. 1, the psychiatric

group in the school nonattendance study, the families referred to a community clinic; whereas our other families frequently scored in the range 4–6 on the FHS, e.g., families from the coeliac clinic and obesity clinic, random sample selected from a school, families in the Norwegian study. Standard deviations are typically in the range 0.8–1.1. Further details, including means and standard deviations for various groups, have been provided in Table 4 of Kinston et al. (1987a).

Issue No. 4: Internal Consistency

A relevant question concerns whether the various tasks in the FTI generate different aspects of family interaction which, taken together, reflect a fairly complete and multidimensional picture of family functioning, or whether the different tasks merely measure repeated instances of a relatively narrow aspect of family functioning. On the face of it, the former is more likely to be the case, but no specific and formal studies have been carried out. Lewis et al. (1976) has demonstrated similarity between tasks in terms of the overall quality of family functioning. Simple observation suggests that the various tasks do evoke different aspects of interaction. This is more marked in healthy families, as the more dysfunctional families tend to respond rigidly and repetitively irrespective of the task stimulus.

Issue No. 5: Validation against Individual Member Psychopathology

The FTI, if valid, should allow family disturbance to be revealed in preference to individual disturbance. We might expect these two levels to move together at the extremes: The healthiest families would have healthy members and the most dysfunctional families would have the most disturbed individuals. However, in the mid-range, lack of congruence would often seem likely. A high degree of congruence at all levels of pathology might suggest that the FTI simply allowed members to present themselves as individuals, rather than enabling family patterns that transcend individual states to be revealed. Full details of the procedure and findings are published elsewhere (Kinston et al., 1987a) and only a brief summary is presented below.

Procedure. Our measure of family health was again the FHS score, and the individual measures were the General Health Questionnaire (GHQ) for parents and children over 16 years (Goldberg, 1972); the Rutter A Scale (PR) for school children from 5–15 years (Rutter, Tizard & Whitmore, 1970); and the Behaviour Checklist (BCL) for preschool children (Richman, 1977). These are all well established self- or parent-administered questionnaires with a cutoff score above which a "case" is identified. All FHS ratings were made in ignorance of scores on these instruments. We judged the family unhealthy on the individual health criterion if one member or more scored as a "case" on the GHQ, PR or BCL; and unhealthy on the family health criterion if the FHS was less than 4.5. Several groups were studied including: (a) the psychiatric group from Issue No. 1 ($n = 12$); (b) a coeliac group containing two subgroups, the families from Issue No. 2 and a further group of 13 families from a subsequent study ($n = 25$); (c) a group of families with an obese child ($n = 37$); and (d) a group of randomly selected families from a nearby school ($n = 15$).

Results. The results for the four groups are displayed in Table 4. As predicted, there is marked incongruence between the two criteria of family health, which varies considerably according to group: from 16% in the school group, to 32% in the coeliac group, to 41% in the psychiatric group to 51% in the obese group.

Issue No. 6: Specificity with Regard to Family Self-Report

Families do have some idea of themselves, but the FTI purports to enable a researcher to see the depth structure of family life and to obtain data which is normally only obtainable through therapeutic interviewing of whole families. From the start, leading figures within the family therapy movement such as Ackerman (1958), Bowen (1966) and Minuchin (1974) have emphasized the difference between whole family interviewing

Table 4
Relation between Family Health Measured on the Family Interaction Criterion and the Individual Health Criterion

Key to matrix pattern presented below for each group:

Healthy on FHS & Healthy members *(congruent)*	Healthy on FHS & Unhealthy member(s) *(incongruent)*
Unhealthy on FHS & Healthy members *(incongruent)*	Unhealthy on FHS & Unhealthy member(s) *(congruent)*

Group	Matrix		No. of Families	% Incongruence
Psychiatric Group	0 2	3 7	$n = 12$	41%
Coeliac Group (1983)	9 4	4 8	$n = 25$	32%
Obese Group	3 10	9 15	$n = 37$	51%
School Group	5 1	1 8	$n = 15$	16%

Table 5
FTI Specificity: Comparison of Different Groups of Families as Judged by the FHS rated on the FTI, and as Self-rated by the Parents using the Family Functioning Index (FFI) of Pless and Satterwhite (1973)

	Hospital Obese $n = 13$	Community Obese $n = 9$	Hospital Coeliac $n = 11$	All Families $n = 34$
Mother's FFI and FHS	−.20	.46	.16	−.02
Father's FFI and FHS	−.29	.04	.30	.09

and individual-oriented approaches. It is, therefore, to be expected that our FHS measures of family health would show no more than a low positive correlation with family members' own assessments of the quality of family life. The work of Reiss (1971) suggests that the FHS might show zero or negative correlation in the case of certain types of families.

Procedure. The instrument we used for the family self-report was the Family Functioning Index (FFI) of Pless and Satterwhite (1973), which is completed individually by both mother and father and, thus, gives two scores. The FFI was administered to 34 families in three groups as part of a larger study. The groups were: (a) families of obese children recruited at a hospital clinic ($n = 13$); (b) families of obese children recruited from a general practitioner's office ($n = 9$); and (c) families of children attending the coeliac clinic ($n = 11$).

Results. Table 5 shows our findings. The picture is unclear, but high correlations are noticeably absent. The families do seem to reveal themselves differently at the FTI than they do on the self-report measure.

Issue No. 7: Test-Retest Reliability

Whilst, given the dynamic quality of family life, one would not expect exactly the same family interaction to occur at two points in time, one would expect a reliable and valid instrument to reproduce similar patterns at different times and reveal the family as functioning at a similar level. If the FTI is to be used in before-and-after experimental designs (e.g., outcome studies), then reliability of this sort is essential.

Procedure. To obviate practice effects and the experience of boredom, rather than administering the FTI-A twice, a second instrument, the FTI-B was constructed on similar principles, but shorter. Its structure is outlined in Table 1. The sample used in this study consisted of the families of 15 randomly selected children from a local primary school. Half of the families received the FTI-A first and the other half received the FTI-B first on a random basis. Two to three months later, each family received the alternate FTI. Each FTI was rated using the FHS by three independent raters. The same raters were used on each occasion. No discussion of families or their scores was permitted.

Results. The six pair-wise correlations of the FHS scores were 0.59, 0.63, 0.59 (FTI-A) and 0.70, 0.77, 0.88 (FTI-B). The first set is lower than usual. The three-way correlation using Kendall's coefficient of concordance is .74 (FTI-A) and .86 (FTI-B). We, therefore, proceeded to use mean FHS scores for comparison of ratings at the two FTIs. The correlation between the mean FHS scores on the FTI-A and the FTI-B was $r_s = 0.79$ ($p < .001$). There was no systematic bias associated with either interview (Wilcoxon Test). We examined for an order effect and found that there was a distinct, but not statistically significant tendency for all raters to rate the second FTI slightly lower than the first. The mean FHS at the FTI-A was 4.3 (s.d.1.1); the mean FHS at FTI-B was 4.0 (s.d.1.0).

Formal qualitative analysis of similarities and differences between interaction elicited at each interview has not yet been carried out. We are currently investigating whether the FTI permits expected changes, such as might occur during therapy, to be revealed (Leff, Asen, Berkowitz, Cooklin, Loader, Piper & Rein, 1986).

Issue No. 8: Acceptability to Families

Any procedure which enters deeply into family life must be judged acceptable by both clinicians and the families themselves. The FTI was designed to be innocuous and we observed that families tolerated the FTI procedure well. However, some more systematic evidence from the families, themselves, was desirable.

Procedure. We ensured that every family given the FTI was given a simple questionnaire (Consumer Assessment Report) immediately after its administration. The Report enquired as to whether the interview was, or was not, interesting, comfortable and helpful, and whether the families believed they had manifested typical family behavior. Families which had also received the SCFI were requested to make comparisons between the two types of research interview. Additional comments were also invited. In the obesity study, which included 67 families in 3 obese and 2 control subgroups who had received a total of 83 FTIs, we also enquired in detail about the families' views of the individual tasks.

Results. All families completed the questionnaire. The large majority found the FTI interesting and only the occasional family reported it as positively boring. Families sometimes reported finding the experience uncomfortable, but most opted for "neither comfortable nor uncomfortable." A similar response was made to the helpfulness question where most families responded neutrally. Twenty percent viewed the FTI as positively helpful, while reports that the FTI was harmful or distressing were rare, despite evidence of severe pain, anxiety and dysfunction that was sometimes elicited during the procedure. Two out of three families stated that their FTI behavior was typical of them, but some commented on the unnatural nature of the procedure. Of those that received the SCFI as well as the FTI, just over half preferred the SCFI.

In the obesity study, no families reported the event as "unpleasant," or "distressing," although a few rated it as "uncomfortable." Varying proportions in the 5 subgroups (8%–77%) reported the FTI to be positively "enjoyable," "comfortable" or "helpful." Most thought the FTI was not too long. Of the various tasks, those requiring activity (the building block task and the card-sorting task), were most liked. The discussion of likes and dislikes and the task to reflect on the experience of the interview were also well liked. Some families disliked the Plan Something Together task (8%–23%), more, the proverb task (33%–62%) and most disliked the affect-fantasy task (33%–77%). Forty-six percent to 77% of the families indicated that they believed the FTI had revealed typical family behavior.

DISCUSSION

Clinically oriented child psychiatric and family research, in particular, family therapy research, requires an instrument to elicit whole family interaction of relevance to clinical work. Of the two possible approaches favored by clinical researchers, a clinical-style research interview (like our SCFI) and a multiple-task interview (like the FTI), the latter has the advantage of built-in standardization and has attracted most attention. Several types of multiple-task inverview have been produced, usually with limited purposes and minimal psychometric evaluation. We developed the Family Task Interview to overcome these disadvantages and provide a common instrument for the field.

The FTI, as developed and described in this paper, has now been used on about 300 occasions with a wide variety of families. Its value is grounded in the experience and evidence generated by previous clinical researchers, especially Elbert et al. (1964) and Lewis et al. (1976). However, our FTI incorporates improvements and has undergone additional psychometric evaluation. It can, therefore, claim a longer period of development and testing, and a clearer, stronger rationale. In addition, we have produced a second version and tested it against the original. It is necessary here to review what has been done and to look in more detail at these methodological and practical claims.

Methodological Issues

The limited claim of our work is that it takes the sophistication and testing of a Task Interview a step further. Clearly, there is a great deal more which needs to be done, both in tackling the issues raised in this paper, and in generally investigating the scope and usefulness of a Task Interview. A limitation in our studies has been the predominant use of the Family Health Scales and less use of qualitative descriptions than would have been desirable. This is partly due to our own research interests, but, as argued earlier, is also a reflection of the current state of the art (also cf. Eisler, Szmukler & Dare, 1985; Loader, Burck, Kinston & Bentovim, 1981; Reiss, 1983). Whatever the reason, the consequence is that it is difficult to know, for example, if the degree of stability of the FTI across time accurately reflects the stability elicited by the FTI, or merely reflects the limits of the reliability or sensitivity of the FHS. It will, therefore, be necessary to study the FTI further with existing and new instruments for family assessment, and via content analyses of transcripts. However, certain criticisms of the methods employed will always be hard to overcome: For example, ensuring rater blindness as to the type of interview being administered may be impossible, or at least not easy to achieve. In any case, validation studies need larger sample sizes, and confidence in a method only develops with time, experience and positive usefulness. We will now review each of the issues in the body of the paper in turn, with a focus on their methodological implications and problems.

Issue No. 1

The finding of clinical validity and qualitative specificity of the FTI, as reported in detail and methodologically reviewed in Stratford et al. (1982), has been extended in this paper by the finding of a significant correlation between overall health as rated in the clinical setting and as elicited by the FTI. The correlation is not high and is consistent with the qualitative observation that many families revealed previous unrecognized strengths or weaknesses in the FTI setting. We suggest that these findings confirm the family therapy axiom that, once the therapist is in the system, the family system is significantly altered. Interactional differences noted at the FTI were readily incorporated into new therapeutic plans for the family; and this strengthens the view that the FTI is a clinically valid method of observing a family.

Issue No. 2

The correlation of FHS scores of interaction revealed by the FTI and FHS scores on the SCFI is significantly positive, though not high. The findings are in line with those of Lewis et al. (1976). Inevitably, the raters were not blind to the method of interviewing. However, memory effects are unlikely and bias is not an issue when similarity is being sought. There was no systematic depression or elevation of ratings of family health between the methods. The differences in interaction between the FTI and SCFI probably reflect both the influence of the interviewer as well as the different demands placed on the family. A study looking at qualitative differences in interaction in the two interview settings failed because the observers could not agree on the influence of the interviewer. Similarly, the FHS ratings of interaction at the SCFI became unavoidably contaminated by reported information on family life. These reports emerged in a variable (i.e., non-standardized) way because the rules of SCFI administration only call for standardization in regard to interviewing style and protocol. Such information, conveniently, does not usually emerge during the FTI.

Issue No. 3

The finding that the FTI allowed discrimination between labelled and nonlabelled families, though probably valid (cf. Lewis et al., 1976), is weak, insofar as no formal study has been conducted specifically to test for this. The absence of methodological safeguards such as blind rating and randomized presentation of videotapes means that our findings might have been influenced by prior expectation or bias. Hence, the evidence presented remains indicative but nonconclusive.

Issue No. 4

Distinction between tasks is a poorly studied area in the field. On the surface, our set of tasks appears superior to previous sets for the reasons outlined in the section on Development of the FTI. However, further studies of the FTI with measuring instruments designed for a delimited purpose (e.g., parent-child attributions, conflict resolution) are necessary to test the quality, uniqueness and validity of tasks used in the FTI.

Issue No. 5

The FTI was designed to reveal family dysfunction, and it has been found that the family context modifies the degree to which the mental disturbance of individual members manifests itself (Lewis et al., 1976). So, the FTI would not be valid if all it did was enable individual family members to reveal their psychopathology. FTI validity is suggested by our finding that of the families scoring as healthy, 50% (17 of 34) contained disturbed individuals; and of the families all of whose members scored as healthy, 50% (17 of 34) were rated as unhealthy on the FHS. The incidence of health and disturbance varied more or less as expected amongst the different groups of families; for example,

it was to be expected that the psychiatric group showed the highest rate of individual and family disturbance. However, too little is currently known about the relationship between individual and family functioning to comment further on these results.

The measures of individual health have had empirical validation of their cutoff points, but the FHS has not been standardized in this fashion. The cutoff point chosen on the FHS (4.5) was based on clinical values inherent in the construction of the scale. Although our empirical finding was that nonlabelled families usually score over 4, 60% (46 of 77) of these nonlabelled families were revealed as unhealthy, using this criterion. More investigation into family functioning in the general population seems indicated.

Issue No. 6

The finding of variable, mainly low, correlations between family health ratings and FFI self-report measures of family life, cannot be regarded as conclusive. However, our results are consonant with findings from other studies (e.g., Olivieri & Reiss, 1984). It does seem likely that the FTI reveals a quality of family life that is normally unrecognized by the family members, themselves, but further exploration of family self-understanding, using other self-report scales and a larger number of cases of different types, is desirable.

Issue No. 7

Test-retest reliability of the FTI, that is to say, whether it elicits the same family interaction when used on more than one occasion, is important. This study used a second version of the FTI and demonstrated a reasonably high correlation in terms of FHS scores. Once again, it was impossible to make raters blind to which FTI was used. However, the aim was not to demonstrate differences, and so memory effects are more important than bias. Although scores may possibly have been influenced by a memory of previous rating, the time gap and the large number of other families being rated in the meantime would militate against this. Qualitative analysis of similarities and differences would be useful, and is planned.

Issue No. 8

Families, if properly prepared, have invariably accepted the FTI process, no matter how severe their disturbance. However, some of the tasks are liked more than others, and the affect-fantasy task seems to be particularly disturbing. The majority of the families regard their behavior as typical, though this varies with the particular sample. We have no evidence as to whether the interaction revealed is, indeed, like that to be seen at home, but in any case, we are more concerned as to whether it is typical of interaction of concern to clinicians.

Practical Advantages

The FTI described in this paper incorporates substantial improvements on previous versions. The FTI is suitable for families of varying types, of varying sizes, with and without disturbed members, and with children of varying ages. The tasks are all straightforward and are rapidly understood by families. The FTI uses a minimum of simple materials and demands no researcher intervention. A range of tasks which elicit joint activity, affects and fantasy, as well as discussion, are provided; and the family is supported and encouraged, throughout, rather than deceived, confused or provoked.

In short, the FTI is fully standardized, easy to administer, requires no expensive or complicated equipment, calls for a minimum of researcher training, is nonoffensive to families, and is accepted by both labelled and nonlabelled families. We believe that these advantages of the FTI are substantial and enhance its usefulness for clinical research work. Given such properties, it is perhaps surprising that the FTI can generate

interaction that feels *clinically real* and *emotionally true;* but we have shown this to be the case (Stratford et al., 1982). Clinicians and researchers without a background in family therapy are usually taken aback or shocked by the intensity of feeling and intimacy that is exposed. Observation of disturbed families is sometimes described as "unbearable," and reluctance to watch or pay attention to the videotape is not uncommon. FTI-elicited interaction can be stored on videotape for further study and, no matter how apparently painful and disturbing the interaction, families almost always permit this.

The FTI also lends itself to modification to suit the task in hand. As long as the basic framework, principles and protocol are adhered to, it seems likely that one, or even two, tasks might be modified to suit particular situations, e.g., a family whose youngest child is an adolescent, without adversely affecting the reliability and validity of the method. Our experience is that using a task which specifically elicits a family's report about a matter of concern, should be considered very carefully.[1] Such a task may sometimes be appropriate and useful, but often, it may run counter to the spirit of the FTI. If a family report is required, we recommend the use of our Standardized Clinical Family Interview (Kinston & Loader, 1984, 1986), modified as needed.

Wider Usefulness

The FTI is not just a research instrument; it has been found of value as an educational and clinical tool. Just because the FTI is standardized, it is possible for students to use it to learn to describe families and to recognize characteristic dysfunctional interaction. This learning is further aided by divorcing the work of describing family interaction from the work of obtaining family reports, and pursuing therapeutic aims. We have already indicated that the FTI can give an insight into family interaction, adding to that derived from clinical interviews and, therefore, useful in family therapy. We have developed, and are now testing, a shorter version that is geared specifically to clinical use.

CONCLUSION

While it is important that the FTI not be regarded as conclusively tested, it is equally important for the family research field to accept that an observational method is now available.[2] Our psychometric studies provide some evidence that the FTI produces family-level data which is valid in comparison to that obtained from therapeutic interviews and clinical-style research interviews with whole families. In addition, the FTI manifests its own specificity by revealing clinically relevant interaction that may be obscured by the presence of an interviewer. The FTI also appears to be a reliable instrument.

Colleagues are using the FTI for a transcript study of family life based on attribution theory (M. Stratton, personal communication, 1985), in outcome research (Leff et al., 1986), to study families of school refusers (Sevitt & Huffington, 1986), and to study the effects of a second child (P.-O. Naess, personal communication, 1986). We have recently completed a study of the family context of childhood obesity using the FTI (Kinston et al., 1987b; Kinston, Loader, Miller & Rein, 1987).

This paper should, therefore, be seen as a report of work in progress. We are currently examining the sensitivity of the FTI to clinical change, and intend to apply the method to other types of families and family problems. We are also studying its potential for contributing to routine clinical work, and applications to specific nonclinical situations where direct observation of family interaction is needed.

REFERENCES

Ackerman, N. (1958). *The psychodynamics of family life: Diagnosis and treatment of family relationships.* New York: Basic Books.

Bentovim, A. & Kinston, W. (in press). Psychodynamic family therapy. In: A. S. Gurman & D. Kniskern, (Eds.), *Handbook of family therapy, second edition.* New York: Brunner/Mazel.

Bowen, M. (1966). The use of family theory in clinical practice. *Comprehensive Psychiatry, 7,* 345–374.

Brown, G. W. & Rutter, M. (1966). The measurement of family activities and relationships: A methodological study. *Human Relations, 19,* 241–263.

Cromwell, R. E., Olson, D. H. & Fournier, D. G. (1976). Tools and techniques for diagnosis and evaluation in marital and family therapy. *Family Process, 15,* 1–49.

Eisler, I., Szmukler, G. I. & Dare, C. (1985). Systematic observations and clinical insight—are they compatible? An experiment in recognizing family interactions. *Psychological Medicine, 15,* 172–188.

Elbert, S., Rosman, B., Minuchin, S. & Guerney, B. (1964). A method for the clinical study of family interaction. *American Journal of Orthopsychiatry, 34,* 885–894.

Framo, J. L. (1972). *Family interaction: A dialogue between family researchers and family therapists.* New York: Springer.

Friedman, N. (1967). *The social nature of psychological research: The psychological experiment as a social interaction.* New York: Basic Books.

Goldberg, D. P. (1972). *The detection of psychiatric illness by questionnaire.* (Maudsley Monograph No. 21). London: Oxford University Press.

Jacob, T. & Davis, J. (1973). Family interaction as a function of experimental task. *Family Process, 12,* 415–427.

Kerns, R. D. & Curley, A. D. (1985). A biopsychosocial approach to illness and the family: Neurological diseases across the life-span. In D. C. Turk & R. D. Kerns. (Eds.), *Health, illness, and families.* New York: Wiley.

Kinston, W. (1983), Pluralism in the organisation of health services research, *Social Science & Medicine, 17,* 299–313.

Kinston, W. (1985). Measurement and the structure of scientific analysis. *Systems Research, 2,* 95–104.

Kinston, W. (in press). A total framework for inquiry. *Systems Research.*

Kinston, W. & Loader, P. (1984). Eliciting whole-family interaction with a standardized clinical interview. *Journal of Family Therapy, 6,* 347–363.

Kinston, W. & Loader, P. (1986). Preliminary psychometric evaluation of a standardised clinical family interview. *Journal of Family Therapy, 8,* 351–369.

Kinston, W., Loader, P. & Miller, L. (1987a). Quantifying the clinical assessment of family health. *Journal of Marital and Family Therapy, 13,* 19–67.

Kinston, W., Loader, P. & Miller, L. (1987b). Emotional health of families and their members where a child is obese. *Journal of Psychosomatic Research, 31,*(4).

Kinston, W., Loader, P. & Miller, L. (in press). Talking to families about obesity: A controlled study. *International Journal of Eating Disorders.*

Kinston, W., Loader, P., Miller, L. & Rein, L. (1987). *Interaction in families with obese children.* Unpublished manuscript.

Leff, J., Asen, K., Berkowitz, R., Cooklin, A., Loader, P., Piper, R. & Rein, L. (1986). *The assessment of outcome in families receiving family therapy.* Unpublished manuscript.

Lewis, J. M., Beavers, W. R., Gossett, J. T. & Phillips, V. A. (1976). *No single thread: Psychological health in family systems.* London: Macmillan.

Loader, P., Burck, C., Kinston, W., & Bentovim, A. (1981). A method for organizing the clinical description of family interaction: The Family Interaction Summary Format. *Australian Journal of Family Therapy, 2,* 131–141.

Minuchin, S. (1974). *Families and family therapy.* Cambridge, MA: Harvard University Press.

Minuchin, S., Rosman, B. L. & Baker, L. (1978). *Psychosomatic families: Anorexia nervosa in context.* Cambridge, MA: Harvard University Press.

Olivieri, M. E. & Reiss, D. (1984). Family concepts and their measurement: Things are seldom what they seem. *Family Process, 23,* 33–48.

Pless, I. B. & Satterwhite, B. (1973). A measure of family functioning and its application. *Social Science & Medicine. 7*, 613–621.
Reiss, D. (1967). Individual thinking and family interaction: II. A study of pattern recognition and hypothesis testing in families of normals, character disorders and schizophrenics. *Journal of Psychiatric Research, 5*, 193–211.
Reiss, D. (1971). Varieties of consensual experience, II: Dimensions of a family's experience of its environment. *Family Process, 10*, 28–35.
Reiss, D. (1983). Sensory extenders versus meters and predictors: Clarifying strategies for the use of objective tests in family therapy. *Family Process, 22*, 165–171.
Richman, N. (1977). Is a behaviour checklist for pre-school children useful? In P. J. Graham (Ed.), *Epidemiological approaches in child psychiatry*. London: Academic Press.
Riskin, J. & Faunce, E. E. (1970). Family interaction scales. I. Theoretical framework and method. *Archives of General Psychiatry, 22*, 504–512.
Rosenthal, R. (1966). *Experimenter effects in behavioral research*. New York: Appleton-Century-Crofts.
Rutter, M., Tizard, J. & Whitmore, K. (1970). *Education, health and behaviour*. London: Longmans.
Sevitt, M. & Huffington, C. (1986). *Family interaction in school phobia*. Unpublished manuscript.
Siegel, S. (1956). *Non-parametric statistics for the behavioral sciences*. New York: McGraw-Hill.
Stratford, J., Burck, C. & Kinston, W. (1982). The influence of context on the assessment of family interaction: A clinical study. *Journal of Family Therapy, 4*, 359–371.
Turk, D. C. & Kerns, R. D. (1985). The family in health and illness. In D. C. Turk & R. D. Kerns, (Eds.), *Health, illness, and families*. New York: Wiley.
Watzlawick, P. (1966). A structured family interview. *Family Process, 5*, 256–271.
Winter, W. D. & Ferreira, A. J. (Eds.). (1969). *Research in family interaction: Readings and commentary*. Palo Alto, CA: Science & Behavior Books.

NOTES

[1]For example, a Social Services Department using our FTI for screening potential foster parents, unwisely asked them to discuss fostering. The anxious interaction which resulted was confusing—was it intrinsic to the family or was it part of trying to make a good impression. Also, there was no reason to think that families who would be successful at fostering would be successful at talking about it!

[2]The Family Task Interview may be obtained by application to WK (Family Research Programme) at Brunel University. In addition, a 3-hour videotape, demonstrating three families taking the FTI, is available.